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EUROPE

# *EVALUATION OF FIGHTING HIV/AIDS IN ESTONIA*



# Evaluation of fighting HIV/AIDS in Estonia

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## Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral
CCM	country coordinating mechanism
CDC	Centers for Disease Control and Prevention
ECDC	European Centre for Disease Prevention and Control
EEK	Estonian kroon
EU	European Union
GF/GFATM	Global Fund/Global Fund to Fight AIDS, TB and Malaria
GP	general practitioner
HBV	hepatitis B virus
HCV	hepatitis C virus
IDU	injecting drug user
M&E	monitoring and evaluation
MOD	Ministry of Defence
MOER	Ministry of Education and Research
MOJ	Ministry of Justice
MOSA	Ministry of Social Affairs
NGO	nongovernmental organization
NIHD	National Institute for Health Development
NSP	needle and syringe programme
OST	opioid substitution therapy
PEPFAR	President's Expanded Program for AIDS Relief
PLHIV	people living with HIV
PR	principal recipient
QA/QC	quality assurance/quality control
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TOR	terms of reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nation's Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development

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## Summary

This evaluation is taking place at a pivotal time in the history of Estonia's response to HIV and AIDS. A major Global Fund grant has recently ended and it is now a perfect time to reassess the progress made and the country's priorities. This evaluation has been requested by the Ministry of Social Affairs and the National Institute for Health Development (NIHD). It forms part of the collaborative agreement between the Estonian Government and the World Health Organization, to support the scaling up the national response to HIV and AIDS. It is being conducted under the joint auspices of UNODC and WHO. It builds on a range of previous WHO work and is expected to feed into the development of UNODC support in Estonia and other Baltic states.

Since 2000, Estonia has been experiencing one of the most severe HIV epidemics in Europe. To date, this has been concentrated particularly among male, Russian-speaking IDUs in Tallinn and East Virumaa. There are, however, concerns that the epidemic is spreading into the general population. This concern is based on the belief that more women are becoming infected and that the epidemic is spreading more and more through heterosexual transmission. However, evidence presented to the evaluation team shows that the number of new HIV cases among women in Estonia has remained the same for a number of years. The proportion of new cases among women has risen, but this is as a result of a falling number of new cases among men rather than an absolute rise in the number of new HIV infections detected among women.

A more credible explanation of this epidemiological information is proposed by the evaluation team, namely that what is being seen is the natural course of an epidemic primarily focused among injecting drug users. The women who are being infected may be becoming infected heterosexually but it is likely that these are almost exclusively sex partners of male IDUs. The reducing number of new infections detected among men is evidence that the prevention measures introduced as part of the national response to HIV and AIDS are beginning to have some effect. If these efforts are reinforced and expanded, it seems likely that further progress will be made in addressing this epidemic.

Evidence presented to the evaluation team shows that the coverage of some elements of the national response, e.g. needle and syringe programmes, is very good and is comparable to the best achieved in other European countries.

- Based on survey data, almost three quarters (73%) of IDUs received needles and syringes from a programme in the four weeks prior to the survey.
- Based on programme data, almost half (40–46%) of all IDUs attend a needle and syringe programme regularly, that is at least twice per quarter. On average, each IDU in Estonia receives 117 sterile needles and syringes annually through these programmes.

In addition, services have been established for other most-at-risk populations, such as sex workers and men who have sex with men. However, these services are currently limited in geographic scope, i.e. available in Tallinn only.

There are other significant gaps in programme coverage of the national response. The most significant of these are as follows:

- Although the number of IDUs receiving opioid substitution therapy has increased significantly in recent years, overall coverage remains low with only 4–6% of opioid injectors receiving this therapy. In addition, services are of highly variable quality.

- Essential services, such as OST and the provision of sterile injecting equipment are invariably interrupted when IDUs enter the criminal justice system because these services are absent in prisons and arrest houses.
- HIV positive IDUs find it difficult to access medical services, including antiretroviral therapy. To be more accessible, they need to be provided at a convenient time and location, at an affordable price, through a trusted provider and in combination with other services, such as opioid substitution therapy and social support.

