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# HIV/AIDS INTERVENTIONS FOR INJECTING DRUG USERS IN ESTONIA: EVALUATION AND RECOMMENDATIONS

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## ABBREVIATIONS

|                 |   |
|-----------------|---|
| <b>AIDS</b>     | Acquired Immunodeficiency Syndrome                  |
| <b>ART/ARVT</b> | Antiretroviral Therapy                              |
| <b>ARV</b>      | Antiretroviral                                      |
| <b>ATS</b>      | Amphetamine-type stimulants                         |
| <b>EDMC</b>     | Estonian Drug Monitoring Centre                     |
| <b>EHIF</b>     | Estonian Health Insurance Fund                      |
| <b>EU</b>       | European Union                                      |
| <b>GFATM</b>    | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| <b>HAART</b>    | Highly Active Antiretroviral Therapy                |
| <b>HCV</b>      | Hepatitis C Virus                                   |
| <b>HIV</b>      | Human Immunodeficiency Virus                        |
| <b>IDU</b>      | Injecting Drug User                                 |
| <b>IEC</b>      | Information, education, counselling                 |
| <b>M&amp;E</b>  | Monitoring and Evaluation                           |
| <b>MoJ</b>      | Ministry of Justice                                 |
| <b>MoSA</b>     | Ministry of Social Affairs                          |
| <b>NGO</b>      | Non-Governmental Organisation                       |
| <b>NIHD</b>     | National Institute for Health Development           |
| <b>NPHAP</b>    | National Programme for HIV and AIDS prevention      |
| <b>NSDP</b>     | National Strategy for Drug Prevention               |
| <b>NSPs</b>     | Needle and Syringe Programme(s)                     |
| <b>OST</b>      | Opioid Substitution Therapy                         |
| <b>PLWHA</b>    | Person Living with HIV/AIDS                         |
| <b>RDS</b>      | Respondent-Driven Sampling                          |
| <b>TB</b>       | Tuberculosis  |
| <b>UNAIDS</b>   | Joint United Nations Programme on HIV/AIDS          |
| <b>UNODC</b>    | United Nations Office on Drugs and Crime            |
| <b>WHO</b>      | World Health Organization                           |

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## BACKGROUND

At present, Estonia operates in a framework of the fourth national strategy for fighting HIV/AIDS – “National HIV and AIDS Strategy 2006 – 2015”. Financial resources for implementation of the strategy were mainly provided by the state budget and grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Estonia started its 4-year GFATM program on the 1<sup>st</sup> October 2003 and finished it on the 30<sup>th</sup> September 2007. Ending this program is an important turning point in fighting HIV and AIDS in Estonia as GFATM has provided significant extra resources to increase the scale of Estonia’s response to the epidemic. At this point local specialists felt a need to reassess the national response to HIV/AIDS and to provide practical recommendations for further improvement of the national response.

The National Institute for Health Development (NIHD) has requested UNODC to assist with evaluation of HIV/AIDS interventions for injecting drug users. The assignment is performed within the framework of the United Nations Office on Drugs and Crime (UNODC) project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Lithuania, Latvia and Estonia” (XEE/J20) and also contributes to an evaluation of the overall response to HIV/AIDS by UNODC and WHO<sup>1</sup>. The main objective of the UNODC project is to establish a favourable environment in all project countries to better implement HIV/AIDS prevention and care activities among injecting drug users (IDUs) and in prison settings. The project addresses normative policy, capacity building and programmatic aspects of national HIV/AIDS prevention activities. WHO has been supporting the response to HIV/AIDS in Estonia since 2002<sup>2</sup>.

This report has been prepared by Anya Sarang (UNODC consultant) and Martin Donoghoe (Senior Adviser, HIV/AIDS, injecting drug use and harm reduction WHO Regional Office for Europe) as a proceeding from the joint UNODC – WHO Mission to Estonia held in 5-12 January, 2008.

## SUMMARY RECOMMENDATIONS TO UNODC

In order to assist Estonian specialists in the development of sustainable, high quality and effective drug services, UNODC, together with WHO and other partner organizations, could undertake the following activities in the area of technical assistance:

### Pilot projects:

- A project focused on a multi-disciplinary approach to drug service/case management could help identify ways to establish such an approach to service provision at the local and national levels and build a continuum of drugs and HIV services. This project could be implemented by a service organization and should have an explicit focus on service interaction, system of referrals and case management. Outcomes of this projects could take the form of a best practice report with recommendations to other organizations / localities in Estonia, that might also be applied to other countries in the region. This pilot project could focus on drug/HIV treatment integration and developed with the funding/methodological support of UNODC, together with technical assistance from WHO, possibly on the basis of West Tallinn hospital. Such a pilot project should focus on cooperation with Tallinn harm reduction services in order to increase their role in recruiting and educating patients and providing peer-support and care.
- Piloting of long-term certified courses on drugs/harm reduction to relevant specialists could help to prepare a new committed cadre for service organizations as well as expert/ executive bodies. These courses could be provided in different ways (for example, given a high level of internet literacy in Estonia development of internet based courses may be a viable option). Another opportunity is developing and inclusion of short curriculum on drugs/harm reduction within existing education programs, for example for social workers. UNODC in cooperation with a local University/Institute could run a project on development/implementation of such courses. Models, developed in other countries (for example, a short 26 hours course on Harm reduction developed by the Open Society Foundation-Slovakia for the Matej Bel University in Slovakia or a MSc distance learning course on drugs and drug policy provided by London School of Hygiene and Tropical Medicine) could be used and adapted for Estonian situation. The involvement of, and collaboration with, the Harm Reduction Knowledge Hub, hosted by Eurasian Harm Reduction Network (EHRN) in Vilnius, might also be helpful in this regard, particularly with regard to the harm reduction training modules already developed.
- Piloting of pharmacy syringe distribution schemes and possibly vending machines could help to identify new ways to increase accessibility of syringes distribution services and reaching out to previously hidden groups of IDUs. UNODC role could be either in supporting a pilot project on introducing pharmacy schemes in Tallinn or Narva on in providing specific training for pharmacists or site visits to places where such schemes are implemented.
- Overdose represents a major health risk and mortality factor for HIV positive and HIV negative drug users. UNODC, together with WHO, could help to pilot programs focused OD education including Naloxone provision via harm reduction programs schemes. A training on OD prevention and management is currently being developed by HR Knowledge Hub in Vilnius.

### Training, site visits and technical assistance

- Representatives of local drug councils could benefit from a training on the importance of integration of HIV prevention and treatment and other harm reduction activities into local drug plans, especially from the counties where harm reduction activities are currently absent.

- In order to support networking and strengthening of horizontal communications between Estonian specialists, UNODC could support exchange visits of initiative group of Estonian specialists to Vilnius in order to exchange networking experience with Lithuanian coalition 'I can live' and the Eurasian Harm Reduction Network.
- UNODC could support a training for specialists working in drug-free rehabilitation centers. This topic is highly demanded in Estonia and was identified as high priority. This training should include components on integration of HIV prevention/treatment and drug harm reduction education in rehabilitation settings. WHO might be included as a partner to provide some support to such training.
- A training on the role of HR services in HIV treatment provision could help to improve peer-led interventions for HIV positive people. Harm reduction services should pay special attention to recruitment of drug users into treatment programs as well as ensure regular contact with medical facilities for early CD4, viral load and OIs diagnostics; they should also provide peer treatment preparedness education and counselling; carry out treatment literacy work among wide groups of HIV positive clients; train and counsel IDUs on adherence support and provide all kind of support structures in order to retain patients including buddy systems, communicating with doctors, case management, home care and a host of other services. A training for current harm reduction services on HR role in HIV treatment work could help to shape the vision of this role and basic skills of HR service staff. Such a training module, developed in collaboration with WHO, is available from HR Knowledge Hub run by EHRN.
- Police training on harm reduction and public health issues could help to convey importance of cooperation between police and public health services and identify the role of police in harm reduction work with drug users. It could also contribute to the development of policy against such measures as confiscating clean syringes or impeding otherwise prevention and harm reduction efforts by unduly intensive harassment of street drug users and repealing such practices as police attendance to health services, such as ambulance. UNODC could play a strong role by supporting focused training / consultation with police as well as helping to bring these issues on the agenda of both National HIV and Drug Committees.
- On-site technical assistance could be provided to local drug services by regional or national experts. A pool of regional experts on various issues was developed by EHRN HR Knowledge Hub as well as UNAIDS. Such on-site consultations could be provided on request from local organizations and could help to identify and solve various problems faced by service providers.

### **Consultations/working meetings**

- A consultation or a working meeting of members of Drug and HIV National Committees is needed in order to strengthen coordination and interrelation between the two bodies. This meeting (s) should focus on defining ways to improve coordination between the two bodies, establishing formal channels for communications between them as well as revision of the role of the Committees in order to provide them with more decision making power and stronger mechanisms to enforce fulfilment of the two strategies and relevant action plans.
- A meeting between representatives of national expert bodies and local drug councils should take place in addition to training for members of local drug councils. Ways to improve regular communication between national experts and the local drug councils as well as mechanisms of involvement of national/international mechanisms in development of local drug plans should be explored.
- A meeting between various stakeholders, including public health specialists, NGOs, police, prison authorities and service clients could help to identify ways to start working as multidisciplinary teams in order to ensure effectiveness of services and outcomes for particular patients/clients.

- A consultation on strengthening the platform for cooperation and networking of service providers could contribute towards improvement of cooperation between services and strengthen their advocacy efforts. This meeting could lead to establishment of Estonian Network of AIDS Service | drug service | harm reduction organizations or considering other channels of regular communications/networking.
- A consultation is needed in order to discuss issues regarding formalising / institutionalizing professions such as outreach/peer consultant or other ways of improvement of their social/working status. This meeting can take place after a review of current practices in human resources management has been finalized and recommendations drafted for discussion (see recommendation below).
- A consultation is needed on ways to improve HCV prevention and treatment among drug injectors. EHRN HR Knowledge Hub, supported by UNODC and WHO could play a leading role in facilitating local discussion on HCV and strengthening prevention and treatment issues and providing training for local specialists.
- A consultation on the issues of stigma and discrimination held between PLWHAs, NGOs (including harm reduction), police, medical and social workers of general medical services, human rights organizations and officials of MoSA, Mol, MoJ and service clients could help to identify major factors, prohibiting equal access of IDUs, including PLWHAs to medical and social care, prevention and treatment programs and identify ways to address this issue.
- Broader socio-economic issues affecting lives of drug users should be taken into consideration while planning health services. In order to bring this message to national policy makers local drug services should increase their advocacy skills and profile. They should play a crucial role in advocating for consideration of various issues related to vulnerable groups such as drug users and structural solutions of social inequality problems. Besides advocating for broader social change and consideration of drug users needs in policy and economic reforms, drug services could examine ways to provide response to pressing everyday needs of drug users. Such issues include: linking drug users with existing shelters or opening specialized shelters for drug users; possible provision of food and second-hand clothes; help with finding employment and acquiring health insurance; professional training or language skills courses. Other immediate and long term solutions could be identified in more thorough consultation with drug users and Estonian and international drug service specialists.

### **Research/analysis/evaluation**

- A focused analysis of structural barriers to integrating health services, including legislation and general organization of the public health system, carried out by WHO and international PH experts could provide recommendations on possible structural changes, including changes in legislation and normative base, as well as actual organization of public health system.
- Human resource management remains a major structural barrier to effective development of drug services in Estonia. A careful audit of current human resource management practices could help to reveal the main problems with sustainable system of human resource management within organizations such as contractual and social protection issues. Legal expertise is necessary in order to analyse the existing situation in organizations and development of guidance for improving working conditions of the employees. UNODC could initiate/fund a legal review of current practices of human resource management , contracting and relevant issues with the aim to develop recommendations for service providers.
- Developing protocols and tools for quality monitoring of drug services is necessary in order to progress in improvement of quality of services and should become a priority issue for NIHD and other local specialists. An evaluation study, similar to on-going evaluation of the quality of opioid substitution therapy in Estonia should be carried out in

relation to NSP and other services for drug users. This study could help to identify important areas for the quality monitoring protocols. It is important that this evaluation, as well as further regular quality monitoring and evaluation work, should focus on participatory approach and place program clients as core contributors. Based on evaluation findings and analysis of international best practice, a Code of Good Practice in Harm Reduction could be developed which could help service providers to adjust their programs quality standards to best international and local practices.

- A needs assessment study for groups with special needs, such as female IDUs, young/intermittent injectors and amphetamine injectors and users could help to identify ways to better involve these groups into current services. Support to a specially designed peer-driven intervention / study could help to establish access and peer-education in these hard-to-reach groups.
- A careful review of national drug policies should be undertaken in order to improve context of HIV prevention and treatment work in the country. A careful analysis could help to identify laws and policies that might undermine public health efforts in dealing with drug problems. Such laws/policies as legal punishments for drug use per se and for possession for personal use and the way they are enforced in Estonia should be reviewed and options for alternative sentencing should be explored and options for optimising the system by decreasing of the rate of imprisonment among drug users suggested. Other recommendations that could help to adjust Estonian drug legislation to increasing public health problems and that do not contradict International Drug Conventions should be explored.

## METHODS

The report is based on two general sources: desk review of existing literature and field data received during mission to Estonia.

The desk review included studies, evaluations, mission reports and other relevant documentation, both published and unpublished.

This data received during the field mission included additional documentation, individual and group interviews, focus groups with key informants and limited observations.

The field interviews were held with people from a wide range of professions and involvement with HIV/AIDS and injecting drug use issues, at sites in the two geographic locations that account for the majority of HIV cases registered in Estonia: Tallinn (and surrounding area in North Estonia called Harjumaa county) and Ida-Virumaa (a county in North Eastern Estonia with the principle city of Narva)<sup>3</sup>. The specialist interviewed included medical specialists, drug services providers (including managers and field workers), representatives of groups of affected communities (such as members of Estonian network of PLWHAs, officials from Ministry of Social Affairs, Ministry of Justice, and Ministry of Internal Affairs. The list of interviewees is provided in Annex 1.

Two focus groups with IDU clients of drug services took place in Tallinn and Kohtla-Järve. The Tallinn focus group included 6 men aged approximately 25-35 y/o. and the Kohtla-Järve focus group included 4 men aged approximately between 23-45 y/o. The focus groups were not tape recorded but recorded by hand. Both focus groups lasted between 1.5 and 2 hours. All participants were informed about anonymity of the results and confidentiality of personal information. They were also provided small incentives for their time and effort.

## COUNTRY HIV AND DRUGS SITUATION

By the end of 2007, Estonia had reported a cumulative total of 6364 HIV cases; 191 of these cases had developed AIDS<sup>4</sup>. However, an estimated number of HIV positive IDUs in Estonia in 2006 was 7,486 (95% 4392-18,575) which is a bit higher than the registered HIV infections<sup>5</sup>. Although the number of newly reported HIV cases peaked in 2001 with 1 474 cases and has been declining since, Estonia has continued to report comparatively high number of new cases each year. For the year 2007, Estonia reported 633 new HIV cases<sup>6</sup>, and 68 new AIDS cases. This reported HIV incidence (peaking at 1078.3 per 1 million inhabitants in 2001 and 496.8 per 1 million inhabitants in 2006) has been the highest in the WHO European Region since year 2001. According to UNAIDS, Estonia has the highest estimated adult national HIV prevalence in Europe - about 1,3% of the adult population (aged between 15 and 49).

While the majority of cases are registered among men and the number of reported cases among women has declined from 353 in 2001 to 259 in 2007, the proportion of women among newly reported HIV cases has been steadily increasing in recent years (from 20% in 2000 to 36% in 2006). Cases among women are either IDU or the sexual partners of male injectors and there is no evidence of a generalization of the epidemic. The proportion of younger people (under 25 years) among newly reported HIV cases has been decreasing in recent years (from 82.8% in 2000 to 45.2% in 2006).

Since 2000, HIV has mainly been transmitted through the sharing of drug injection equipment. Injecting drug use is the predominant route of transmission of HIV cases in most eastern European countries. Although the proportion of non-IDU cases has been increasing in recent years, particularly among women, the majority (approximately 83% of those with a known transmission route in 2006) of new infections were among injecting drug users (IDUs). The majority

of non-IDU cases among women are the sexual partners of male injectors. Most HIV infections are reported from IDUs in Kohtla-Järve, Narva and Tallinn among Russian-speaking Estonians.