The absence of essential HIV prevention services for IDUs, such as provision of sterile injecting equipment and OST, in Estonia's criminal justice system is of concern, as sharing of injecting equipment is particularly common in these settings. As many IDUs spend time in prisons and arrest houses, there is a risk that the lack of these services in those settings could undermine the gains from delivering these services in the community.

Global Fund support has been instrumental in the successes of Estonia's national response to HIV and AIDS, not only in services delivered, but also in systems established and organizations strengthened. A most significant development is the Estonian Government's decision to maintain financial support to activities supported by the Global Fund. This decision is applauded by the evaluation team. It is inevitable that some problems will be experienced as other ministries take on responsibilities previously handled by the National Institute for Health Development. Perhaps the most severe of these are being experienced by NGOs providing youth education. Although the decision of the Ministry of Education and Research to embed HIV education for young people in the curriculum is appropriate, the ministry and municipal departments of education may need to take some interim measures until the new curriculum is adopted.

In conclusion, significant progress has been made in providing effective HIV prevention services for most-at-risk populations, particularly IDUs. However, this needs to be done even more, with a focus, not only on expanding needle and syringe programmes, but also on OST and improving ART access for IDUs. There is a pressing need to ensure that services available in the community are also available in prisons and arrest houses.

## Introduction

Estonia's response to HIV and AIDS is conducted within the framework of the National HIV/AIDS Strategy 2006-2015. In 2005, it was estimated (WHO, 2007a) that Estonia expended EEK 122.4 million<sup>1</sup> on its response to HIV, AIDS and TB. Of this, just under 80% came from the state budget<sup>2</sup> and just over 20%<sup>3</sup> came from a grant from the Global Fund. This grant was worth US\$ 10.5m over four years from October 2003 to September 2007.<sup>4</sup> With the conclusion of this significant source of funding, Estonia's national response to HIV and AIDS now faces a period of transition.

This presents an opportunity to reassess the national response to HIV and AIDS and this is the purpose of this evaluation. It aims to give practical input to Estonia to develop appropriate responses to HIV and AIDS. The evaluation focuses on two main areas:

- structures and systems
- coverage and quality of services.

The evaluation has been requested by the Ministry of Social Affairs and the National Institute for Health Development (NIHD), who have been managing Estonia's national HIV/AIDS prevention programme and who have also been Principal Recipient for the grant from the Global Fund. The evaluation forms an integral part of the collaborative agreement between the Estonian Government and the World Health Organization to support the scaling up the response to HIV and AIDS in Estonia. It is being conducted under the joint auspices of UNODC and WHO. It builds on a range of previous WHO work to support the response to HIV and AIDS in Estonia (e.g. WHO, 2002, WHO, 2005 and WHO, 2007a) and is expected to feed into the development of UNODC support in Estonia and other Baltic states (UNODC, 2006). An evaluation of the programme supported by the Global Fund grant was conducted in December 2005 (Drew and Laukamm-Josten, 2006).

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<sup>1</sup> Approximately US\$ 95 million.

<sup>2</sup> Of the total amount, 12% came from the Ministry of Justice, 38% from the Estonian Health Insurance Fund, 29% from the Ministry of Social Affairs and 0.7% from the Ministry of Education and Research. The amount from Ministry of Social Affairs consisted of 17% for drugs and services for uninsured people and 12% for programmes. Less than 1% of total expenditure on HIV, AIDS and TB came from municipal budgets.

<sup>3</sup> This figure compares funding from the Global Fund grant with total funding for the responses to HIV, AIDS and TB. As this grant was for HIV and AIDS only, it would account for a significantly higher proportion of funding for the national response to HIV and AIDS (i.e. excluding expenditure on TB).

<sup>4</sup> For a short summary of this programme, see Trummal, 2007.

## Methods

This evaluation was conducted by a team of consultants working under the joint auspices of UNODC and WHO. Work was carried out during two country visits to Estonia in December 2007 and January 2008. Issues relating to HIV and AIDS interventions among injecting drug users and in prison settings were the focus of the visit in January 2008 (see Annexes 1A and 1B, from p. 48). Other issues were covered in the first visit in December 2007. Full terms of reference for the evaluation are presented in Annex 1 (p. 44).