The estimated number of IDUs in Estonia is 13,801 (95% CI 8 132-34 443) of whom 12 387 are male and 1 414 are female<sup>7</sup>. Rates of drug injecting are higher among the Russian minority group in Estonia: according to a 2005 RDS study, while the overall prevalence of injection drug use reaches 2.4% of the general population of Estonia aged 15-44, it could be as high as 7.3% among Russian speakers and as low as 0.43% among Estonian nationals<sup>8</sup>. The illicit opioid drugs, methylfentanyl and methylfentanyl mixed with fentanyl, known as China and Persian white (*Valge hiinlane* and *Valge parslane* in Estonian) first appeared in Estonia in 2001 and are the most commonly injected drugs in Estonia, used by 65% of injectors in Tallinn and Kohtla-Järve in 2005. Drug injectors also inject amphetamine (62%) and homemade opiates (30%). Heroin injection is less common (24%)<sup>9</sup>. Many injectors are poly-drug users. Seizures of fentanyl and methylfentanyl have become bigger than those of heroin, further evidence that these drugs are increasingly available<sup>10</sup>.

The recent sharing of syringes (in the four weeks prior to interview) was reported by 29% of injectors – 32% in Tallin and 19% in Kohtla-Järve - (in 2002 it was estimated that 50% of IDUs shared injecting equipment), although 81% knew that syringe sharing can spread HIV infection<sup>11</sup>. These reductions in sharing rates are comparable with those observed in other European countries, but greater reductions in sharing might be expected given the high prevalence of HIV in Estonia. HIV prevalence among injectors in 2005 was reported to be 54% in Tallinn and 90% in Kohtla-Jarve<sup>12</sup>, among the highest rates reported anywhere in Europe and in the World<sup>13</sup>. Sharing rates are lower in Kohtla-Järve possibly because of the higher HIV prevalence, but also because of the greater coverage with NSPs (see below). Only 12% of injectors report having never shared.

There is no surveillance of hepatitis B or C among drug injectors and the surveillance system does not allow for identification of risk factors, so there are no official prevalence estimates for hepatitis among IDUs. HCV prevalence among drug injectors of 90% in Tallinn and 89% in Ida Viruma has been reported<sup>14</sup>. Results of 2005 community survey revealed that 65% out of 450 IDU-participants have ever experienced overdose. Of those, two thirds (69%, 203/293) have experienced overdose within the last year (mean number of episodes: 2.2, range 1-48).

The overall HIV and drugs situation has changed little in the last 5 years, with an HIV epidemic that remains primarily concentrated among IDUs (and to a lesser extent in their sexual partners) in specific geographic areas. As in 2002 targeted (harm reduction) interventions for injecting drug users, including opioid substitution therapy, still offer the best solution to the ongoing HIV crisis in Estonia.

## 1. OVERALL SYSTEM OF SERVICE PROVISION TO DRUG USERS

### 1.1 VISION, STRATEGY AND COORDINATION IN THE FIELD OF HIV/DRUGS

There are 2 main strategic frameworks which define Estonia's work in the area of drugs and HIV: the Estonian National HIV and AIDS Strategy for 2006-2015 and the National Drug Strategy.

Estonian National HIV and AIDS strategy for 2006 – 2015 was accepted in 2005. The main goal of the strategy is to is “achieve a constant decline tendency of HIV incidence rate in Estonia”. The strategy utilizes the Three Ones principles and is based on important general principles, such as respect for human rights, based on evidence, harm reduction, involvement of affected communities, versatility and comprehensiveness, gender equality, cooperation and partnership, consistency and sustainability, transparency, consideration of international declarations on HIV. The strategy explicitly prioritizes prevention activities among injecting drug users by applying harm reduction strategies. The Governmental Commission on HIV/AIDS is the main body, responsible for coordinating and oversight of the implementation of the strategy. The main organ responsible for implementation of the strategy is the Ministry of Social Affairs.

National Strategy for Prevention of Drug Dependency 2006-2012 (NSPDD) was accepted in Estonia in 2006. It succeeded the first multi-disciplinary drug strategy for 1997–2007 and replaced it in 2004. Concrete measures and actions are described in relevant Action Plans. The new strategy includes six fields of activity – prevention, treatment/rehabilitation, harm reduction, supply reduction, drugs in prison and monitoring and evaluation of the drug situation. The aim of the strategy is to develop a common drug policy focused at supply, demand and harm reduction. One of the priorities of the new strategy is strengthening the drug addiction treatment and rehabilitation system as well as raising the quality of the services offered and making them better accessible to the drug users<sup>15</sup>.

An earlier WHO evaluation noted that the linkages between the previous Alcohol and Drug Abuse Prevention Programme and HIV/AIDS prevention had been weak, with no joint activities and little evidence of cooperation<sup>16</sup>. In this regard little has seemed to improve since 2002. In fact, some specialists mentioned as a positive development that there is no overlap between the two programs: for example all harm reduction activities are covered by the HIV/AIDS Strategy.

The main body responsible for coordinating all drug related activities in the country is Government Committee for Drug Prevention (GCDP) established in 2006. The commission consists of representatives of all ministries involved in the implementation of the drug strategy, the Estonian Psychiatrist Union, Estonian Cities Union, Board of the Border Guard and Estonian Drug Monitoring Centre (according to MoSA specialists, many experts overlap with HIV Committee). The GCDP is responsible for revising the strategy, as well as approving the annual implementation plans and draft action plans for the years 2007-2009 and 2010-2012. The Government Commission has to draft an overview of the implementation of the drug strategy and submit it to the Government by 1 March. According to the Government Order No 172 of March 10, 2006 the EDMC is responsible for providing the GCDP with a report on drug situation twice a year (February 1st; July 1st)<sup>17</sup>. Both the Ministry of Social Affairs and part with other ministries, such as the Ministry of Justice, Department of Interior and Ministry of Education, are responsible for the realization of the drug strategy. The main body responsible for implementation of the strategy and its Action Plan is the National Institute for Health Development.

The facts that there is no overlap between the drug strategy and HIV/AIDS strategy and that the drug strategy indicates that all issues related to harm reduction are included in the HIV/AIDS strategy, raises the issue that harm reduction is still viewed in Estonia not as a cross-cutting approach to all drug related issues, but as a separate set of activities related exclusively to issues of HIV/AIDS. This is also reflected in the overall organization and coordination of services. As discussed in Section 3 of this report, issues such as policing and law enforcement are important factors for success of efforts aimed at HIV prevention and treatment and reduction of other health related harms among drug users. These factors fall under the sphere of drug control rather than HIV strategy. At the same time, this report as well a previous 2005 evaluation<sup>18</sup>, finds that drug users are cautious and fearful of law enforcement practices and policing which often deters them from approaching health services, even in life-threatening situations such as drug overdose, let alone less urgent issues. There is an urgent need for much closer coordination and interrelation between the drug and HIV strategies and coordinating bodies. Issues related to health and quality of life of drug users should be included in the drug strategy.

A good example of coordinated expert work on drug and HIV issues was provided by a working group on harm reduction that was operating during the development of the National HIV/AIDS strategy. However, according to NIHD specialists, this group did not meet since 2005. Potentially, an expert group like this could become a steering body for development of overall drugs and HIV strategies, reviewing the current state of affairs, developing suggestions for improvement of the situation and making these suggestions issues for approval of the National Drug and HIV Committees. However, while both HIV and Drugs Commissions are ascribed the role of supervision of the National Strategies, the actual power of the Commissions to act in case of deviations from the set targets or action plans appears to be weak. The following example illustrates this.

**What can the National HIV/AIDS Commission do? The case of OST in prisons.** According to the National AIDS Strategy, the OST programs in correctional facilities were due to start in 2006. However, at the time of the evaluation, in early 2008, there was still no clear vision of initiating these programs. The particular issue was mainly due to two factors: (1) uncertainty within the MoJ on the general ministry policy in regards to OST programs and (2) absence of coordination mechanisms with other ministries, particularly with the Ministry of Interior who were to start OST provision in the Mol jurisdictional Arrest Houses simultaneously with the MoJ programs in their facilities in order to prevent service provision gap between receiving OST outside and inside prisons. However, it was difficult to coordinate this issue with the Mol who didn't have similar plans. According to the MoSA specialists, neither the HIV nor Drug Commissions could do anything in this situation in terms of steering coordination between the relevant ministries, and they were also not assigned a power to issue formal decrees or regulations or any other formal tools to enforce the Strategy implementation and their role would be limited to "persuading the ministries" which apparently wasn't very effective.

**Box 1**

While the Ministry of Social Affairs was supposed to be one of the main actors for realization of the Drug Strategy and the main coordinating/supervising body for the HIV/AIDS Strategy with large drugs-related/harm reduction component, the capacities of the Ministry in this area were rather limited. According to the Ministry officials, the position of the main drug specialist within the Ministry was vacant for 1.5 years. A new specialist started her work in summer, 2008 and still has to grasp all the development work that remains undone. According to these officials, drugs are the least developed area within the Ministry and the main expertise in the area lies within NIHD.

Additional complexity to overall coordination of drugs and HIV, is coordination with rural municipality and city governments, which have their own plans on drugs and HIV approved by the Local Government Councils<sup>19</sup>. Each of 15 counties in Estonia has their own county drug councils which plan the local activities on drugs. These councils comprise people who work on a voluntary basis and are usually nominated by the local county leaders and may have limited knowledge of drugs and HIV issues, According to MoSA officials these councils coordinate both national and local funds and the Ministry, together with other Republican government executives, do not have any power of authority over these Councils. In terms of National Funds, in 2006, EUR 89,157 was allocated from the National Strategy on the Prevention of Drug Dependency 2004-2012 to local drug prevention or health promotion boards. Different counties received from EUR 5,369 to EUR 7,286. These resources were mainly spent on activities in schools, 'general drug prevention' or various local conferences<sup>20</sup>. It seems that the level of coordination/communication with the local councils and other stakeholders, for example, NIHD is quite low and they can rarely influence each others planning and implementation of activities, despite the fact that NIHD channels the funds to the county councils. NIHD specialists expressed concern regarding the lack of communication with the local councils, especially in the area of coordination of targeted activities. Since funds allocated to the counties are rather small it was proposed that better use would be targeted prevention among IDUs and other risk groups, however, the local councils lack special expertise on issues related to drugs and HIV and prefer not to tackle more specific harm reduction issues.

So far, only Tallinn City Government has funded activities aimed at prevention or reduction of HIV transmission among risk groups<sup>21</sup>. At the same time, local funding may become a crucial source of support for targeted interventions on the local level, especially in counties and municipalities where no interventions among IDUs are currently implemented (See Section 2 on gaps in geographical distribution of services for IDUs).

## **Recommendations:**

There is an urgent need for much closer coordination and interrelation between the drug and HIV strategies and coordinating bodies.

UNODC could help to organize a working meeting and facilitate discussion between experts involved in the Committees on Drugs and HIV aimed at defining ways to improve coordination between the two bodies including such options as having regular joint meetings of the two Committees, uniting the two bodies or at least establishing formal channels for communications between them.

The experts involved in 2 Committees should also review the role of the Committees in order to provide them with more decision making power and stronger mechanisms to enforce fulfilment of the two strategies and relevant action plans. Clear and transparent mechanisms of accountability for fulfilment of the action plans by responsible parties should be developed.

Ways to improve regular communication between national experts and the local drug councils should be explored. It is important that planning of prevention work on the local level is guided by expert advice, and international and national evidence base. It seems that for some localities strategic planning of allocation of scarce resources is vital for supporting local targeted prevention that is not currently supported from national sources. As for UNODC role, it could fund/organize training on harm reduction issues for members of local councils especially from counties where harm reduction programs are currently absent. It would also be good to organize at least one working meeting between representatives of local drug councils from different counties with the national experts, such as NIHD and NGO Convictus, where mechanisms of communication with the national and international experts and involvement of them into development of local strategies and action plans could be discussed.

## **1.2 SYSTEMATIC APPROACH TO SERVICE PROVISION**

Organization of the public health system in Estonia has been regulated by the Public Health Act (1995–2001) and since 2002 by the Health Services Organisation Act. These Acts have settled the status and the principles of the public health network in Estonia. They have provided a legal base for national health programmes of prevention of transmittable diseases, alcohol and drug addiction<sup>22</sup>. However, according to field data and literature review, these acts have so far not been utilized to the extent sufficient to improve coordination and communication between different services.

Creating an integrated, client oriented and friendly system of service provision is essential in delivery of timely and high quality services to injecting drug users. Best practice experience demonstrates that services best serve IDU clients needs when they are designed in a model of 'one stop shopping' – when a person can receive as many services as needed in one conveniently situated and client-friendly place. This model not only makes access to essential prevention and treatment services easier for drug users themselves, but also promotes collaboration and exchange between specialists in different fields. For HIV treatment programs for drug dependent individuals, as well as for treatment of other conditions, such as tuberculosis data from various studies provides evidence, that integrating services at a single site may improve both medical and substance dependence treatment outcomes<sup>23</sup>. This concept is yet to be strategically developed in Estonia.

As noted in the 2006 evaluation report, fragmentation of services in Estonia is one of the main barriers to effective service provision to drug users and is a legacy of the Soviet health system that Estonia had not yet fully overcome<sup>24</sup>. Meetings with representatives of various service providing organizations revealed that the situation hasn't really changed during the past 2 years: while separate services, for example, needle provision in some sites could be quite well developed, the overall system on both national and local levels seem to be very fragmented. This may be related to the issues discussed above, particularly difficulties with development and

adhering to a unified vision, strategy and coordination on drugs issues on the national and local level. Wherever the problem roots, fragmentation of services has direct negative consequences both for access by those people who are supposed to benefit from them, i.e. drug users and for efficiency of separate services and the overall health system.

One story told by a young HIV positive drug injector who participated in the focus group in Kohtla-Järve illustrates an extreme example of the fragmentation of medical services for people with severe health conditions.

**Seeking for medical help in Kohtla-Jarve.** In December, 2007 Sergey<sup>25</sup> (HIV positive, opiate user, about 24 years old<sup>26</sup>) started to have epileptic seizures. He was very scared by this new health condition and couldn't figure out what was going on with him. Since all HIV positive people have to receive treatment for general health conditions in infectious disease hospital, Sergey had to consider appealing to his infectionist. During the initial examination, he was told that he would be accepted to the hospital, but only with the condition that he brings along his own medications for his epileptic condition. In order to receive this medication Sergey had to seek an appointment with a neurologist, for which he had to enroll into a waiting list. In addition to that, he had to travel to social services in order to receive a guarantee letter that the medication costs will be covered by the State. However, even after the neurologist examination, the required drugs were not provided directly to Sergey: according to the procedure, the neurologist had to write a recommendation to Sergey's GP so that the GP could prescribe the drugs to Sergey. After the recommendation has been issued, Sergey visited his GP, who prescribed drugs, recommended by the neurologist. Still, after he received the drugs, he could not just go directly to the hospital as he had to receive the referral from his treating infectionist. Since the infectionist sees patients only on Thursday it was difficult for Sergey to organize his appointment. At the time of the focus group he was on what seemed to be a late stage of this process and was looking forward to seeing the infectionist and finally get into hospital but, had to admit that the whole procedure had taken a lot of his energy and he would never had sought treatment if the condition was not so frightening.

**Box 2**

This example clearly illustrates the client's perspective on the not integrated and client unfriendly service provision as a system (or lack of such).

A particular area where bringing services together is crucial for achieving positive outcomes is provision of antiretroviral therapy for drug dependent individuals. The WHO Clinical Protocol for the European Region (Chapter 5, HIV/AIDS treatment and care for injecting drug users)<sup>27</sup> states that:

"HIV/AIDS treatment and care, including HAART, should be delivered as part of a comprehensive care model. Combining or integrating HIV/AIDS and substance dependence services provides opportunities for HIV prevention, enhances adherence to both HIV/AIDS and substance dependence treatment and provides better overall care. A comprehensive service develops expertise in effectively treating substance dependence and providing HIV care".

The Protocol provides several models for effectively combining HIV prevention, treatment and care with substance dependence treatment, including:

- a single site for both HIV/AIDS care and substance dependence treatment:
  - on-site HIV/AIDS medical care in substance dependence treatment facilities or
  - substance dependence treatment in HIV/AIDS services ;
- separate HIV/AIDS and substance dependence treatment services in close proximity with good coordination and liaising, including referrals to other services; and

- primary care services for both drug dependence management and HIV/AIDS care through general practitioners or office-based practice”.

Furthermore, the Protocols explicitly call for integration of drug and HIV treatment programs, stating that:

“Where substitution therapy is available, consideration should be given to offering HIV/AIDS medical care and providing HAART at the same site from which drug substitution therapy is provided. This approach can:

- achieve maximal levels of treatment supervision
- enhance efficacy
- reduce the risk of developing ARV drug resistance
- facilitate the management of interactions between methadone and HIV/AIDS medications.

Other benefits of prescribing HAART in OST clinics include:

- the possibility of concurrent long-term treatment for drug dependence and HIV/AIDS;
- the opportunity to use directly observed treatment (DOT) in dispensing ART to patients who already visit the clinics daily to receive methadone ; and
- experience in treating medical conditions related to substance use”.