The team members for the two trips were:

- December 2007 – Roger Drew, Agris Koppel, Ulrich Laukamm-Josten and Claudio Politi; and
- January 2008 – Roger Drew, Martin Donoghoe, Signe Rotberga, Anya Sarang and Heino Stöver.

Methods used to gather information for the evaluation included:

- review of key documents. A list of all documents reviewed is presented in Annex 3 (p. 56);
- interviews with key informants, both as individuals and as small groups. A list of all people interviewed is presented as Annex 2 (p. 52). In particular, focus group discussions were held with IDUs using prevention services in Tallinn and Kohtla-Järve; and
- visits to selected project sites in Tallinn and East Estonia.

During the first visit, a meeting was held with staff conducting an internal audit of HIV and AIDS-related activities for the Ministry of Social Affairs in order to share information on respective activities. However, these two processes were quite separate with distinct terms of reference. In particular, this report is of an independent evaluation, i.e. team members are made up of independent experts unrelated to organizations involved in the implementation of the response to HIV and AIDS in Estonia.

A debriefing session was held at the end of each visit with staff of Ministry of Social Affairs, the National Institute for Health Development and WHO to check facts and to present and discuss initial results. The second debriefing meeting was also attended by a representative of the Ministry of Justice.

The working language of the evaluation team was English. The majority of interviews were conducted in English. Where this was not possible, interviews were conducted in Estonian through a translator or directly in Russian with Russian-speaking members of the team, National Institute for Health Development staff or an interpreter translating. Discussions with IDUs using prevention services were conducted in Russian by Anya Sarang.

## Findings

This section presents a brief overview of the current status of the HIV epidemic in Estonia. There are then detailed sections structured under headings drawn from the terms of reference. Material under those headings is structured broadly<sup>5</sup> according to questions posed in the terms of reference (see Annex 1, p. 44)

### Overview

#### *Current status of the HIV epidemic in Estonia*

The emergence of an HIV epidemic in Estonia has been extensively described (e.g. in Rüütel and Lõhmus, 2007). The first person with HIV infection was reported in 1988. There was a rapid increase in the number of people detected with HIV in 2000 and the country recognized that it had a concentrated HIV epidemic among injecting drug users in 2001. In 2001:

- virtually all (98%) new HIV diagnoses were in two areas of Estonia, Tallinn or Ida Virumaa;
- almost all (90%) new HIV diagnoses made in AIDS Counselling Cabinets<sup>6</sup> were reportedly acquired through injecting drug use;
- more than three quarters (77%) of new HIV diagnoses were among men; and
- almost all new HIV diagnoses were among those with non-Estonian ethnic background.<sup>7</sup>

Estonia still has the highest rate of new HIV diagnoses in Europe (see Figure 1; ECDC, 2007b, Jakab, 2007). However, the number has declined since a peak in 2001 and has now reached a steady level (see Figure 2; Rüütel and Lõhmus, 2007). This has resulted in some describing the epidemic as 'stable' (UNAIDS and WHO, 2007a). This simply means that the number of new diagnoses is no longer increasing at a rapid rate. It does not imply that the rates of infection are insignificant or acceptable.

The proportion of women among those newly-diagnosed with HIV in Estonia has been steadily rising, from 20% in 2000 to 36% in 2006 (Jakab, 2007; Rüütel and Lõhmus, 2007). However, this is an effect of the declining number of new HIV diagnoses among men.

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<sup>5</sup> Questions have been summarized as headings to aid readability. In some places, the structure of the report has been adjusted and simplified to avoid unnecessary duplication.

<sup>6</sup> Information on source of infection is available from those diagnosed at AIDS Counselling Cabinets but not from other sources.

<sup>7</sup> Particularly among ethnic Russians. Although figures for 2001 are not provided (Rüütel and Lõhmus, 2007), it was reported that non-Estonians accounted for 86% of all new HIV diagnoses in 2006 (ECDC, 2007a, p. 4).