However, this best practice guidance has obviously not been adopted within the Estonian health system. ARV and related services are still provided separately from drug treatment and communication between the two services is sometimes poor. Even in what seems to be the most developed medical institution in Estonia - the West-Tallinn Central hospital - no consideration is given for providing on-site access to opioid substitution treatment for HIV patients with drug dependence. This service is provided separately in the Psychiatry Centre, situated in a different location. At the same time, while this obvious measure of improving the system of service provision is ignored, medical specialists expressed their concern regarding adherence of drug users to HIV therapy. According to the specialists, the “blame” for poor adherence and treatment uptake lies with the patients rather than imperfect ways the services are provided.

A continuum of drug services should not only comprise medical institutions, but all actors who contact drug users, including the police and law enforcement services who see drug users on a very regular basis. There is great potential for police involvement in effective provision of HIV and drug – related prevention and treatment services, ranging from referral to medical and prevention services, such as drug treatment and harm reduction programs, to direct provision of prevention materials, such as sterile needles.

However, during our meeting with officials from the Ministry of Interior it became clear that referral to medical services for IDUs and provision of health related information, let alone services, is not applied or even conceived in the police settings. When we talked to possible prevention interventions with officials from the MoI they seemed keener on police involvement in school based drug prevention interventions than in providing health information to current drug users. At the same time, global scientific research provides no evidence base for effectiveness of police-led drug prevention school programs, in fact several studies pointed out that such programs have not been effective at all. Besides, as noted in the previous evaluation report “unfortunately, most of the vulnerable populations are not in school”<sup>28</sup> and in order to influence the situation with HIV the police have to focus their prevention efforts with people who already inject drugs.

Generally, the officials viewed police involvement in HIV care for IDUs as limited mainly to provision of ARV drugs within the arrest houses; this is the role that was prescribed to the police by the National AIDS Strategy. Currently, communications of the police with medical facilities while dealing with IDUs is limited to referral by police to specialized hospitals in case of severe health conditions. However, it was stated, that the police already started cooperation with the MoSA. MoSA has provided information on drugs and infections which will be delivered to all

police officers who work on the streets and meet drug users. It is expected that police officers will then be able to deliver the same information to drug users. However, this information will only be provided in written form and no training will be held to help police officers develop their communication approaches and skills on HIV and other drug related risks counselling. The police could have a much bigger role in preventing HIV and other drug-related health risks if better strategic communication and collaboration was maintained with the police and health authorities. Drug users in Estonia seem to have more respect for police officers than for example in many other countries of the former Soviet Union, e.g. during focus groups it was noted by drug users themselves that Estonian police officers are not corrupt and for example, as a general rule they would not take bribes or plant drugs on drug users. This more or less favourable attitude could provide additional credit to police officers in providing health information, advice and referral to drug users. Systematic cooperation and communication between police, the MoSA and drug/HIV service providers in Estonia could provide a useful platform for developing of additional and more intensive prevention and care measures.

Another obvious place where many drug users congregate at times is correctional facilities, which will be the focus of a separate report. However, it is important to note, that lack of a systematic approach to developing services for drug users can lead to serious problems, such as interruption of medical treatment for drug dependence which currently presents a big challenge for Estonian service providers. Several drug users who participated in the Tallinn FG shared their experience of such treatment interruption, for example: *I went to the [methadone] program for half a year, then I got into prison for half a year [where they don't have methadone]... so for 3 months I was 'recovering'*. This person did not come back to the methadone program after his release, reasoning that since he managed to get rid of methadone dependence in prison he didn't want to return to the program. However, after a short period of time, he returned to illicit drug use and the previous level of problems related to it. Another person shared that he experienced very painful withdrawals while in prison, but the *"prison doctor just said: so what do you want, you should have been thinking with your head when you got enrolled into methadone..."* As many drug users experience imprisonment and are aware of the risk of imprisonment, the perspective of treatment interruption in correctional facilities serve as a powerful disincentive for them to enrol into opioid substitution treatment programs.

As in most other countries prison is a common experience for injectors in Estonia; 64% report being in prison at some time and 58% had been arrested at least once in the prior year. Multivariate analysis demonstrates that IDUs in Estonia who had ever been in prison had nearly twice the odds of being positive compared to their counterparts.

This is one of many possible examples, how one service cannot really be fully effective in a situation when a systematic approach to building a continuum of services is absent. This issue should be one of the main priorities for consideration between policy makers and service implementers in Estonia.

### **Recommendations:**

While this evaluation revealed many inconsistencies and fragmentation of the public health system, its scope was not broad enough to analyse in detail the structural roots of such a situation. UNODC/WHO could invite international experts in order to carry out a focused analysis of structural barriers to integrating health services, including legislation and general organization of the public health system which could provide recommendations on possible structural changes, including changes in legislation and normative base, as well as actual organization of public health system.

Apart from broader structural changes, a more regular interaction between existing public health service providers could help to identify ways to forming a multi-disciplinary approach to service provision and building a continuum of drugs and HIV services. Various stakeholders, including public health specialists, NGOs, police, and prison authorities should start working as multidisciplinary teams in order to ensure effectiveness of services and outcomes for particular patients/clients. There are two ways to address this issue – either by supporting a pilot project on

multi-disciplinary approach in one city, or by trying to facilitate a dialogue between different service providers on the national level and developing recommendations for cooperation on the local level. Such consultation should include not only service providers but also clients and patients.

### 1.3 NETWORKING AND PARTNERSHIP OF SERVICE PROVIDERS

Partnerships, alliances and networking, between various individual and organizational stakeholders are key to designing, sustaining and optimizing an effective system of drug/HIV service provision, exchanging of best practices and advocating for more effective services and more enabling environments. Estonia provides several good practice examples of such mutually beneficial alliances.

There are several good practice examples of collaboration between two or groups of organizations, one of the most notable was preparation of the National Strategy on HIV AIDS and the working group on harm reduction when several organizations and experts worked in one effort.

The Network of People living with HIV/AIDS is a new organization, which was formed 1,5 years ago when separate people and organizations decided that joint efforts on advocacy and service provision for PLWH would be stronger than divided initiatives. The Network was registered as an official organization with its Statute and formal membership. The main aim is to represent the interests of PLWHs and advocate on their behalf and also improve communication between people with HIV. There are about 50 official members of the network with a core group of 20-25 actively working members. Currently the main project of the Network is support of peer counseling cabinets in Tallinn and Narva. The Network is represented in the National AIDS Committee and recently they were also included into the National Commission on ARV procurement.

***Estonian NGOs unite in response to possible budget cuts.*** One spontaneous and strong joint advocacy effort helped to secure the previous level of funding of programs previously supported by GFATM. In June 2007, several AIDS service NGOs, including Convictus, The Network of PLWHAs, AIDS Information and Support Centre, Rehabilitation Centres from Narva and Sillamäe, women's organization LiGO and other organizations were participating in a meeting on advocacy which was organized for Estonian HIV/drug service organizations and hosted by the GF Civil Society Team and the World AIDS Campaign representatives. Coincidentally, right during the meeting, the local press published an article, that the Government was going to dramatically decrease the level of funding for HIV-related activities previously funded by GFATM. When one of the participants brought this information to the attention of other trainees, they decided that they should jointly act upon this information. They initiated an appeal to the government, which was supported by 17 organizations in Estonia. They also circulated the letter among international HIV activists, such as International Treatment Preparedness Coalition who also provided swift reaction to the situation – as a result more than 100 civil society organizations, unions and activists from over 40 countries have sent their support to the Estonian NGO Coalition by signing on the appeal calling upon the Estonian Government to live up to its commitments made in the Declaration of Commitment on HIV and AIDS. The international public appeal was sent to the Estonian Government and published in the media on the 20th August 2007. As a result of this action, the government declared its decision not to cut down the funding for HIV programs and decided to support them at the previous level<sup>29</sup>.

**Box 3**

Another good example of collaboration is provided by NGO Convictus and the Ministry of Justice:

**Cooperation between non-governmental and governmental organizations in prisons.**

A good example of established and enriching partnership is provided by collaboration between the Ministry of Justice and NGO Convictus. Convictus Eesti is a non-governmental organization situated in Tallinn and specializing in providing psychosocial help and counseling for HIV-positive drug users. It started its work in October 2002 and one of the main directions of the organization's work includes providing counseling, support and access to prevention information and materials for inmates and personal in all Estonian prisons. This work was started in 2002 and Convictus was working hard on establishing their position and relations with inmates as well as prison staff. Convictus also played a leading role in initiating a system of social support for people that are released from prisons including case management, referral to medical social institutions, and group support. In 2003-2007 the work of Convictus inside and outside prisons was supported within the program funded by GFATM. While implementing these activities, Convictus established good working relations with the Ministry of Justice. When the GFATM grant finished, the Ministry of Justice supported and even increased the level of financing of the Convictus prisons-related activities. Moreover, the Ministry is currently adopting and institutionalizing the best practices developed by Convictus: the current reform within the Ministry envisages developing a comprehensive approach to social support to inmates and the released. It includes creation of a Social Care Division within the Prisons' Department of the MoJ<sup>30</sup>. One positive outcome of this new comprehensive strategy is creating a wider platform for communication of various organizations and services that work in the field. However in February 2008 the authors of this report were informed of signs of local policy shift in the Estonian MoJ and suggestions to cut down the role of Convictus within prison system and relevant budget decrease. While hoping that the situation will change to the better, this situation should be taken as a serious sign of instable and vulnerable position of NGOs in partnership with the government and lack of genuine consideration of importance and professionalism of their expertise.

**Box 4**

Overall, these examples illustrate that networking in Estonia has a good potential, however, interviews with stakeholders showed that while some structures and platforms for intersectoral collaboration, such as the Commission on HIV/AIDS have been formally introduced, and despite the positive examples provided above, the regular horizontal cooperation and communication between partners or potential partners is rather weak. It seemed from the interviews that even people doing the same work, such as needle and syringe provision in one city, rarely communicate with each other. When prompted to provide examples of cooperation and networking, representatives of these organizations often referred to situations that happened 3-4 years ago. In fact, sometimes, relationships between different organizations can even be characterized as hostile and competitive.

The WHO Clinical Protocol on HIV treatment for Europe states that "The effectiveness of the [integrated treatment] models will depend on the infrastructure and organization of the health care system. Where specialized departments (for example, drug treatment centres and departments of internal medicine) exist, liaising and case management should be common practice<sup>31</sup>. In Estonia it seemed that weak cooperation and communication between service providers leads to difficulties in development of effective case management systems. While the concept of case management was mentioned many times and by different stakeholders, this approach is not developed in Estonia. As stressed by one interviewee: *"case management approach is virtually absent. The Network [of PLWHA] provides some support they can take their clients to other organization, but all that is not done on a systematic basis"*

Given the patchwork character of service provision in Estonia, establishing viable channels of regular communication and wider platform for expert collaboration, problem solving and advocacy efforts may be vital for improving the overall system of service provision, help to identify and find solutions for existing and newly emerging problems.

## **Recommendations:**

Strengthening the platform for cooperation and networking of service providers is crucial in order to improve services and strengthen advocacy efforts of single organizations. This could be achieved by facilitating networking activities for example establishment of Estonian Network of AIDS Service |drug service|harm reduction organizations or considering other channels of regular communications/networking. UNODC could play a role in facilitating such networking by supporting an initiative group of people who wish to work on establishment of such network and providing a space for a first network meeting, other options include exchange of experience with Lithuanian colleagues or similar networks in other countries.

### 1.4 HUMAN RESOURCE DEVELOPMENT

The history of harm reduction in the Central and Eastern European region demonstrated that one area that is rarely considered when shifting from pilot projects to systematic government supported work is consideration for new requirements and quality of human resources involved in the field. When harm reduction work started in the countries of the region it was most often led by enthusiasts who were ready to work without weekends and salaries in order to advance the harm reduction approach to drug issues. A great number of these enthusiasts and highly motivated professionals still work in the drug and HIV fields in Estonia. However, shifting to wider institutionalization of drug and HIV services also means that the system cannot rely only on enthusiasts and highly motivated individuals any longer. It has to provide a platform for systematic 'nurturing' and sustaining of human resources in the area. Interviews with specialists in Estonia demonstrated that development of human resources in this field clearly lacks a strategic and methodical approach, and this serves as an indicator that the general systematic work in the field is underdeveloped. Several issues appear to be current strategic priorities in the development of human resources: including a lack of systematic education and poor conditions of work for professionals involved in the field.

#### EDUCATION FOR DRUG SPECIALISTS

The MoSA specialists reported that currently there is no state educational program to prepare drug specialists in Estonia. There is one educational centre in Tartu (Department of Public Health, University of Tartu) which has a master program on public health and prepares general Public Health specialists. This Centre has capacities to prepare about 10 specialists per year. However, this program does not provide any special training on drugs issues. There are other courses and university educational programs for social workers, but no special drug-related information, apart from very basic bio-chemical issues of drugs actions, is integrated within the curriculum. Even drug treatment specialists in Estonia have no special training, just general medical education.

As for current staff of drug services such as harm reduction, particularly NIHD sub-recipients, it was reported that NIHD managed to establish an on-going system of training support. The trainings provided by NIHD are carried out in the form of 1-3 day sessions on different matters that are required by the sub-recipients. In the beginning of year, NIHD carries out a needs assessment in order to find out which topics should be covered by the training program and then shapes this program accordingly. Most service providers expressed satisfaction with the system and sufficient coverage of topics. These trainings are provided in a centralised manner, so besides getting information and education, service providers also get a chance to network and exchange best practices with each others which is also an important part of the activity.

In 2007 the trainings organized or financed through NIHD for drug services service providers included:

- social work principles – trainer Natalja Umarova (as an independent trainer)
- case management principles – trainer Linda Brandt through WHO
- conducting the Respondent Driven Sampling study among IDUs – trainers from Tartu University and NIHD
- HIV in Estonia – trainers from West-Tallinn Central Hospital

- Infection control - trainers from West-Tallinn Central Hospital and North Estonia Medical Centre
- Stigma and discrimination related to HIV and AIDS – trainer David Parker, University of South Carolina
- Training for pharmacists on drug abuse and drugs – Anu Neuman and Anu Harjo (as independent trainers)

In addition to trainings provided by NIHD, a few trainings were available by the Regional Harm Reduction Knowledge Hub for Europe and Central Asia: for example, a training on needle-syringe programming was carried out in Estonia in November, 2007 (funded by UNODC), Estonian Psychiatric Association also organizes trainings for psychiatrists involved with methadone treatment.

However this cannot compensate for lack of special education on all aspects related to drugs and drug harm reduction for drug specialists.

Training needs not covered.

Most specialists in Estonia, whom we talked to expressed their opinion that the topic that is least covered and most demanded by local specialists is the issues related to rehabilitation programs. Generally the opinion expressed by local specialists was that while rehabilitation services are developing in the country, there are very few specialists who are professionally trained in this area and further training is needed.

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## WORK CONDITIONS

One very problematic area for intensive development of drug/HIV services in Estonia is poor work conditions for key staff involved in providing services to drug users, such as outreach workers, peer counsellors and other types of social workers. It is interesting to observe how the situation in the area of professional compensation progressed during the last 6 years. One internationally known conflict during the first disbursement of the Global Fund grant to Estonia was a fight between the harm reduction experts and the Ministry of Social Affairs, which refused to allocate appropriate compensation fees for medical doctors and outreach workers involved in needle syringe programmes (NSPs). The average fees of the NSP personnel turned out to be higher than the average pay of medical workers in the country but at the same time, it was obvious that the level of payment suggested by the local standards would not be enough to retain professionals in these difficult jobs. However, back then it was argued that if harm reduction services want to be accepted by the government they had to fall in line with other norms that exist in the country<sup>32</sup>. However, during the mission in early 2008 it seemed that the situation had turned to be directly the opposite: both MoSA officials and harm reduction workers reported that the salaries in the field are much lower than similar professions in other areas, and sometimes even below minimal wages in Estonia. This might be related both to underestimation of the effort and professionalism required from people working directly with drug users but also to the fact that professions of outreach workers and peer counsellors are still not recognized in Estonia. These professions are not included in the existing labour registry which is regulated by the Labour department within the MoSA. The MoSA officials also mentioned that discussions about institutionalizing these professions do not currently take place in the country. Such institutionalizing may have both negative and positive consequences which have to be carefully considered by all parties, but it is clear that without consideration of inclusion of these professions under the national labour registry it will not be possible to talk about full integration of existing drug services into the broader official public health system.

This issue is not only theoretical, but leads to direct consequences for people in the field: lack of institutionalization of these professions decreases general competitiveness of salary/social packages offered to these workers, as well as decreases career opportunities and personal development for those involved in the harm reduction field. The MoSA officials admitted that the area is far from being competitive with other medical services, as the current salaries of outreach workers are much lower than those of social workers and nurses. One interesting argument provided by MoSA officials was that the profession is supposed to be “morally

rewarding". While this opinion was also shared by all the outreach workers in Tallinn and Kohtla-Järve, they, except for one person, clearly didn't indicate that moral reward is the only thing they expect as a means of compensation for their hard daily work. Outreach workers in Kohtla-Järve said that their salaries are below minimal wages in Estonia, although they also said that NIHD works to improve the situation at the moment and they expect better salaries within the new contracts. Employers of one harm reduction organization in Tallinn shared that they cannot provide paid vacations or other social benefits to their workers as the staff works under short-term labour agreements, which do not provide for such compensations. Despite the fact that some people work under such agreements for many years, they are still not eligible for any kind of social benefits that are usually provided by employers in other organizations. Whether this situation presents a management problem of a particular organization, or a more general rule, it needs to be carefully revised and improved. People who are involved into a hard daily work which is as much morally rewarding as it is stressful, regularly dealing with issues of death, loss, pain and social injustice, should not be finding themselves as marginal to the national labour market and should receive all due compensation and appreciation for their effort.

### **Recommendations:**

The education and working conditions of those working in HIV/drug services need to be significantly improved to ensure sustainability and growth of services and protection of workers' rights. The following steps could be taken in this regard:

Piloting of long-term certified courses on drugs/harm reduction to relevant specialists could help to prepare a new committed cadre for service organizations as well as expert/ executive bodies. These courses could be provided in different manners (for example, given a high level of internet literacy in Estonia development of internet based courses may be a viable option). Another opportunity is developing and inclusion of short curriculum on drugs/harm reduction within existing education programs, for example for social workers. UNODC in cooperation with a local University/Institute could run a project on development/implementation of such courses. Models, developed in other countries (for example, a short 26 hours course on Harm reduction developed by the Open Society Foundation-Slovakia for the Matej Bel University in Slovakia or a MSc distance learning course on drugs and drug policy provided by London School of Hygiene and Tropical Medicine) could be used and adapted for Estonian situation.

Human resource management remains a major structural barrier to effective development of drug services in Estonia. A careful audit of existing services could help to reveal the main problems with sustainable system of human resource management within organizations such as contractual and social protection issues. Legal expertise is necessary in order to analyse the exiting situation in organizations and development of guidance for improving working conditions of the employees. UNODC could initiate/fund a legal review of current practices of human resource management, contracting and relevant issues with the aim to develop recommendations for service providers.

An issue regarding institutionalizing professions such as outreach/peer consultant should be carefully reviewed and all pros and cons weighted in common discussions between service providers and officials from MoSA (including Labour Department). UNODC could help to accommodate this discussion.

## **2. ACCESS, COVERAGE AND QUALITY OF SERVICES FOR IDUS**

In Estonia national and local Government and non-government organisations provide a range of services and programmes for HIV/AIDS and drugs prevention, treatment and rehabilitation and targeted (harm reduction) interventions for injecting drug users and other especially vulnerable groups. The range of services and activities being implemented (including needle and syringe programmes (NSP); drug dependency treatment, notably opioid substitution therapy (OST) and access to anti-retroviral therapy) is broadly consistent with international and European recommendations for universal access to HIV prevention, treatment and care for IDUs (e.g. Donoghoe et al. 2008<sup>33</sup>; the Dublin Declaration on Partnership to fight HIV/AIDS in Europe

and Central Asia; UNODC 2008<sup>34</sup>). However, access, coverage and quality of services for IDUs may vary greatly depending on location and provider agency.

Generally all services that contact IDUs can be divided into specialized services for IDUs (such as needle and syringe programmes, drug treatment programmes, low threshold centres etc) and general services which also include IDUs as their clientele (such as hospitals including specialized hospitals providing HIV/AIDS treatment and care, shelters, social services etc). In addition to medical and social services a number of organizations also contact IDUs on a regular basis, these include for example, police and prisons.

## 2.1 ACCESS AND COVERAGE OF SPECIAL SERVICES

### PROVISION OF NEEDLES AND SYRINGES

#### *Designated NSPs*

The number and coverage of designated NSPs have significantly increased in the recent 5 years from 15 sites in 2002 to 25 NSP sites and 3 low-threshold services in 2007. These programs typically include provision of syringes and needles to drug users as well as other services such as counselling, provision of condoms and education materials.

7 NSPs sites and 1 low threshold centre are situated in Tallinn, 18 in North-East Estonia, 1 in West Estonia and 1 low threshold centre works in Tapaa<sup>35</sup>. In Tallinn NGO "Elulootus" has a mobile outreach bus that serves 250 regular clients per month and distributes 3,000 syringes per month. Five organisations offered NSP services in the framework of the GFATM programme in Estonia – Convictus Estonia (Tallinn); AIDS Information and support Centre (Tallin); Rehabilitation Centre for Alcoholics and Drug Addicts (Narva); NGO "We Help You" (East Estonia) and JSC Corrigo (East Estonia).

Geographical distribution of NSPs is uneven; most of the services cluster in 3 counties in North-East Estonia, while in the other 12 counties these programs are absent. This can be explained by perception that services are most needed in localities with high IDU and HIV prevalence. The prevalence of IDU was found to be higher in Harjumaa (4,3%) and Ida-Virumaa (3,5%) counties, while in the rest of Estonia the IDU prevalence was found to be 0,5%<sup>36</sup> which is still pretty high but lower than in the two most affected counties. HIV prevalence among IDUs in the 2 counties is also particularly high. In 2006 Ida-Virumaa county was responsible for 47% of new infections in all Estonia, Harjumaa county – for 41% and the rest of Estonia for 12% of new infections<sup>37</sup>. Intensifying prevention interventions in these counties is very important. At the same time, research literature emphasizes importance of early development of targeted HIV prevention activities in sites with low HIV prevalence - these interventions are found to be especially effective and cost-effective before HIV is introduced into the IDU population or at least before it exceeds 5%<sup>38</sup>. This makes one wonder why virtually no services are available for drug users in the 12 counties outside the 3 North-east ones.

Table 1 shows changes in coverage of NSPs (measured as the proportion of IDUs reached). In 2002, between 20-30% of IDUs were reached by needle exchange programmes. In 2002 no information was available on retention rates (how many IDUs regularly used the services) so this 2002 coverage estimate (based on number of clients reached in a year) may be considered optimistic. In 2007 40-46% were regularly reached increasing to 66-76% if regular reached is defined as reached at least once a quarter. Coverage at this level is considered to be "very good<sup>39</sup>" and comparable with the best achieved in other European countries.

**Table 1: Coverage of needle syringe programmes in Estonia (clients reached) 2002 and 2007**

| Date | Number of IDUs (estimated) | IDUs reached     |        | 60% Coverage |
|------|----------------------------|------------------|--------|--------------|
| 2002 | 10,000 -15,000(1)          | 3,000(2)         | 20-30% | 6,000-9,000  |
| 2007 | 13,800(3)                  | 5,465-6,329 (4)  | 40-46% | 8,280        |
|      |                            | 9,125-10,461 (5) | 66-76% |              |

- (1) Estimates of the number of IDUs from the 2002 GFATM application. A lower estimate of 10,000 – 12,000 was presented in the National HIV/AIDS Prevention Programme for 2002-2006.
- (2) Estimated number of new clients visiting needle exchange programs in the year 2001.
- (3) 2004 capture-recapture study 13,801 IDUs (95% CI 8,132-34,443) (Uuskula et al. 2005)
- (4) Clients reached at least once a quarter
- (5) Clients reached at least twice a quarter

Table 2 shows that in 2002 the number of syringes distributed was woefully inadequate to impact the HIV/AIDS epidemic. To achieve the optimal situation of a sterile syringe for every injector every day, the number of syringes distributed needed to be dramatically increased. In 2006 the number of syringes distributed increased considerably to 1.6 million syringes per year. This represents coverage of 116.3 syringes per IDU per year in 2006 (compared to 62.8 in 2005 and just 12.2-18.3 in 2002). Debate continues as to the optimum number of syringes per IDU per year required to impact HIV epidemics and the NIHD estimates that at least 5 million syringes should be provided in Estonia per year<sup>40</sup>. An earlier recommendation suggested that a drug injector should use a new syringe for each injection<sup>41</sup> (for a person injecting twice a day 730 syringes per injector per year). Lower levels of syringe distribution (140 syringes per injector per year) have been demonstrated to be effective<sup>42</sup>.

A behavioural study, using respondent driven sampling<sup>43</sup>, supports the finding that syringe coverage in Estonia is adequate, with a reported mean of 17.9 syringes obtained per injector each week, 13.5 kept for personal use and 4.5 distributed to other people. This level of coverage extrapolated over a year would give coverage of 702 syringes per IDU per year, much higher than that calculated by the number given out by the NSPs and the estimated number of drug injectors. Higher coverage is explained by the fact that data collection for the behavioural study was conducted at NSPs.

**Table 2: Coverage of needle syringe programmes in Estonia (syringes distributed) 2002 and 2007**

| Date | Estimates of the number of IDUs | Number of syringes distributed per year (per IDU per year) |           |
|------|---------------------------------|--|-----------|
| 2002 | 10,000 -15,000                  | 183,000  | 12.2-18.3 |
| 2007 | 13,800                          | 1,615,604  | 117.1     |

Research conducted in 2005 suggests that 68,7% of injectors in 2 sites where NSPs operate (Tallinn and Kohtla-Järve) mentioned NSPs as sources of new needles and 37.3% get them from outreach. For 45,5% injectors in these sites NSPs including outreach NSPs represented the main source of new syringes and needles<sup>44</sup>.

#### *Outreach and secondary distribution.*

As in many other countries outreach plays an important role in syringe distribution in Estonia, with 37% of IDUs reporting outreach programmes as a source of syringes and 11% their main source. Outreach is a more important source in Kohtla-Järve than in Tallinn. 28% of injectors from Kohtla-Järve mention it as their main source compared to just 7% in Tallinn. Secondary distribution via drug users networks also plays a vital role with almost 52% of injectors mentioning friends (and 36% "other" IDUs) as a source of syringes (although less than 3% as the main source). Drug dealers also have a role in secondary distribution with 16% of injectors mentioning dealers as a source. There is scope for scaling up outreach as a source of syringes. This is demonstrated by the report that 50% of drug injectors in a behavioural study had never received syringes from an outreach worker.

#### *Pharmacies*

Apart from designated needle and syringe programmes syringes can be obtained by drug users in pharmacies. All pharmacies operating in Estonia are private. According to MoSA officials and focus groups participant access to syringes through pharmacies is not impeded by any kind of

prescription legislation and any one can buy syringes. There are many pharmacies that also operate during night hours. In a 2005 RDS study in 2 sites in Estonia where NSPs operated, it was found that pharmacies represented a source of needles and syringes for 83.8% of injectors and for 49.8% it was the main source<sup>45</sup>. However, as it was noted by focus groups participants, cost of syringes in some pharmacies may be prohibitive. According to FG participants the cost is determined by pharmacies and can vary significantly for the same type of syringes, depending on a pharmacy.

#### *Low threshold centres (LTCs)*

Three centres were launched as low threshold centres: in Tallinn, Kohtla-Järve and Tapa\*. Some of them host NSPs (e.g Narva) others put more emphasis on other services such as social services. Their share of needle and syringe provision is much lower than of designated NSPs programs. For example in 2006 2 LTCs (in Narva and Tallinn) distributed only 8615 syringes (4,307 average) compared to 1 606 989 distributed by 5 other NSP services (321,399 average) supported by NIHD<sup>46</sup>. The centres focus on provision of additional services for drug users including drop-in zones, snacks, laundry facilities etc.

One such centre in Tallinn was legally prohibited from distributing syringes to drug users on its premises: when the centre was opened the local neighbours raised a media campaign against provision of services for drug users in their neighbourhood. A court hearing was held and while the centre remained in its place, the court stated that no syringes could be provided in the building. Currently the centre provides a limited amount of syringes via its outreach workers operating in areas of the cities where drug users congregate.

The LTC in Tallinn is funded from the municipal budget with some funding comes from NIHD within realisation of the National HIV Strategy.

#### **Recommendations:**

Access to NSP should be improved by increasing number of sites particularly in those counties that are currently under served. This should be done without re-allocating resources from currently operating services, but by increasing resources for the currently un-covered sites from various sources, including national and county budgets. This could be done using local budgets after negotiation with local drug councils (See recommendations for Section 1.1)

Although coverage of IDUs in cities where NSPs are currently implemented appears to be good more efforts should be made in order to establish contacts with new clients who may come from harder to reach groups (discussed below). Intensifying prevention activities in low HIV prevalence localities/groups could help to decrease the level of annual HIV incidence.

The role and location of the LTC in Tallinn and Kohtla-Järve should be critically examined and discussed with local authorities, service providers and funders.

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## DRUG TREATMENT PROGRAMS

### *Opioid substitution therapy*

As of September 2007, 654 persons received OST for substitution maintenance, representing about 5-6% of the estimated need. Although OST has been scaled up in Estonia, coverage falls far short of the 40% recommended by WHO and UNODC and that typically achieved in most western European and European Union countries. 71% of people receiving OST were PLWHA.

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\* According to information received in personal communication with local specialists one LTC operates also in Tartu, but further details were not received.

**Table 3: Coverage of methadone maintenance/OST in Estonia 2002 and 2007**

| Date | Estimates of the number of IDUs | IDUs reached |            | 40% Coverage  |
|------|---------------------------------|--------------|------------|---------------|
| 2002 | 10,000 -15,000                  | 10)          | (0.06-0.1% | 4,000 – 6,000 |
| 2007 | 13,800 (all)                    | 654          | 4.7%       | 5,520         |
|      | 11,178 (primarily opioids)      | 654          | 5.85%      | 4,471         |

OST with methadone is provided at eight sites, with linkages to social and other services. Great variation in the quality and philosophies underlying the principles and operational practices of OST programmes in Estonia has been previously reported<sup>47</sup>. This may be summarized as two different approaches: 1) OST (or methadone maintenance treatment MMT) as an abstinence oriented treatment with long though time limited duration, targeted to select groups of IDUs motivated to abstinence and 2) OST (MMT) as a public health intervention and effective HIV and other infectious disease prevention, relevant to the majority of IDUs rather than selected and highly abstinence –motivated groups. Provision of opioid substitution treatment in Estonia faces serious problems which have been reviewed in detail and reported during the earlier UNODC mission in June 2007 <sup>48</sup>

Drug treatment guidelines adopted by the Estonia Psychiatric Association in 2005 include a number of restrictions on recruitment of patients and criteria for discontinuation of treatment. These restrictions have implications for the quality of OST services in Estonia. These investigators confirmed such restrictions were operating – for example age restrictions, need for prior treatment failures, requirement to initiate treatment in specialized inpatient wards, etc. Restrictions are not in line with WHO/UNODC recommendations and limit access to OST.

It has been previously reported<sup>49</sup> that OST has a negative image among IDUs and no specific strategies have been developed or implemented to educate IDUs regarding the benefits of such treatment. The image of the programs is also undermined by poor quality of service provision. The bad image of methadone programs among clients was confirmed in focus group discussions with IDUs during the mission in January, 2008.

All of 6 focus group participants in Tallinn knew about the existence of methadone programs and all held negative attitude to these programs. *“Methadone programs are not popular”* – was the general opinion of the group. While 3 participants had been enrolled in OST programs in the past, no one was currently utilising the service. One finished methadone when in prison, and didn't want to continue after his return, one had experience of methadone detoxification. Negative attitudes were explained with perceived strength of withdrawal from methadone compared to withdrawal from other opiates:

*Even China White withdrawal is nothing compare to methadone...*

*Before I was locked up [in prison] I was on methadone for 5 days, I received about 75 mgs. Then I got into the arrest house for 2 months. For one month I got such a severe withdrawal – I couldn't care about anything – just to get rid of this pain.*

*I went to the [methadone] program for half a year, then I was imprisoned for half a year... so for 3 months I was 'recovering' from it: for month you get severe pains, one month after you cant sleep, and then one month you try to put your head together again.*

This strength of methadone withdrawals seems to be fuelled by fears and myths that are circulating among drug users in Estonia<sup>†</sup>, perpetuated by general negative attitude, bad experience of methadone prescription and also, reportedly, Russian (and some Estonian) press. However, taken all together these “myths” and “realities” of methadone programs construct the drug as a powerful and undesired drug which is difficult to handle.