Figure 1: New HIV diagnoses per million population in selected European countries: 2006<sup>8</sup>

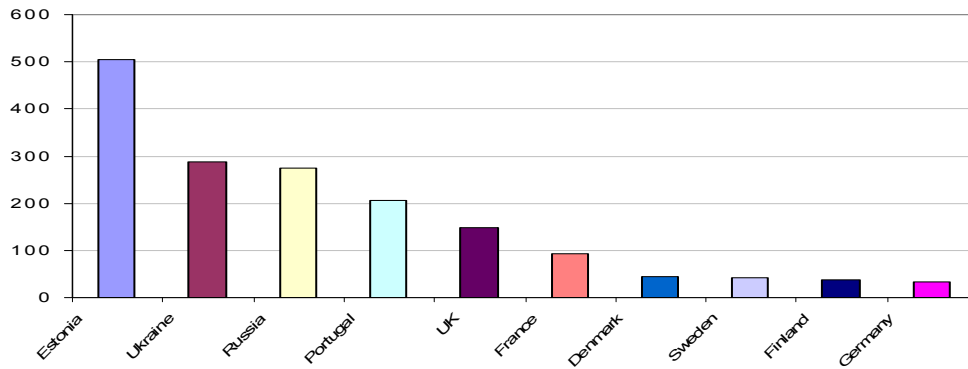


Figure 2: New HIV diagnoses in Estonia: 2000–2006

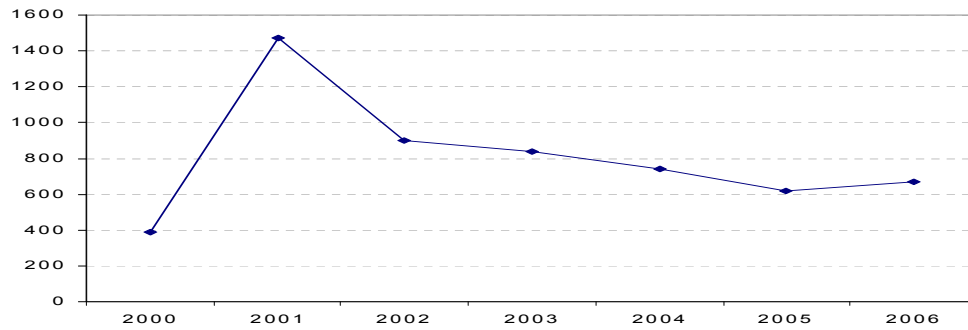
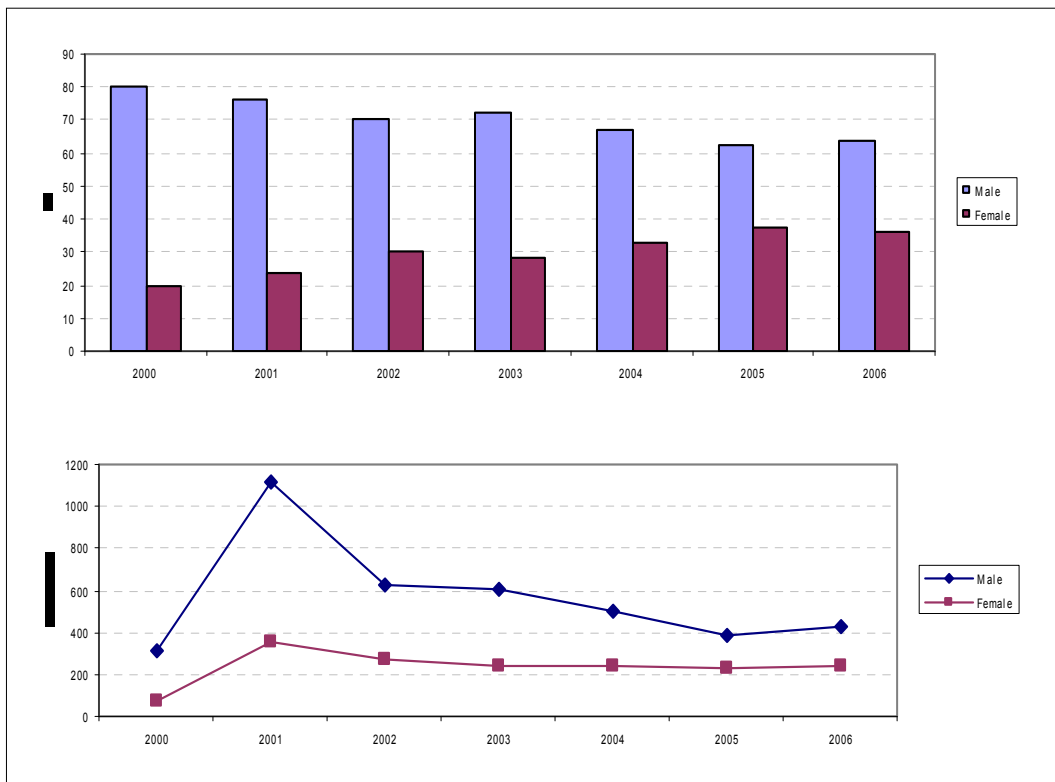