It seemed that in many cases negative reaction of former OST patients was more related to the way services were designed and provided:

*You have to come [to receive methadone] every day*

*They [methadone programs] are not free of charge and it's really difficult to get there*

One person said that it was really difficult for him to get into the program: he had to visit all kinds of specialists during one week which was really complicated to organize. Another important deterrent for people to enrol into programs is the fact that many drug users are aware of their high risk of getting arrested and locked up either in arrest houses or in prisons where OST is not provided. This fact, in combination with perception of severity of methadone withdrawal makes a reasonable dependent user think twice before enrolling into a program. Prison staff attitude is not very helpful in terms of OST promotion among patients:

*If a person from methadone program gets into prison he wouldn't get any help there. And methadone withdrawal is very severe! So what they [prison medical staff] say is: "what were you thinking about before, when you decided to sign up to the methadone program".*

Professionals (particularly infectious disease specialists) lacked proper information about the long term effects and goals of OST and expressed little enthusiasm for learning more, particularly with regard to using OST to improve access and adherence to HAART. Lack of communication and cooperation between infectious disease hospital staff and OST staff identified previously<sup>50</sup> were confirmed during our discussions with infectious disease specialists.

The image of methadone is no better among services providers, including those who deliver methadone to drug users. A word that comes up almost in any discussion regarding methadone in Estonia from both drug users and service providers in relation to methadone is “toxic”. For example, it has been reported on several occasions that OST providers recommend their patients to keep low dosage of methadone in order to decrease its “toxicity” and harmful health consequences<sup>‡</sup>. Several service providers mentioned current development in the OST

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<sup>†</sup> The extent to which drug withdrawal is a bio-chemical “reality” and to which it is socially constructed is debated in drug sociology literature. The social construction approach suggests that the meanings of objects or acts including such subjectively strong experiences as drug dependence and withdrawals do not represent their intrinsic qualities but are socially fabricated and ascribed, consequently absorbed by culture and tradition and reproduced in the form of beliefs and interpretations. In order to understand how drugs and their consequences are experienced we must analyse such factors as perception, beliefs and expectations of certain drugs on the level of individuals and society. My own favourite example shedding some light into the power of constructing methadone withdrawal is drawn from the work of Dole and Nyswander (1966) who piloted and promoted first methadone maintenance programs in the US: “The absence of any significant drug sensation on taking the daily dose of methadone has been verified by experiments in which, unknown to the patient, d-methadone (a pharmacologically inactive isomer) was substituted for the usual morning dose of racemic drug. The patients not only failed to notice the substitution, but when mild symptoms began to appear about 36 hours later they even failed to identify the symptoms with abstinence. Unaware of any change in their medication, the patients believed that they had caught cold”. This report provide an interesting contrast to experiences of drug users in Estonia and underlines importance of personal and shared believes in constructing drug experiences.

<sup>‡</sup> Evaluators have previously cautioned against low dosages of methadone. WHO guidelines suggest that high doses of methadone (above 60mg) results in better retention in treatment and less heroin use than lower doses (less than 40mg). In Estonia the average dose is low (in the range of 15-20 mg in the abstinence oriented programmes and higher in the more public health oriented programme).

programs that all pregnant IDUs should be put on Subutex rather than methadone, as it is “less toxic” (as worded by at least 2 methadone providers).

Our investigations and analysis of the situation leads us to support the recommendations previously made to expand MMT (OST) and its role in HIV prevention in Estonia<sup>51</sup>.

#### *Other modalities of drug dependence treatment*

Several organisations (including NIHD, EHIF and local authorities) are now funding drug treatment, but as the system of regular data collection is only just being installed it is not possible to get reliable and comparable information on drug treatment in Estonia<sup>52</sup>. A 2005 EDMC survey showed that just 1,339 persons received treatment in 19 medical institutions. 825 of treatment visits were related to opiate related problems, 5% to stimulants and 12% to other substances. An indication of low coverage of drug dependence treatment is provided by reports that in a behavioural study of drug injectors only 12% were currently in treatment and 55% had never been in treatment (60% in Tallin and 35% in Kohlta-Jarve).

In 2008 drug rehabilitation centres remained a popular concept of drug treatment in Estonia. These usually include such modalities as out-patient ‘day centres’ and in-patient long term rehabilitation programs (up to 6 months). One such long-term centre is situated in East Estonia and supported by the government and PHARE funds; others are run by NGOs and funded from various sources. Currently no rehabilitation centres exist in Tallinn. As in 2002 the capacity of in-patient centres is very low, they usually can provide space for 10 to 16 people at one time and people are kept there for quite a long time, 6 months or sometimes even longer. As well as substitution treatment programs, these programs mostly accommodate needs of opiate dependent people but not people with problematic amphetamine-type stimulant (ATS) use. However, as in 2002, it has been reported by the officials from the MoSA that waiting lists for such centres are quite long and these types of services are demanded by users. As reported by the MoSA they include such components as development of social skills (e.g. computer skills, learning of Estonian language; psychological support; ‘working therapy’ (or “compulsory work”) group work, etc. According to our informants, no harm reduction curriculum is taught in these centres and programs such prevention of overdose and infection prevention in case of relapse does not currently exist.

According to the NIHD, in 2006, 43 drug treatment providers were registered with the Estonian Health Insurance Fund, including central or local hospitals, private medical centres and doctors. The number of clients receiving drug free treatment is unknown, but such treatment is known to include: psychotherapy; cognitive, group and family therapy; and twelve step/Minnesota model programmes. Medically assisted treatment includes OST programmes (see above); treatment and rehabilitation centres.

Local community activists have a very strong stand on the necessity of further development of the rehabilitation system. Local ideological resistance to implementation of substitution treatment programs can partially be explained by lack of rehabilitation centres in Estonia and enthusiasm in regards to their implementation. The strong position of international organisations such as UNODC and WHO as well as funders such as GFATM in regards to prioritisation of OST programs over drug-free treatment were sometimes characterised as imposing and driven by organizations own agenda rather than local needs. As noted by one respondent:

*“If we declare that all components of harm reduction work should be integrated, and that this work should be effective and comprehensive, than it is very important to facilitate development of professional rehabilitation programs – the structure of such programs is absent in Estonia today. While the methadone programs were imposed by the Global funds the terms have been misplaced and methadone program started to be called rehabilitation rather than substitution treatment. Methadone is now seen by some people as panacea while [drug-free] rehabilitation treatment is completely signed off as not interesting for international organizations”.*

The same person noted that the number of rehabilitation specialists is really small – about 10 people in all Estonia. “Comprehensive rehabilitations are absent” he noted that simultaneously

with development of OST it is necessary to support drug-free rehabilitation programs as an alternative solution for various groups of drug users. Absence of specialists education, lack of methodological materials (especially in the Estonian language), lack of drug-free treatment in prisons (along with methadone programs), lack of alternative sentencing, prioritization of long-term, rehabilitation therapeutic communities over more cost-effective intensive in-patient and out-patient programs were mentioned among other problems by our respondents.

### **Recommendations:**

Opioid substitution therapy is still extremely limited in Estonia in terms of both access and coverage. A significant scale up of OST services for IDUs is vital. Quality of OST services is extremely variable. OST should be provided according to international guidelines. UNODC should promote recommendations from the 2007 focused mission on OST evaluation.

UNODC could support training for specialists working in drug-free rehabilitation centers. This topic also corresponds to a perceived training need for Estonian specialists discussed in section 1.4. This training should include components on integration of HIV prevention/treatment and drug harm reduction education in rehabilitation settings.

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## HIV/AIDS TREATMENT FOR IDUS

*"There are not hard-to-reach populations – but there are hard-to-reach services."*

– Participant, Correlation Conference, Sofia 2007<sup>53</sup>

In 2005, 256 seropositive individuals were receiving ART in Estonia, but the demand for treatment was projected to grow tenfold in the coming years<sup>54</sup>. As reported by WHO office in February 2008, there were 772 patients on ART<sup>55</sup>. As in many other countries in Europe, particularly eastern Europe<sup>56</sup> injecting drug users in Estonia are still facing major problems related to access to highly active anti retroviral therapy (HAART). In 2002 just two persons (or 4% among the total reported people on HAART with a known transmission route) know to have been infected through injecting drug use were receiving HAART. In 2004, this improved to 45 person (or 44% of the total on HAART) and in 2006 to 300 IDUs ( or 67% of 449 with known transmission route). The situation has further improved by November 2007 when people who got HIV through unsafe injection practices (current or former IDUs) reportedly comprised 85% of 680 patients receiving treatment<sup>57</sup>. However, in personal interview during the mission, specialists from Narva hospital estimated that in 2007 only 30/35% of 151 HAART patients were current injecting drug users. Given systematic problems with surveillance of HIV transmission route in Estonia, it is difficult to assume the level of validity of either estimate but we need to emphasise the need to equally include IDUs into HIV treatment provision and addressing their special needs in order to improve recruitment and retention in treatment.

Stigma and discrimination among service providers and lack of supporting infrastructures to meet special needs of drug using HIV patients represent major barriers to IDUs accessing and being retained in health services in general and HAART in particular. While claiming that Estonian health system provides 'equal access' to HAART, HIV/AIDS specialists were vocal in their belief that IDUs are often inappropriate patients for HAART, because of their unstable lifestyles and inability to adhere to treatment. There was a tendency among many service providers to blame the patients and not see the obvious shortfalls of the system for inequities in treatment access and retention for IDUs.

It is now internationally accepted that equal access to HIV treatment does not mean the same conditions for every group, on the contrary, equal access is based on the principle that needs of special population groups should be reflected in the ways services are tailored and provided to clients. The WHO HIV/AIDS Clinical Protocols for Europe<sup>58</sup> suggest key principles for effective provision of HAART to IDUs:

- accessibility

- free-of-charge
- user-friendly with non-judgmental and unbiased staff
- tailoring to individual needs
- continuity of care through referral systems among health services, community organizations, injecting drug use networks and families.

As previously discussed in section 1.2 OST improves IDUs' access and adherence to HAART but there was no integration of those services treating HIV/AIDS and those treating opioid dependence. HIV/AIDS specialists showed no enthusiasm for being able to prescribe OST. Of 92 HIV+ OST patients at the Narva Rehabilitation Centre just 10-15 patients were receiving HAART.

In 2005 68% of IDUs reported that they had been tested for HIV in the previous 12 months. Specialists at West Tallinn hospital confirmed that over 50% of IDUs know their status. Specialists at Narva hospital reported that only 20% of diagnosed patients returned for treatment. The majority would be lost to treatment, only to reappear three to four years later with advanced AIDS.

Participants of FG in Tallinn, most of whom were PLWHAs also shared the opinion that HIV positive IDUs prefer not to show up for treatment until they have visible manifestations of health problems. They said that even people who received their diagnosis 6-7 years ago may never come for further diagnostics and treatment. Only one participant said that he did CD-4 and viral load tests last year. Our interviewees also expressed reluctance to go for treatment due to severe side effects. Only one participant in Kohtla-Järve said that he started ART, but stopped taking ARV drugs after 22 days of treatment due to severe side effects and refusal of the medical nurse to allow him an appointment with the doctor in order to discuss possible corrections to the drug combination. Another person said that he started combination treatment of HCV, but stopped taking it after first injection of interferon. These stories indicate several problems: poor quality of HIV pre and post-test counseling, lack of work with drug users on HIV treatment literacy and treatment preparedness on behalf of medical organizations as well as harm reduction programs and peer groups, insufficiency of current system of adherence support.

Outside medical settings special services for IDU PLWHA seem to be limited to several support groups and 2 peer counselling cabinets run by the Network of PLWHA. Lack of specialised services for IDUs who live with HIV/AIDS run not only by medical institutions but also by NGOs seem to be in appalling contrast with the acute need for such services. Given the well-known fact that the overwhelming majority of injecting drug users in Estonia are HIV positive and majority of these people were infected back in 2000-2002 this need is urgent. Presumably many IDUs already are, or soon will, in need of HIV treatment and care. Definitely they are in immediate need of surveillance of their health conditions, immune status, viral load and opportunistic infection (OI) prevention and treatment.

Linkage of harm reduction and treatment services and development of 'one stop shop' type of programs is an effective tool to ensure that HIV treatment is effectively provided to all those drug users who are in need of it<sup>59</sup>. Such programmes increase recruitment of drug users into treatment programs as well as ensure regular contact with medical facilities for early CD4, viral load and OIs diagnostics; provide peer treatment preparedness education and counselling; carry out treatment literacy work among wide groups of HIV positive clients; train and counsel IDUs on adherence support and provide all kind of support structures in order to retain patients including buddy systems, communicating with doctors, case management, home care and a host of other services. NGOs and harm reduction programs are also effective advocates and sometimes pioneers in integration of different type of services (such as, OST and HAART provision; TB and HIV services, etc) and stirring multi-discipline teams of specialists and peers which ensure effective case management for clients. Civil society organizations and PLWH groups have also been the main driver for ensuring ARV price reduction all over the world and advocate for equal access to ARVT for all groups of society, including poor people, drug users and other groups which previously were considered 'problematic' from treatment perspective.

Not only treatment provision, but continuing prevention work including information, peer education and counselling, needs to be continuously delivered to PLWHA IDUs in Estonia and harm reduction efforts should be strengthened in order to emphasise specific issues relevant to

this group. The findings of a 2005 RDS study revealed that HIV positive IDUs aware of their serostatus shared syringes and other injecting materials more often than IDUs aware of their HIV negative serostatus (OR=2.39; 95% CI 1.34–4.24). There were no significant differences between HIV negative IDUs and the IDUs not aware of their HIV positive serostatus (OR=1.19; 95% CI 0.57–2.50). When comparing HIV negative IDUs and HIV positive IDUs aware of their positive serostatus, the latter shared significantly more frequently syringes/needles with their sex partners (OR=4.47; 95% UV 2.36–8.46) and had significantly more drug injecting sex partners (OR=2.42; 95% UV 1.31– 4.47). The findings of this study highlight the need to develop and expand different education, treatment and care services for PLWHA to reduce their high risk behavior. Also, they question effectiveness of current pre and post test counseling and call for its improvement<sup>60</sup>.

### **Recommendations:**

Injecting drug user's access to HAART should be universal and equitable. Adherence to HIV/AIDS treatment should be encouraged through non-discriminatory and supportive practices, including provision of opioid substitution therapy. Estonia should develop co-located integrated care delivery systems for drug injectors. Such systems should provide both HIV/AIDS and drug dependence treatment. A pilot project on drug/HIV treatment integration could be developed with funding/methodological support of UNODC, possibly on the basis of West Tallinn hospital. This pilot project should also focus on cooperation with Tallinn harm reduction services in order to increase their role in recruiting and educating patients and providing peer-support and care.

Peer-led services for HIV positive people should develop as separate interventions and also in the framework of current harm reduction services. Harm reduction services should pay special attention to recruitment of drug users into treatment programs as well as ensure regular contact with medical facilities for early CD4, viral load and OIs diagnostics; they should also provide peer treatment preparedness education and counselling; carry out treatment literacy work among wide groups of HIV positive clients; train and counsel IDUs on adherence support and provide all kind of support structures in order to retain patients including buddy systems, communicating with doctors, case management, home care and a host of other services. A training for current harm reduction services on HR role in HIV treatment work could help to shape the vision of this role and basic skills of HR service staff. Such training module is available from HR Knowledge Hub run by EHRN.

## 2.2 SERVICE QUALITY

International scientific literature on development of drug services places more and more focus on issues related to measuring quality of services along with their coverage and other quantitatively measured outcomes. For example, the draft WHO/UNODC/UNAIDS Technical Guide, suggests that quality describes the scope, completeness, effectiveness, efficiency and safety of interventions as well as client satisfaction with the intervention<sup>61</sup>. Additional issues such as human rights orientation, friendliness of services, community involvement and empowerment, and advocacy for better policies may be more difficult to measure, but they all provide important dimensions for evaluating the effectiveness and impact of work in the harm reduction field. In fact, evaluation of drug services founded on quantitative indicators, with the level of coverage being the core one, may significantly differ from evaluation of the services from clients' and workers' perspectives, which often emphasise various aspects outlined above. While international scientific harm reduction and drug treatment communities are only approaching the issue of developing a comprehensive set of qualitative indicators, some of them have already been suggested in literature. Among them geographical proximity of services and time of program operation, quality of the prevention materials offered by the program, access to needed information on health and other issues, attitude of program staff, possibility to access various services not limited to syringe exchange, rules and regulations of the program which respond to clients needs, and general satisfaction with the program work<sup>62</sup>.

Given the limited time and specific format of communication during site-visits during the evaluation mission, it is not possible to provide careful examination regarding quality of services

provided by the programs. Quality assessment requires well designed specific evaluation work with involvement of many parties, most importantly service beneficiaries. Within this report it will be possible to share only very general observations regarding the issue of quality.

Services we visited vary greatly in different aspects of their quality. For example, some services are better located, more strategically staffed and user friendly which makes them more frequented by clients. Others provide a wider spectrum of services, not limited to access to syringes and health information, but including such services as shower, laundry, snacks, warm and comfortable drop in zones.

The client perspective seems to be one of the most important determinants of evaluating service quality, however a chance to communicate with clients was provided only by 2 visited service: a needle provision site run by NGO Convictus in Tallinn and a similar centre run by NGO "We help you" in Kohtla-Jarve. Focus groups held in these sites revealed that clients are generally very satisfied with the services provided by the organizations. The important factors emphasized by the clients included proximity of services and convenient operation time (several participants were also operating secondary provision sites bringing needles even closer to the target group); wide range and good quality of needles and syringes provided by the programs, friendly (or even friendship) relations with program staff.

From an outsider's perspective, the key to good uptake and perception of programs is involvement of peers in service provision and design. In both programs, service outreach workers and volunteers included a wide range of peers: from former abstaining drug users to methadone clients, to active drug users of both opiates and amphetamines. While we didn't have time for in-depth discussions on organization management issues, it seemed that the programs managers feel quite comfortable and experienced in dealing with various issues related to managing peers as program workers, the issues briefly discussed included flexible schedules of work, prevention and management staff relapse into (problematic) drug use and others.

Other programs we visited were obviously less frequented by IDUs. For example, during 1,5 hours spent in the low threshold centre in Tallinn we didn't see any visitors. While the idea and ambition of the program to provide a wider range of services to drug users deserves a lot of respect, the actual implementation of the program and particularly attractiveness for the clients requires careful consideration. Particularly, the fact that the service is situated on the city outskirts and is difficult to reach by public transportation deters many potential clients from visiting it. Similarly, staffing is less strategic; it doesn't include peers or native Russian-speakers.

Most quality related concerns were shared by specialists and drug users in relation to current OST programs. However some current practices of NSPs may also be not in line with the most up-to-date evidence base on effectiveness of needle provision to drug users. Among these practices is that needles and syringes are provided on a conditional basis, namely, in most situations, clean syringes would only be provided in exchange for used ones. While programs said that there is no strict one-to-one rules applied in relation to clients, and clients also didn't express many objections to the existing system, we noted that the rate of syringes that has to be returned is even set in programs contracts with NIHD. These regulations contradict international evidence base which suggests that in order to achieve maximum effectiveness NSPs should move towards unconditional syringe distribution. It has been demonstrated, that restrictive exchange policies limit needle and syringe availability and can increase risk of HIV transmission. There is much international evidence to indicate that coverage is increased as restrictions on exchange policies are decreased<sup>63</sup>. As in other countries, strict regulations may discourage users to attend programs and obtain more syringes and even contribute to development of HIV outbreaks among IDUs<sup>64</sup>. Besides, literature review doesn't suggest enough evidence in support to prevention significance of collecting used syringes. First, according to WHO review, there was not a single case reported globally of HIV infection stemming from an accidental stick with a syringe discarded in a public place and the risk of infection due to accidental stick with a needle discarded by IDUs is practically absent<sup>65</sup>. Therefore the restrictions applied by the programs seem to be a futile relict impeding NSPs work while not compensating it by public benefit.

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## OVERALL SYSTEM OF QUALITY MANAGEMENT

The National Health Development Institute has built a good foundation for development of an efficient quality management and monitoring system. The systems that proved effective during implementation of the GFATM-funded program will also be applied within the new nationally-funded program. They include a clear and working system for financial disbursements; a well-established, streamlined system of monthly reporting; a strong system of communication with the programs.

The new procurement and supply management system was a remarkable improvement since the 2006 evaluation. The new system was elaborated by the NIHD legal consultant allows sub-recipients to procure a wide variety of syringes and needles of different brands directly from the wholesaler on the monthly basis. However, the situation with the quality of condoms remains difficult. We observed that only one type of condom was provided by the services, and both service providers and clients (FG participants) complained of its poor quality. Another issue raised by NIHD was the fact that they still could not provide a wider range of materials, including additional injecting paraphernalia essential for HCV prevention such as cookers, filters and water for injections.

NIHD elaborated comprehensive contract packages with Annexes regulating various aspects of service provision. These service descriptions were used by the Institute as a way to ensure quality of services. These service provision recommendations were drafted as consensual paper of different providers and other parties involved and reportedly reflect the current situation and needs. However as noted in 2006 evaluation they are not utilised by service providers as a useful tool for quality assessment<sup>66</sup>. The MoSA specialists also shared the concern that there are no real mechanisms to influence the quality of service provision (except for contractual mechanisms that can be used by NIHD). Indeed, these tools will only be effective under condition that all drug/HIV services in Estonia hold contracts with NIHD, which may not always be the same. In relation to this, NIHD specialists suggested that some form of recommendations could be developed to guide existing and future service providers. These guidelines could take different forms and have different regulatory levels. In a more restrictive format, these guides could take a form of National quality standards for various services, for example, needles provision, which could also have negative impact of restricting services and cutting off more unique best practice operations. Other possible positive and negative consequences of such standards are discussed in more detail in previous evaluations reports<sup>67</sup>. Alternatively, in less restrictive form, these tools could take a form of 'Good practice guidelines' or 'Code of good practice'.

Neither separate service providers nor NIHD specialists could indicate any established mechanisms that are used in order to ensure regular and genuine clients feedback on the quality of services and suggestions for its improvement. Within the on-going UNODC project NIHD together with the Dutch Trimbos Institute are currently working on evaluation of the quality of opioid substitution therapy in Estonia. The findings of the evaluation should be used to revise the current treatment guidelines and to introduce mechanisms for regular monitoring of the quality of the services.

### **Recommendations:**

Developing protocols and tools for quality monitoring of drug services should become a priority issue for NIHD. An evaluation study, similar to on-going evaluation of the quality of opioid substitution therapy in Estonia should be carried out in relation to NSP services. This study could help to identify important areas for quality monitoring protocols. It is important that this evaluation as well as further regular quality monitoring and evaluation work should focus on participatory approach and place program clients as core contributors.

Based on evaluation findings and analysis of international best practice, a Code of Good Practice in Harm Reduction could be developed which could help service providers to adjust their programs quality standards to best international and local practices.

On-site technical assistance could be provided to local drug services by regional or national experts in order to address issues of quality of work of current services. A pool of regional experts on various issues was developed by EHRN HR Knowledge Hub as well as UNAIDS. Such on-site consultations could be provided on requests from local organizations and could help to identify and solve various problems faced by service providers.

## 2.3 WAYS FORWARD

There are many issues which can be potentially looked at in terms of improving coverage and quality of harm reduction services in Estonia. Ideally, services for IDUs, including access to information, counselling and prevention materials such as syringes and condoms should not be limited to designated services, such as needle provision/outreach programs but should be integrated within other existing health and social infrastructures. These infrastructures include medical institutions (hospitals, clinics), social services (such as shelters), police and other services that have regular contacts with IDUs. Intensification of current services in localities/groups with high HIV prevalence and establishing new high quality services in localities/groups with low HIV prevalence could help to decrease the stable levels of HIV incidence in Estonia.

### INCREASING COVERAGE

#### *Establishing new services*

As mentioned in the previous section, it seems most timely and important to initiate new services for drug users in low-prevalence areas, especially in large cities such as Tartu (second largest city in Estonia with population over 100 000 people) and Pärnu (population 45 500). Possibilities to implement harm reduction programs in smaller cities and rural area should also be explored.

#### *Pharmacy schemes*

A realistic short-term strategy for expanding such work would be utilizing the established widespread network of pharmacies in order to provide free syringes and referral to other institutions. The Estonian National HIV/AIDS Strategy foresaw development of pharmacy-based NEPs, but it is not yet in place. Two types of pharmacy schemes are most widely used in the world: voucher schemes (when drug users receive vouchers in designated NSP programs or medical or other institutions which they can later use in the pharmacies in order to receive a safe injection kit) and provision of such kits without vouchers. The safe injection kit can include one or several syringes, condoms, other injection paraphernalia, stick-proof containers etc. Pharmacies can not only provide clean syringes but also place containers for return of the used one. Similar scheme's have been already piloted and established in many countries including countries of Former Soviet Union such as Ukraine and Central Asian countries and found viable by the World Health Organization<sup>68</sup>.

In 2007 NIHD has carried out a study and a series of round tables with specialists on feasibility of development of pharmacy-based (free) needle provision schemes. It has been found that some pharmacists hold negative attitudes to their drug using clients and were sceptical about possibilities of development of pharmacy schemes. However, NIHD plans to look further into possibilities of developing of such schemes.

While pharmacy schemes were not yet piloted in Estonia it is difficult to suggest how effective and valuable this work could be and there is a number of questions that need to be considered prior to implementation. However, it is quite clear that piloting of these schemes could significantly improve the geographical coverage of NSPs and make them more accessible for clients. Drug injectors in Estonia already use pharmacies as a source of needles and syringes. Almost 84% of IDUs report pharmacies as a source and 50% (55% in Tallinn and 32% in Kohtla-Järve) as a main source. Pharmacies whether as part of a new scheme or as part of the existing syringe distribution network clearly have an important role in increasing syringe coverage in Estonia.

## Vending machines

Another perspective that was mentioned by NIHD specialists is piloting use of syringe distribution machines (that either sell injecting equipment, provide it for free or in exchange for used equipment). Such machines are used in many countries including Switzerland, Germany, Italy, Denmark, Netherlands, Australia and others. Among their benefits is low maintenance costs (no human resources) 24\*7 access, and possibility to get needles to hard-to-reach locations of IDUs congregations. A recent review on effectiveness of vending machines<sup>69</sup> and mobile outlets demonstrated effectiveness of both methods in bringing services to especially to harder- to-reach and higher-risk groups of IDUs who for several reasons do not or cannot attend conventional NSPs. They were found complementary to other modes of needles and syringes provision. The vending machines allow access to drug users who avoid contacting with NSPs being concerned about their anonymity or need access to services at night or weekends. A study in Marseille, France found that vending machines were utilized by users who were significantly younger, homeless and not enrolled in OST programs<sup>70</sup>. Studies in other countries also found that vending machines can be more effective than traditional outreach/NSP services in reaching young, occasional and experimenting injectors who may not consider themselves drug dependent and may not be in favour of contacting special agencies for drug users<sup>71</sup>. However, reviews also emphasise importance of balancing vending machines with available IEC services for younger injectors and other hard-to-reach groups of IDUs.

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## SERVICES FOR SPECIAL IDU GROUPS

The Estonian National HIV and AIDS strategy emphasizes that *"An important feature in the development and delivery of different services to the injecting drug users is the point that those services would be easily accessible to the children/young people experimenting with drugs, as well as to women. The drug users injecting non-opioids and multi-drug consumers require separate treatment"*<sup>72</sup>. However, in practice there are no services tailored to meet special needs of these groups which may be especially vulnerable to HIV and other drug related harms.

### Women IDUs

While the number of new HIV diagnoses among women has been relatively unchanged from 2002-2006<sup>73</sup> the proportion of women among those newly-diagnosed with HIV in Estonia has been steadily rising, from 20% in 2000 to 36% in 2006<sup>74</sup>. The absence of any kind of specific services for women injectors is quite striking. From conversations with service providers it became obvious that the majority of NSP programs clientele are men in their 30s. Even special services for sex workers were provided only by one organization in Tallinn. Drug rehabilitation centres do not accept female clients and new residential centres for women IDUs are just being opened, but with very low capacities of 10-15 people.

The situation in Estonia reflects the global situation of underdevelopment of gender-responsive services and lack of efforts aimed at inclusion of women into drug treatment and harm reduction services. While, according to a recent focused study "Women, Harm Reduction and HIV"<sup>75</sup> and 2004 UNODC review<sup>76</sup>, women appear to be much more vulnerable to adverse consequences of drug use, including stigma, violence, coercive non-protected sex, sexual and labour exploitation etc, and many factors limit their access to drug treatment and harm reduction services, including need to care of children and household, fear of abuse etc. services worldwide remain insensitive to these special needs and concerns.

However, just a few years ago this issue has been successfully tackled in Estonia by NGO Convictus:

**Peer support of female drug users in Tallinn**<sup>77</sup>. For 3 years NGO Convictus has run a support group for women IDUs. The main activities of the group included support in social, legal and psychological issues. The project was started by a woman that had a long personal experience of drug injecting and maintained contacts with many drug using women in Tallinn. She invited women to visit the group, informed them about services, provided them with clean needles and condoms. One of the most popular activities of the group was art-therapy sessions where women could realize their creative ideas. Step by step, the group grew into a strong self-support body. Later on, when the group was established and stable, the project received some governmental support. It expanded its activities to provision of humanitarian aid to children of HIV positive mothers (nappies and foods) and to women themselves (clothes, shampoos etc). The project also included regular IEC component – issuing of information materials for women, counseling, training sessions on health, culture, human rights etc. Once a month Convictus also visited women prison where they also facilitated a support group for women. Later, the project also included home visits to women who couldn't attend group meetings, as apart from active drug use they had children to take care of, work etc. During home-visits the project outreach workers documented special needs of their clients, provided them with informational materials, syringes, counseling and support. Many clients circulated between prison and society. One issue that felt particularly acute was absence of drug rehabilitation programs for women where drug users could be referred to. Currently this project does not exist any more, and the services will be provided within the general harm reduction services. Besides, Convictus will soon start its own rehabilitation program for women IDUs.

**Box 5**

In 2006 this group ceased its work as the organization decided to integrate the service with the new rehabilitation structure. These efforts should be revived and strengthened in Estonia. In addition, drug treatment options for women should be increased and not be limited to long-term rehabilitation.

*Young injectors/initiators*

The importance of preventive interventions among occasional and experimenting drug injectors and non-injectors including young people, has become more explicit in research and interventions literature<sup>78</sup>. One of the well known interventions in this area is "Break the cycle" developed in the UK by Hunt and colleagues<sup>79</sup> and successfully piloted in other countries, including countries of Eastern Europe and former Soviet Union. Such interventions aim to help occasional and experimenting drug users to stop all drug use, or avoid initiation into injection and more problematic modes of drug use as well as educate them on harm reduction measures. They also include work with those who already inject in order to intervene at early stages of injecting career and prevent grave health consequences such as HIV, hepatitis and drug overdose. They also target more experienced IDUs encouraging them to 'break the cycle of initiation into injection by not: helping others initiate IDU; injecting in presence of non-IDUs; talking about 'benefits' of IDU.

Need for such targeted effort in Estonia seems to be quite high. Literature reveals high prevalence of drug use including injection among younger people. For example, in a 2003 study it was found that 5% of Estonian young people in the age between 14 and 29 years have ever injected drugs. A study of HIV risk behaviour among IDUs in Tallin and Kohtla-Järve (Usskula et. Al.) reported a mean age of initiation to drug use of 17.2 years and 19 years for heroin. By 2006, 80% of the new registered HIV cases occur among the persons aged less than 30 years<sup>80</sup>. While the proportion of younger people (under 25 years) among newly reported HIV cases has been decreasing in recent years (from 82.8% in 2000 to 45.2% in 2006) they still represent an important group which requires specially designed interventions. As noted by IDU participants of the FG in Tallinn: "*People start to use drugs at very early age. Nowadays, more youths are getting involved into drugs compared to the old times. They use all kind of drugs: amphetamines, China White, everything. Some start by smoking...*". This person noted that initiation into drug use happens more often by smoking or inhaling which was not the case in

earlier times – back in early 1990's people were starting their drug use with homemade poppy-based opiates which was usually used in solution so initiation of drug use would more often coincide with initiation of injection. According to this and other participants today more young people start with smoking and move into injecting only after they develop more problematic patterns of use, including drug dependency and financial problems. This leaves quite a large room for the early stage prevention interventions such as 'Break the cycle'. In Estonian situation with very high HIV and HCV prevalence among IDUs such interventions would be especially important as young injection initiators are at higher risk of acquiring one of the infections and sharing syringes with more experienced injectors than in countries with lower prevalence. Developing of these type of interventions could in fact be one of the most effective ways to put HIV epidemic under control and avert its spread among injecting drug users.

### *Amphetamine injectors*

Use of stimulant drugs has particular characteristics which influence effectiveness of HIV prevention, treatment and other harm reduction services. The main relevant characteristics are much higher frequency of injections (5-6 per day compare to 1-2 per day for opiate users) and consequently higher risks of syringe sharing<sup>§</sup>. Another characteristic is higher sexual activity of stimulant injectors including unprotected sex and sex trade<sup>81</sup>. Lack of effective drug treatment (such as, for example, opiate substitution treatment for opiate dependent people\*\*), and higher co-morbidity with mental problems such as severe depression and psychosis makes access to the group and prevention programs especially challenging as well as aggravates problems related to adherence to HIV and other treatments. Some guidance on the management of non-opioid dependence (including amphetamine type stimulants) is available – for example in the WHO HIV/AIDS treatment and care protocols for injecting drug users.