Figure 3: New HIV diagnoses in Estonia: Males and females: 2000–2006:



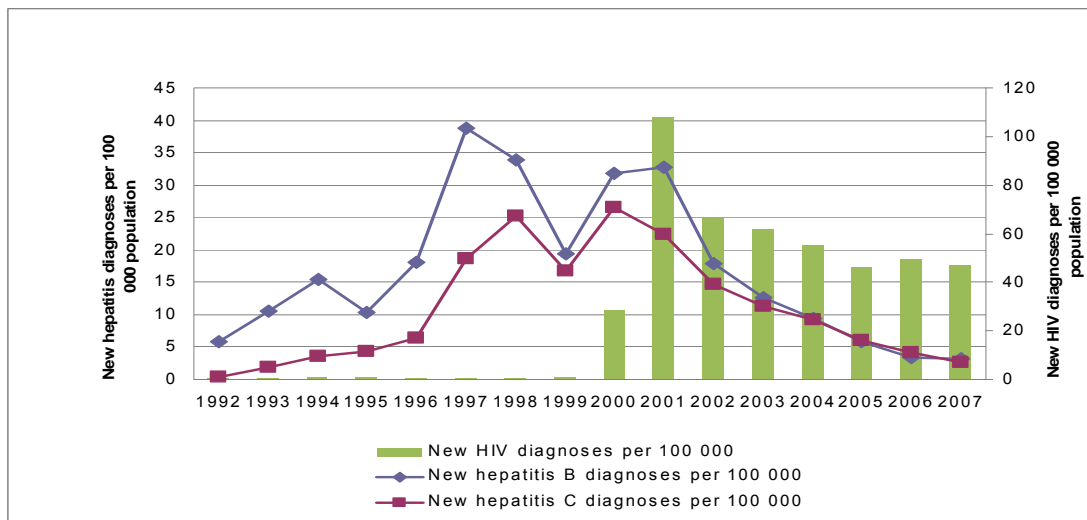
<sup>8</sup> Source of data for these figures is as follows: Figure 1 – ECDC, 2007b, Jakab, 2007; Figure 2 – Rütel and Löhmus, 2007; Figure 3 – supplied to evaluation team by NIHD.

The number of new HIV diagnoses among women has been relatively unchanged from 2002–2006 (see Figure 3). In the absence of evidence to the contrary,<sup>9</sup> it is likely that these women are almost exclusively the sex partners of male injecting drug users.<sup>10</sup> There is currently no evidence of generalization of the epidemic, e.g. men becoming infected, who have not injected drugs or had sex with men. Consequently, the major way that HIV infection of women could be avoided in Estonia is through ‘positive prevention’ and partner management of male IDUs.

### ***Effectiveness/Appropriateness of the response to date***

These figures provide evidence that the response in Estonia has had an effect on slowing the transmission of HIV among male injecting drug users. Further evidence of this is provided by declining rates of new diagnoses of hepatitis B and C since 2001 (see Figure 4). A recent ECDC country report (ECDC, 2007a) praised Estonia because needle exchange/harm reduction programmes had been launched quickly in the most-affected populations in Tallinn and Ida Virumaa.<sup>11</sup>

Figure 4: New diagnoses of HIV and hepatitis in Estonia: 1992–2007



Data Source: Health Protection Inspectorate.

There is a perception that the response to HIV and AIDS in Estonia has been focused on services for most-at-risk populations, such as IDUs. However, in 2005, expenditure on specific HIV-related services was estimated at EEK13.5m. This amounted to 11% of total estimated expenditure on HIV, AIDS and TB. A similar amount was spent on youth-focused services.

<sup>9</sup> A study is currently underway among female sex partners of male IDUs and this may provide further information on this issue. Preliminary results are said to show low rates of HIV infection but high rates of hepatitis C. If confirmed, these results might suggest that female sex partners of male IDUs have higher rates of injecting drug use than declared through self-reporting.

<sup>10</sup> There is a perception among practitioners that this is not the case and that women are being infected who have no history of injecting drug use or sex with an injecting drug use. However, it appears that this may be based on the belief that professionals are able to identify IDUs from their appearance and/or conversation. At least one practitioner noted that women who might appear to have had no contact with injecting drug users were found to have had sex with an injecting drug user at some time in the past. Given the nature of HIV, this sexual contact may have occurred some years in the past.

<sup>11</sup> More details of Estonia’s response to HIV among IDUs are given in the relevant section of this report (p. 40).

However, all the IDU-related services were financed from external services, whereas almost half of the expenditure focused on youth was from the Health Insurance Fund (WHO, 2007a).

### ***Lessons learned for the response in the future***

Evidence from Estonia and other countries shows that HIV transmission through injecting drug use can be controlled by effective prevention measures, such as harm reduction interventions.<sup>12</sup> These measures not only protect those who inject drugs but also the entire population. They need to be prioritized and delivered at an increased scale if further progress is to be made in reducing the rates of HIV transmission through injecting drug use in Estonia to levels seen in other parts of the EU.

#### **Recommendations**

1. The team recognizes the need to avoid encouraging complacency among the general population of Estonia about their risk of contracting HIV and/or increasing the stigma and discrimination experience by most-at-risk populations. However, care is needed in stating that the HIV epidemic in Estonia is generalizing beyond IDUs and their sex partners. It is the view of the evaluation team that available information does not support this assertion. More detailed information about current transmission routes is required.
2. There is evidence that Estonia's HIV prevention programmes, based on harm reduction interventions among most-at-risk populations, particularly injecting drug users are beginning to be effective. In particular, targeted (harm reduction) interventions for injecting drug users, including opioid substitution therapy, still offer the best solution to the ongoing HIV crisis in Estonia. They should be continued and further scaled-up.

## **Management, coordination and capacity development**

### ***Coordination and management capacity***

A key strength of the national response to HIV and AIDS in Estonia is that it is based on an agreed strategy and costed action plan (Government of Estonia, 2005b-c; 2007). This was recently praised as ambitious (ECDC, 2007b). This provides a basis for a comprehensive and effective response to the epidemic. However, linkages could be stronger between HIV/AIDS strategies<sup>13</sup> and those for related issues, such as drug prevention and treatment. All actors, both national and international, need to contribute to delivery of the national AIDS strategy and action plan, rather than developing stand-alone projects.

The national response to HIV and AIDS is coordinated by a Governmental Commission (see Annex 5, p. 62). However, its activities have been somewhat limited recently apart from receiving an annual report from the Ministry of Social Affairs. This was partly because of the operations of a Country Coordinating Mechanism (CCM), which directly affected the working lives of those receiving money from the Global Fund grant. However, this has now disbanded because the Global Fund grant has ended. The Governmental Commission is currently in a period of transition. For example, the CCM had two representatives on the Commission and it is unclear what will happen to these. The Commission had four expert groups<sup>14</sup> which reportedly

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<sup>12</sup> Including drug dependence treatment, such as OST.

<sup>13</sup> And their coordinating bodies.

<sup>14</sup> On health and social care; surveillance and monitoring; prevention; and harm reduction. In addition, the Commission also had sub-groups for different sectors, e.g. NGOs.

worked well at the time that the strategy was being developed.<sup>15</sup> The terms of reference for the Commission may need reviewing, particularly how the Commission interacts with other related issues, including aspects of health and illegal drug use.