While in Estonia opioid users have a significantly higher odds of being HIV positive than injectors of amphetamines, stimulant users represent a very-high-risk group in terms of HIV prevention in demand of specially tailored services and approaches. Failure to reach out to this group and provide them with specific information and other services can undermine effectiveness of well developed harm reduction intervention. A globally known case is presented by evaluation of Canadian needle exchange programs which did not manage to prevent spread of HIV among their clientele despite high level of coverage and needle provision<sup>82</sup>. As found by subsequent evaluation research, one of the main reasons of perceived 'failure' of programs in Montreal and Vancouver was epidemic of stimulants injection at the localities as well as inadequate programmatic rules, including exchange of syringes rather than unlimited distribution.

According to Tallinn focus group amphetamine injection is very widely spread in Estonia fuelled by local production of ATS drugs. According to the UNODC World Drug Report, 2007, the highest prevalence rates of ATS use in Europe are reported by the UK, Denmark and Estonia. In contrast, the pilot drug treatment database study carried out by the NIHD revealed that only 1.4% of drug treatment clients are ATS users. In 2006 only one day-care centre, NGO *Eesti Abikeskus* provided services for patients with dual problems related to drugs and mental health, the annual number of the centre was limited to 23 people<sup>83</sup>. A recent study focusing on the first time and multiple visitors of syringe exchange points in 2006 shows that amphetamines are most frequently used injecting drugs - 53% of SEP visitors had injected amphetamine in the last 4 weeks; followed by heroin (40.9%), poppy liquid (38.9%) and fentanyl (9.1%)<sup>84</sup>. A behavioural study, using respondent driven sampling<sup>85</sup> reported that 63% of injectors had recently (within the previous few weeks) used amphetamine and 19% reported it as their main drug (22% in Tallin and 10% in Kohtla-Jarve). In this group of injectors the mean age of first use of amphetamine was 18.1 years (range 12-39).

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<sup>§</sup> In Estonia, amphetamine injectors have higher sharing rates than heroin injectors (19% v. 17%) but lower than fentanyl injectors (29%).

\*\* Although some efforts in amphetamine prescribing are taking place in countries such as UK, they have not reached the level of scientific and political acceptance

While it looks like ATS users are well represented among NSP clients in Estonia, we could not identify any specific interventions for this group. These interventions could include specific information and counselling, support groups, referral for mental health services. The focus of information for this group could include: alternative routes of consumption (non-injection) and reduction of related harms; sexual safety; regulation of drug use (including ways to reduce binge using and related health harms; prevention of ATS overdose).

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## ADDITIONAL HEALTH ISSUES

Both issues mentioned below have high relevance as specific important health issues for drug users in general, and also as specific issues in HIV prevention and treatment. For example, infection with hepatitis C virus (HCV) represents the main co-morbidity for HIV positive IDUs in Estonia. Drug overdose represents a major cause of death in PLWHA IDUs in Europe<sup>86</sup>, and studies indicate that risk of lethal overdose is higher in HIV positive users<sup>87</sup>.

### *Hepatitis C*

The data submitted by Estonian country focal point for a regional review on Hepatitis C<sup>88</sup> revealed the following facts: Estonia is among 4 countries with the highest prevalence of HCV among IDUs in the region of Central and Eastern Europe and has the highest prevalence of HCV among all 12 new EU Member States<sup>89</sup>. HCV is also a predominant co-morbidity for HIV positive patients: a study among PLWHA seeking medical care demonstrated that HCV prevalence in this group approached 80%. HCV is especially prevalent in young people and those injecting for less than five years. Rates of HCV prevalence among prisoners are very high: from 82% to up to 97.4% (though sample sizes were small)—while none of the inmates in the sample tested positive for HIV. According to the review testing for HCV at NSPs and OST sites is limited. HCV treatment guidelines were developed in 2006 by the Society of Gastroenterologists and Society of Specialists in Infectious Diseases and they indicate that current drug use can be viewed as a possible contradiction to treatment of hepatitis: in practice, at least a six-month abstinence period was demanded from potential patients of HCV treatment. While diagnostic tests, including confirmatory antibody test, RNA and genotype tests, liver biopsy for people with chronic HCV and before treatment are available, they can only be provided free of charge to people with medical insurance. By the time when data was submitted (late 2006) treatment schemes included combination PEG-IFN+ribavirin or interferon mono-therapy and the price of therapy could be reimbursed by the state insurance. While treatment in prisons was not available back in 2006, the MoJ officials said that from 2008, free HCV treatment will be available for all prisoners who need it.

As noted in the 2007 REITOX report: "Although Estonia has made substantial achievements in the field of HIV/AIDS prevention among the general population and risk groups, prevention of HCV and HBV among IDUs has not been a priority despite high prevalence of HCV"<sup>90</sup>. Lack of prevention activities reflects in low hepatitis awareness among drug users: for example, participants of the 2005 RDS study in 2 cities have reported practices potentially risky in terms of HCV transmission: in addition to 29% (out of 450 participants) who reported sharing syringes in the last 4 weeks, almost fifth of the sample (27% / 123) reported front loading, 42% sharing water, 26% - sharing spoon or container and 12% - sharing filter in the last 4 weeks<sup>91</sup>. In that study 73% had been tested for HCV and of those tested 41% (135/329) reported a positive test result. MoJ officials reported on low concern of prisoners regarding HCV: while HCV testing is offered in prisons, its uptake is very low (in contrast to high uptake of HIV testing).

In terms of prevention of HCV, specialists from NIHD mentioned that they would like to include paraphernalia other than syringes and needles which may help to strengthen HCV prevention (including filters, cookers, water, etc) in the range of harm reduction products provided at NSPs. In general more work should be done in order to increase HCV awareness both among IDUs and service providers.

### *Overdose*

Drug overdose (OD) represents a major health danger for injecting drug users (IDUs), especially for opiate users. Despite the HIV pandemic, overdose-related death remain a major cause of

mortality in this group, and in many countries OD is the leading cause of premature death among adults<sup>92</sup>. Within the European Union, death rates more than doubled between 1985 and 2000. In early 2000s the annual figure of OD deaths in the region was between 8,000 and 9,000, however that was thought to be an underestimation of the true rate<sup>93</sup>.

However, this problem has been largely neglected globally and particularly in the countries of the former Soviet Union<sup>94</sup>. For example, routine mortality statistics tend to underreport the number of overdose deaths in many countries<sup>95</sup> including Estonia: according to Estonian 2007 REITOX report "Absence of toxicological information has been a problem in Estonia for a long time"<sup>96</sup>. The same report indicates that according to official statistics, a total of 68 direct drug-related deaths (59 men and 9 women) were registered in Estonia in 2006 which is similar to levels registered in the previous years. However, a 2005 community survey reveals that 65% out of 450 IDU-participants have ever experienced overdose. Of those, two thirds (69%, 203/293) have experienced overdose within the last year (mean number of episodes: 2.2, range 1-48). Only half of them (59%) reported having received medical assistance in case of an overdose during the last year<sup>97</sup>. Participants of FG in Tallinn noted that while OD, including lethal overdose was very common (due to rapidly changing quality of drugs '*one doesn't really knows what he gets [from a drug dealer]*').

According to 2007 Estonian REITOX report: "Prevention of drug-related deaths and overdoses has been defined as an important strategic objective of the NSPDD until the year 2012. In 2006 no specific interventions aimed at the prevention of drug-related deaths and overdoses among IDUs were introduced". The report further notes that "substantial achievements have been made in terms of information dissemination among IDUs on prevention of overdoses"<sup>98</sup>. However, these informational activities are definitely not scaled up to the level efficient for achieve significant impact. For example, the most vulnerable group in terms of lethal overdose are people who re-start opiate use after a period of remission, for example, after return from drug-free rehabilitation programs or from prisons. But no OD prevention education is provided within rehabilitation programs or in prisons, according to MoSA and MoJ officials.

A major contributory factor as to whether or not an overdose is fatal is the responses of those present<sup>99</sup>. Research emphasizes the clear potential for reducing fatalities and harm associated with overdose should those present respond rapidly and appropriately. But this response also depends on many environmental factors, including police practices and legal environment. While admitting being witnesses to many drug overdoses, respondents of Tallinn FG also confirmed that people rarely call ambulance or seek professional help: '*Last year I was resuscitated 2 or 3 times, but [his friends] did it themselves, they never called an ambulance because police comes along in 100% cases. They can lock you up for 2 days then*'. They also mentioned that people avoid calling an ambulance because there were cautious that people were charged with murder when their friends died of overdose and ambulance witnessed it. Rumors or reality, this information being circulated in drug users' circles can significantly influence IDUs willingness to contact medical services.

Accordingly, recommendations coming out of many studies emphasize the importance of providing peer education to drug users on OD prevention and management of OD cases when they occur including provision of Naloxone to drug users. Naloxone is a specific opioid receptor antagonist used to reverse an opiate overdose and having almost none side effects<sup>100</sup>. Naloxone has long been prescribed to drug users in Europe and the US. A pilot project of naloxone distribution via harm reduction programs has also just started in Russia<sup>101</sup>.

While Naloxone (produced by Ratiopharm) is registered in Estonia, it is used only in medical services such as emergencies<sup>102</sup> and is a prescribed medication. A short survey of about 10 largest pharmacies in Tallinn carried out in January 2008 revealed that Naloxone was not available in Pharmacies neither with nor without prescription.<sup>103</sup> A Tallinn FG participant who used to work in emergency services said that the price of Naloxone in Estonia was very high – about 50\$ per a 2 cc ampoule and so it is used by ambulance very carefully.

It should be noted that while less prevalent, stimulant related overdoses can also represent an important public health concern and users of ATS drugs should receive special education on OD prevention.

### **Recommendations:**

Ways to increase accessibility of NSPs particularly by piloting pharmacy schemes and possibly vending machines should be explored. UNODC role could be either in supporting a pilot project on introducing pharmacy schemes in Tallinn or Narva or in providing specific training for pharmacists or site visits to places where such schemes are implemented.

Existing services should pay special attention to groups with special needs, such as female IDUs, young/intermittent injectors and amphetamine injectors and users. A needs assessment should be carried out in these groups in order to design IEC and other specific and attractive services for them. UNODC could support a consultation on such topic or specific needs-assessment study. Support to a specially designed peer-driven intervention could help to establish access and peer-education in these hard-to reach groups.

Issues such as hepatitis C and drug overdose represent a serious outstanding health problem but are also relevant in terms of HIV prevention and treatment especially as most prevalent co-morbidity and mortality factors for PLWHAs. Special attention should be given to these issues by service providers.

In terms of hepatitis: efforts to prevent HCV spread among drug injectors should be strengthened, including more focused awareness campaigns and provision of wider spectrum of injection paraphernalia. HCV treatment should be made available to people that need it, including current injectors and people without health insurance. EHRN Knowledge Hub, supported by UNODC could play a leading role in facilitating local discussion on HCV and strengthening prevention and treatment issues and providing training for local specialists.

In terms of overdose: Increased focus on OD prevention and management education should be placed in current IEC services for drug users, including opiate and ATS users. Programs that include focused OD education and Naloxone provision schemes should be piloted, possibly with support from UNODC.

## **3. ENVIRONMENT**

The World Health Organization endorsed principles of the new public health movement outlined by the *Ottawa Charter for Health Promotion*<sup>104</sup>. The five principles are: developing individual personal and social skills; reorienting health services toward improving access, availability, and use; facilitating and strengthening community participation and collective action; creating local environments that are conducive to individual and community health; creating public policies supportive of health. Harm reduction approach reflects these principles by emphasizing importance of community, policy, and environmental change for achieving sustainable results in HIV prevention efforts. The International Guidelines on HIV/AIDS and Human Rights state that "States should, in collaboration with and through the community, promote a supportive and enabling environment..."<sup>105</sup>. These environments are not limited to health issues, but relate to wider political, economical and social spheres in which HIV prevention and treatment efforts are realized.

### **3. 1 DRUG LEGISLATION AND ITS ENFORCEMENT**

#### *Legal framework*

The fact that drug-related legislation and the way it is enforced represents a crucial factor of effectiveness of HIV combating efforts is now widely acknowledged<sup>106</sup>. Drugs laws and their enforcement may be crucial contextual factors for success or failure of HIV related activities and more general public health efforts to reach out to drug users.

Estonia has ratified the main international drug control conventions: the United Nations Single Convention on Narcotic Drugs (1961), United Nations Convention on Psychotropic substances (1971), United Nations Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances (1988), and the Council of European Convention on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime (1990). These conventions provide a framework for the Estonian drug legislation. This legislation on drugs has been in the process of on-going change since the mid-1990s when drug problems started to increase. Since then, Estonia has moved towards toughening its drugs policies<sup>107</sup>.

The main Estonian drug law is the Narcotic Drugs and Psychotropic Substances Act that entered into force on 1 November 1997. The revised and renamed Narcotic Drugs and Psychotropic Substances and their Precursors Act (NDPSPA) replaced the previous version and entered into force on 1 July 2005. NDPSPA regulates the procedure for preparation and approval of schedules of narcotic drugs and psychotropic substances and precursors, the procedures of handling, inspection, identification of such substances, the procedure regarding information and reporting on drugs, and the procedure for drug prevention and treatment. The NDPSPA foresees responsibility for illegal acquisition, possession and use of a small<sup>††</sup> amount of narcotic drugs and psychotropic substances for one's own consumption. Drug use is viewed as a misdemeanor punishable by a fine or detention up to 30 days in the police arrest house.

Illegal trafficking or mediation of small quantities of narcotic drugs or psychotropic substances, or illegal manufacture, acquisition or possession of small quantities of narcotic drugs or psychotropic substances with the intention of trafficking is punishable by a fine or up to 3 years' imprisonment (Penal Code (PC) §183)<sup>108</sup>.

#### *Prosecution, judicial practice and policing*

There is no explicit provision in all 3 International Drug Conventions that require that countries apply punishments for use of illegal drugs, although it has to be limited and, in the case of psychotropic substances, prohibited<sup>109</sup>. Countries in Europe differ in regards to legislation related to drug use per se, but even in countries where there are provisions against drug use or possession for personal use, the actual enforcement seem to avoid mass arrests and rarely drug use or possession of small amounts for personal use entails consequences as serious as deprivation of freedom even for a short period. For example, while drug use is illegal in France, the country with one of the most repressive drug laws in Europe, the actual policy emphasizes prevention, harm reduction and drug treatment rather than prosecution. Regarding penal policy, the law of prohibiting drug use has not been modified since 1970 but the Minister of Justice invites prosecutors to avoid imprisonment and to promote treatment which translates into prevention and information in the context of diversion away from the criminal justice system. The police and the criminal justice system generally must facilitate harm reduction, as far as users are concerned<sup>110</sup>. In many European countries, even where the criminal law is applied to drug use or possession, the person could be diverted from the criminal process to treatment or social facilities.

In Estonia, in case of criminal or administrative cases, the prosecutor's decision can either be a diversion from prosecution or an official charge. There are no official guidelines how to prosecute various types of drug offences. According to the Penal Code, the judge has a right to apply a suspended sanction or release from punishment, if he/she supposes that this is more appropriate in the circumstances (taking into account the features of the offence and characteristics of the offender). There are no conditions which forbid such a decision to be made, but probation for a period of three to five years shall be ordered. A possibility to

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<sup>††</sup> According to NDPSPA §31, a "large" quantity of narcotic drugs or psychotropic substances is an amount that is sufficient to cause intoxication of at least ten persons. The State Prosecutor's Office has issued relevant guidelines on most common controlled substances.

implement alternative sanctions (i.e., other than fine, detention or imprisonment) is provided only in cases of juvenile offenders and is regulated by the Minors Sanctions Act (1998)<sup>111</sup>. However, in practice, our respondents noted that even for misdemeanors such as drug use per se, the courts rarely provide for alternatives to imprisonment: the long waiting lists exist not only for medical institutions but also for arrest houses! One respondent in Tallinn FG told a story that he had to break a court order punishing him for drug use: while the court ordered him to serve a sentence until August, 1<sup>st</sup>, when he contacted the arrest house they told him that places will only be available in September. This problem was confirmed by other participants as well. They also indicated that imprisonment is a common experience of majority of drug users in Estonia: *"Four people out of ten would ever have been imprisoned"*. *"Every other drug user has ever been in prison"* A 2005 study among 450 IDUs confirms that almost two thirds of the respondents (64%, 286/450) have experienced imprisonment. The median number of lifetime imprisonments was two (range 1 – 35)<sup>112</sup>.

### *Policing*

The police have no rights of discretion and they are obliged to notify any offence discovered on duty. According to § 13 of the Police Act, Police has the right to "take persons who due to alcohol or narcotic intoxication might present a danger to themselves or to other persons, and also persons who have violated public order to a medical institution or to the police for the identification of such persons and where necessary, for the preparation of a misdemeanor report.