The leading ministry in Estonia's response to HIV and AIDS is the Ministry of Social Affairs (MOSA). However, the Ministry has been less active in leading the response to HIV and AIDS than some respondents hoped for. This may reflect limited capacity in this area, including to coordinate and monitor the activities of other ministries. Responsibilities on HIV and AIDS are divided between public health and health care departments. The public health department only has two staff to work on this. One of these posts has recently been empty for a number of months.

The National Institute for Health Development (NIHD) is an agency of the Ministry of Social Affairs. NIHD has significant management capacity related to HIV and AIDS having acted as Principal Recipient for the Global Fund grant. This strengthened management capacity of NIHD appears to be a major factor in the perceptions reported of an improved coordination environment currently compared to the past. A particular feature of the expanded capacity of NIHD has been the expansion of its human resource base in a number of key areas, e.g. employing more ethnic Russians and recruiting staff to work explicitly on issues relating to MSM. However, respective roles of NIHD and MOSA could be more clearly-defined by clearer agreement on and communication of the roles of NIHD, MOSA and other stakeholders, related to HIV and AIDS. Although formal roles may be clear, with MOSA responsible for developing and steering policy and NIHD responsible for implementation, there are overlapping areas that could be agreed. This includes the practical problem that NIHD currently advises on policy development and implements the resulting policy.<sup>16</sup>

A key feature of the Global Fund grant was that additional management capacity was provided through a firm of accountants acting as Local Fund Agent. Their role differed significantly from the usual ex-post audit role. While it is recognized that there are significant differences between donor and governmental funding, the principles of assessing grant recipients before agreeing contracts and reviewing reports before disbursing further tranches of funds could be usefully adopted. It is unclear if there is any provision for these principles to be adopted in the future.

### ***Positive benefits of the Global Fund grant***

Estonia's capacity to manage its response to HIV and AIDS has developed massively over the past five years, particularly through the funding support provided by the Global Fund. This is not limited to the government sector but is also seen among NGOs who now demonstrate greater capacity to design and manage projects (see p. 16).

Global Fund support was also instrumental in building capacity for the governmental and nongovernmental sectors to interact constructively with each other. This included establishing systems for channelling funds through government to NGOs and mechanisms for dialogue, e.g. the CCM.

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<sup>15</sup> It is reported that they have been less active since that time.

<sup>16</sup> It appears that there is a difference between the way the roles of MOSA and NIHD are formally defined and the way they are practiced. A key factor in this has been lack of staff capacity in MOSA. As a result, the role of setting policy, which should be carried out by MOSA has increasingly been carried out by NIHD.

Systems established with resources from the Global Fund have made a positive contribution to the national response to HIV and AIDS in Estonia. Time is needed to see if these systems can be maintained or effectively replaced now that funding is coming from the state budget. In particular, it remains to be seen if:

- the Governmental Commission can prove to be an effective coordinating mechanism involving NGOs in addition to government; and
- other government ministries<sup>17</sup> can effectively take over responsibility for their sector from NIHD.

### **NGOs**

An effective national response to HIV and AIDS needs a strong public sector (see p. 23) and vibrant, sustainable NGOs. Channelling funds to NGOs from government is part of this but it also requires a stronger regulatory framework, e.g. requiring NGOs to produce balance sheets, financial audits, risk analyses and reserves policies. There is also need for a systematic programme of capacity building among NGOs to improve their professionalisation, including the development of relevant skills, e.g. organizational management, public fundraising etc.

There are still relatively few service providers in the field of HIV and AIDS, particularly in some areas, e.g. provision of services for sex workers. Networks of NGOs are beginning to develop, e.g. Estonian Network of NGOs and Development Cooperation Round Table. However, these are not particularly focused on HIV and AIDS. Also, the Development Cooperation Round Table is relatively new. There is currently no network focused on HIV and AIDS representing all NGOs working in the area.<sup>18</sup>

The key development has been the commitment by government to maintain financing to the response to HIV and AIDS at Global Fund levels. Structures either exist to ensure this or are being established (see p. 16). However, there are some barriers, e.g. Estonia's law that medical services can not be provided by NGOs. This has resulted in many NGOs setting up parallel companies to provide these services.