This provision is taken quite seriously by the Estonian police, which leads to quite strong influence of policing on behaviours of drug users. According to the Tallinn FG participants, many people are just afraid to walk the streets, let alone contacting services and the main legal 'threat' for drug users on the streets in terms of legal punishment is presented by the law prohibiting illegal drug use. The police have quite a strong presence and visibility: according to 2005 RDS report, 71% of the 450 IDU respondents in 2 cities have reported having been stopped and 58% having been arrested at least once during the last 12 months. The reasons for being stopped or arrested provided by respondents point out that "crimes" as serious as possession of used or sterile needles may represent a serious threat to drug users freedom: The reasons for being arrested or stopped by the police during the last year were as follows: for drug use 48.6% of the respondents, for having sterile needles - 8.6%, for having used syringes - 16%, for theft - 27%, for drug sale - 4.0%, for alcohol use - 4.0%. Within the 4 weeks preceding the study, the police had confiscated syringes at least once from 9,8% (N=44) of the IDUs surveyed, and within last 12 months from 24% (N=107) of the respondents.

The presence of the police may play a crucial role even in emergency situations such as risk of overdose and death. Our FG participants in Tallinn said that users tend to avoid calling ambulance services in case of OD, as the police always follows the ambulance to places where drug overdose took place.

### **Recommendations:**

Taking into consideration that repressive national drug policies are among the main obstacles for ensuring adequate access to HIV treatment and prevention programs for IDUs, the government should consider removal of repressive laws and actual policies against IDUs and prioritise healthcare principles over law enforcement approaches in dealing with drug problems. These principles should be also highlighted in all relevant strategies, such as National HIV/AIDS and Drug Prevention strategies. Particularly, legal punishments for drug use per se and for possession for personal use and the way they are enforced in Estonia should be reviewed and options for alternative sentencing should be explored carefully and without delay and options for optimising the system by decreasing of the rate of imprisonment among drug users suggested.

Police training on harm reduction and public health issues among drug users should be strongly improved. Official recommendations should be issued against such measures as confiscating

clean syringes or impeding otherwise country prevention and harm reduction efforts by unduly intensive harassment of street drug users. Practices such as police convoy of health services, including ambulance should be repealed. UNODC could play a strong role by supporting focused training / consultation with police as well as helping to bring these issues on the agenda of both National HIV and Drug Committees.

### 3.2 STIGMA AND DISCRIMINATION

Stigma and discrimination of drug users was a cross-cutting issue in almost all of the meetings and interviews. Patronizing at best, or disdainful or discounting attitude of medical service providers was mentioned many drug users as one of the main barriers to ask for, or adhere to, doctors and other medical staff: *"They don't count drug users as people, they [health institutions] recruited a lot of these young girls [as medical staff] who just bully these poor junkies, who sometimes can barely walk..."* - said one of focus group participants in Kohtla-Järve. Focus group discussions revealed several shocking cases of refusal of medical assistance to drug users. This was particularly an issue in prisons settings: *"no medical assistance is provided; they would never call up an ambulance whatever happens"*. For example, one participant of a focus group in Tallinn described a situation when he had an epileptic seizure while being incarcerated: *"a medical nurse came in, looked at me and just didn't do anything"*. Problems with ambulance service occur not only within but also outside prisons, for example several FG participants from both Tallinn and Kohtla-Järve reported that if while calling an ambulance a person reports that the case was related to use of drugs, the ambulance may simply not bother to arrive, or if it arrives it is accompanied by police.

Such shocking examples can explain drug users' reluctance to contact medical services and the fact that many people avoid seeking for any assistance until the health condition is really bad. Interviews with medical specialists provided similar observations. Even the most progressive medical doctors we interviewed viewed failure to recruit and retain IDU patients in HAART as failure of the patients, rather than failure of the system to provide the necessary support and respond to special needs of IDUs.

Literature review confirms our findings. For example a recent study on access barriers for PLWHA in Estonia revealed a high level of HIV fear and stigma among medical professionals in Estonia<sup>113</sup>. The negative attitude of medical staff toward IDUs was also stated as a primary barrier to hepatitis C treatment by respondents from Estonia in a situation review on Hepatitis C among IDUs in the New EU Member States and Neighbouring Countries<sup>114</sup>

According to a UNDP report on access barriers for PLWHA, while there are no specific anti-discrimination provisions for PLWH or risk groups in the Estonian legislation, the constitution has established general equality before the law and prohibits any discrimination on the basis of nationality, race, colour, sex, language, origin, creed, political or other persuasions, financial or social status, or other characteristics. The constitution also guarantees citizens the right to health care. Estonia is a party to the UN Universal Declaration of Human Rights (1948) and the European Convention of Human Rights (European Council 1961). However, according to UNDP report, very few studies have evaluated how these laws have been implemented with respect to PLWHA in Estonia, and no court case has addressed PLWHA rights.

#### **Recommendation:**

Stigma and discrimination represent major factors, prohibiting equal access of IDUs, including PLWHAs to medical and social care, prevention and treatment programs. This problem could be tackled by systematically being addressed in all forms of medical and other services staff education. A consultation held between PLWHAs, NGOs (including harm reduction), police, medical and social workers of general medical services, human rights organizations and officials of MoSA, Mol, MoJ on how best systematically address the issue of stigma and identifying major target groups may provide a good start for such discussion and addressing this issue on a regular national basis.

### 3.3 ECONOMY AND ETHNIC POLICIES

As noted in previous reports the Estonian economy is undergoing a transition period related to integration into the EU economy. This generally positive economical development can have dual consequences for people, and especially for socially and economically marginal groups of society, such as drug users whose needs may not always be taken into account while developing new strategies and structures.

Available data offers little doubt that economical status, wealth distribution; living and social conditions and related health consequences in Estonia directly correlate with the intended or unintended consequences of the country ethnic policies. The 2005 data shows that the unemployment rate among the non-Estonian population was twice as high as compared to that of Estonians<sup>115 116</sup>. Unemployment is especially high in areas with predominant ethnic Russian population – in 2004-2005 the highest unemployment rate (17.9%) was in Ida-Viru County<sup>117</sup> with 81.4% Russian population and the lowest (4.1%)<sup>118</sup> on the island of Saaremaa with only 2%<sup>119</sup> Russian population. Data on overdose shows that OD mortality is disproportionately higher among people with Russian citizenship and people without Estonian citizenship compared to people with Estonian citizenship<sup>120</sup>. The previous evaluations noted "distinctly higher rates among the Russian speaking population of drug addiction, HIV infection or other problems that seem to cluster in the Russian-speaking community"<sup>121</sup> they also emphasized that current analysis of correlation of health, economic and political status of different ethnic groups in Estonia is insufficient.

The issues of ethnic minorities on the labor market have been under serious consideration in Estonia in the recent years so situation might have changed on the policy level since the time of 2005 evaluation. Particularly, under the country Development Plan for the Implementation of the EU Structural Funds Estonia was trying to increase employment and the largest resources have been invested in areas with lowest levels of employment such as Ida-Viru County. Other measures for reduction of unemployment of non-Estonians and prevention of HIV/AIDS are envisaged within a new integration programme for 2008-2013. These measures include continuing support to language training, workforce exchange programmes in different Estonian regions, shaping tolerant attitudes toward different national groups and their cultural peculiarities, elaborating and implementing adaptation programmes for the prevention of migration related social problems<sup>122</sup>.

Suggesting solutions for problems related to economic, social and political disparities is clearly outside the scope of this report. However, in resonance with previous reports we emphasize that without addressing these broader political and social issues, it will be impossible to fully tackle IDU/HIV problems in the largely affected group of Russian population of Estonia. Indeed, participants of both focus groups in Tallinn and Kohtla-Järve (all Russian drug users) mentioned unemployment, homelessness, lack of means for living and absence of medical insurance as their main problems. For them, solving issues like finding a place to sleep, finding money for drugs, food and family needs, avoiding contacts with police etc on a daily basis present much more pressing issues than taking care of health. It therefore should be of no surprise that drug users contact medical services only in most critical situations and addressing these pressing needs of drug users it will be impossible to focus their interest in issues related to HIV prevention and treatment and other less urgent matters.

Studies show that IDUs and PLWHAs come from disadvantaged socio-economic groups. This was noted in a study of access barriers for PLWHA in Estonia – most participants of this study reported educational and financial disadvantages compared to the general Estonian population. Of all respondents, 40% had not finished secondary school, and only 5% reported any education beyond secondary school. Poverty was common: 42% of participants' families earned less than 77 USD per month per family member, and 37.4 % were unemployed or seeking work at the time of the study. The report also notes that since participants were recruited from doctors' offices, these rates may overestimate the employment situation among PLWHA; it is possible that PLWHA who seek medical care are more aware of social and medical services available and also more likely to be employed.

Participants of the Tallinn FG said that the major issue that preoccupied them was housing. At least 4 people out of 6 didn't have a place to live. They said that like many drug using peers they have to find shelters in house entrances, basements, huts. When asked about social shelters they noted that even though the services were social they were not free – in one shelter a person had to pay 400 EEK as the first deposit, in another – 150 EEK per month and 25 EEK for every change of linens. While comparatively low price it still did not seem realistic to respondents, who do not have regular sources of income and have to prioritize expenditures in order to pay for drugs. However, even if money was found, the services were still not open for drug users, said FG participants. “When I came they just refused to take me saying that there were no slots. They just don't want to deal with drug users”. While an option to cue for social accommodation was in principle possible, it was not a viable option for our respondents as most of them came from other cities and didn't have residency permits in Tallinn. In terms of employment they emphasized that since they were Russian speakers or even Russian citizens it was extremely hard to find one: “You come to a firm, the first question – do you have the *blue passport* [Estonian citizen]. If not – ok, please leave your contact information we'll call you later...”. “I was born here, all my kith and kin live here, but still I'm an alien. The Motherland and the State are not the same things for me” – said one participant expressing the common sentiment of the group.

Socio-economic disparities should be taken into consideration when developing and adjusting harm reduction strategies for drug users. Besides, special issues related to social and economical disadvantaged groups such as drug users should be taken into account while developing broader social and economic reforms. One example provides quite a shocking illustration of unintended consequence caused by absence of due considerations of needs/problems of socially marginalized groups and subsequent development of balancing harm reduction strategy while developing and implementing a new economic and social policy:

#### **Discontinued child care for IDU women**

One of the three pillars of Estonia population policy is increasing the number of births to reproduction level. The family policy concept incorporates such tasks as improving the quality of life of children and families with children; support for combining family and work life; attachment of value to raising children. A system of state benefits to families has been developed in order to support the policy. The new Parental Benefit Act took effect on 1 January 2004 and envisages financial support to working as well as not working parents. This includes a birth grant of about EUR 320 for all newborns and the monthly compensation with established minimum of 2 480 EEK (EUR 159) per month. Non-working parents have the right to parental benefit for 14 months starting from childbirth. The parental benefit is paid from the state budget through regional Pension Boards<sup>123</sup>. However, this positive policy has reportedly led some IDU or alcoholic women to give birth to undesired children which are often abandoned after 14 months when the government support expires. There is no system in place to help these women during the 14 months to develop their parenting skills or any kind of support aiming to prevent child abandoning. It is important to note that discussion of this situation should avoid any kind of moralizing and victim-blaming and the focus for decision makers should be establishing a system in place in order to help IDU mothers to continue child care and support their families after the child support expires.

#### **Box 6**

#### *Health insurance*

Issues related to employment also have direct impact on access to health services as they reflect in individuals abilities to hold health insurance. Health insurance in Estonia is funded through a compulsory scheme which came into effect on 1 January 1992. According to this scheme employers are obliged to pay a social and health insurance tax for their employees. Emergency care is available regardless of the person's insurance status. Coverage of Estonian health insurance is based on residency, not on citizenship.

Information on coverage of health insurance is different in different sources. While the national web-site of Estonia states that the coverage by health insurance is universal, according to the information provided in the Estonian National HIV and AIDS Strategy for 2006-2015, only 94% of the population were covered by the insurance in 2003<sup>124</sup>.

However, the 2005 RDS study among drug injectors in 2 sites revealed that only 45.3 % (N=204) of all study participants were covered by state health insurance at the time of the study. The difference in health care coverage by study site was noted: only 50% (N=165) of the participating IDUs in Tallinn and 38% (N=37) in Kohtla-Järve ( $p=0.029$ ) reported having the state health insurance<sup>125</sup>.

The contrast between relatively high overall population coverage of health insurance and strikingly low coverage among IDUs points out that there are some structural issues within the national economy which prohibit equal access to health services for groups that may need these services most such as drug users. As health insurance is provided in Estonia by employers, the issue of getting access to health insurance becomes tightly connected to issues of finding employment that are mentioned in the beginning of this section.

### **Recommendations:**

Broader socio-economic issues should be taken into consideration while planning health services for drug users. In order to bring this message to national policy makers local drug services should increase their advocacy skills and profile. They should play a crucial role in advocating for consideration of various issues related to vulnerable groups such as drug users and structural solutions of social inequality problems.

Besides advocating for broader social change and consideration of drug users needs in policy and economic reforms drug services could examine ways to provide response to pressing everyday needs of drug users such issues as linking drug users with existing shelters or opening specialized shelters for drug users; possibly provision of food and second-hand clothes; help with finding employment and acquiring health insurance; professional training or language skills courses. Other immediate and long term solutions could be identified in more thorough consultation with drug users and Estonian and international drug service specialists.

ANNEX 1 LIST OF INTERVIEWEES AND SITE VISITS

**National Institute for Health Development**

Annika Veimer, Development Director

Aljona Kurbatova, Head of the Department of Prevention of Infectious Diseases and Drug Addiction

Kristi Rüütel, HIV and AIDS Expert

Aire Trummal, Analyst

Ave Talu - head of Estonian Drug Monitoring Centre;

Katri Abel - researcher, Estonian Drug Monitoring Centre

Kaire Vals - coordinator of the drug treatment database, Estonian Drug Monitoring Centre

**Ministry of Social Affairs**

Ulla-Karin Nurm, Head of the Public Health Department

Merilin Mäesalu, Chief Specialist, HIV/AIDS

Maris Salekesin - Chief Specialist, Drug Abuse

**West-Tallinn Central Hospital**

Kai Zilmer, Head of the Infections Centre

**Narva Rehabilitation Centre for Drug Users**

Tatjana Magerova, Head of Organisation

**AIDS Information and Support Centre/Health Centre Elulootus**

Jüri Kalikov, Head

Nelli Kalikova - Project Coordinator

Julia Korsakova - Needle Exchange Worker

**Narva Hospital**

Leonid Sizemski, Infectionist

Dimitri Jaaniste, Infectionist

Lilia Novikova, Infectionist

Vladimir Gruzdev, Pulmonologist

Andrei Lossev, Pulmonologist

**We Help You**

Aleksander Lannemann, Head of Organisation

Ruth Tera, Needle Exchange Worker

Pavel Grjaznov

Jüri Kumpin, Outreach Worker  
Vladimir Lüde, Outreach Worker  
Roman Sidorov, Outreach Worker  
Roman Mazajev, Outreach Worker  
Sergei Mazajev, Outreach Worker  
Clients of services

#### **Tallinn Low Threshold Centre**

Ene Villak - Manager of the Centre  
Ingrid Säär - Social Worker  
Kristiina Niitsoo - Social Worker  
Ruth Murakas - Nurse

#### **Ministry of Justice**

Aire Põder - advisor, Prisons' Department, Social Care Division  
Kristel Jürgens - advisor, Prisons' Department, Social Care Division

#### **Ministry of Internal Affairs; Police Board**

Veiko Kommusaar - Adviser, Law Enforcement Policy Bureau, Ministry of IA  
Siiri Pars - Chief Commissar, Law Enforcement Department, Police Board  
Meelis Smitt - Commissar, Law Enforcement Department, Police Board

#### **Convictus Estonia**

Kristina Joost – Head of the Organisation  
Igor Sobolev - Project Coordinator, Needle Exchange  
Klavdia Kondratjeva - Needle Exchange Worker  
Elena Ivantšikova - Needle Exchange Worker  
Roman Družinin - Needle Exchange Worker  
Ija Tšerenkevitš - Needle Exchange Worker  
Pjotr Kutuzov - Needle Exchange Worker  
Krista Joost – Support Group Leader  
Tatjana Serdjuk - Needle Exchange Worker  
Latšin Alijev - Prisons' Project Coordinator and Support Group Leader  
Alla Tannil - Support Group Leader  
Helena Tarvis, Strategic Planning Officer  
Clients of services

## ANNEX 2 FOCUS GROUPS TOPIC GUIDE

### Introduction

Please tell about situation on the drug scene

- Types of drugs
- Injected not injected
- Who uses what

What are the main problems that drug users face?

- Health?
- Police?
- Social problems?
- Other?

Which of these problems are addressed by the HR projects?

Which are not?

How the services could be improved?

- coverage
- time, location, assortment, range of services?

Exchange rules

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