The capacity of service-providing NGOs to manage projects has improved significantly, although there is still wide variation in these abilities of NGOs. Some new providers and models have emerged, e.g. Healthy Estonia Foundation, who have established a workplace HIV education programme with funding from the private sector.

However, NGOs have made less progress in developing some of the other skills needed for a strong and vibrant third sector in Estonia. Examples of such skills include:

- *Contract negotiation* – previously, NGOs have largely implemented donor-funded projects. In the future, activities are more likely to be funded in the same way as NGO activities in other EU countries. This is likely to involve government-funded contracts. Designing and managing these requires a slightly different skills set from donor-funded projects, e.g. negotiating and managing issues such as pricing of services, contract gaps and payment after performance of services.

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<sup>17</sup> Particularly Ministry of Social Affairs, Ministry of Defence, Ministry of Justice and Ministry of Education and Research.

<sup>18</sup> There is a network for PLHIV and a 'Body of Experts'. The latter is not a formal organization but is an informal group of people who join together to advocate on particular topics.

- *Risk analysis and management* – the regulatory environment in some countries, e.g. the United Kingdom (Charity Commission, 2007) requires NGOs<sup>19</sup> to review the major risks to which the NGO is exposed and establish systems to manage those risks. This approach could be very helpful to NGOs in Estonia in that it would identify the main risks to which they are exposed. For example, one of the major risks over recent years has been dependency on one time-limited source of funding, the Global Fund. Analysis of this risk might have resulted in NGOs diversifying their funding base, e.g. through public fundraising, ‘selling’ of services<sup>20</sup> etc. However, in most cases, very little of this has been done.
- *Public fundraising* – given Estonia’s improving economic position, it is likely that NGOs will be able to raise increasing amounts of money from the general public, both in Estonia and in other European countries. However, NGOs working on HIV and AIDS have not yet explored this possibility to any meaningful extent. Indeed, many of the leading players in the field believe that this is not possible. This belief fails to recognize the value of even small amounts of money raised in this way because of their unrestricted<sup>21</sup> nature and the fact that public fundraising is often a slow and incremental process requiring the nurturing of a support base.
- *Reserves planning and development* – the level of unrestricted funds available to an NGO that can be expended at its discretion can be considered its ‘reserves’. The regulatory environment in some countries, e.g. the United Kingdom, requires NGOs<sup>19</sup> to have a ‘reserves’ policy. This should ensure that reserves are not too low, putting the viability of the NGO at risk, or too high, leading to concerns that funds may not be being used maximally to achieve the NGO’s purpose. NGOs working on AIDS in Estonia report having minimal or no financial reserves. Indeed, some leading players argue that they would not be allowed to hold such reserves because they would be considered ‘profit’. This approach constitutes a major risk for these organizations as they have a ‘hand to mouth’ existence based on project funding.
- *Resource management and planning* – although NGOs working on HIV and AIDS have received considerable funding for their work over recent years, e.g. from the Global Fund, some still lack essential resources required to deliver their services. For example, Convictus delivers its needle exchange services from a two-roomed building without any toilet facilities. This constitutes a significant health and safety risk. While recognizing some of the challenges in obtaining additional premises, these are not dissimilar to challenges faced by NGOs working in similar fields in other countries. Ensuring adequate premises for an NGO’s work requires different skills from those needed to deliver and manage the direct programme activities.
- *Advocacy* – there are some advocacy and lobbying areas where NGOs have been extremely successful, e.g. in securing financial resources from the state budget following the end of the Global Fund grant. However, this could be developed further and made more systematic, by recognizing the collective strength of NGOs acting together, e.g. through a

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<sup>19</sup> In the United Kingdom, the regulatory framework applies to ‘charities’. Most United Kingdom NGOs working on HIV and AIDS are registered charities.

<sup>20</sup> This is already done to a limited extent, e.g. the Estonian Sexual Health Association ‘sells’ Internet counselling services to the Health Insurance Fund and the Healthy Estonia Foundation sells its seminars to private sector companies.

<sup>21</sup> Funding raised for a specific reason, e.g. a project is ‘restricted’ for that purpose. Funds given to the general work of an NGO are said to be ‘unrestricted’ and can be used for any relevant purpose as decided by the NGO’s governance systems.

network focused on HIV and AIDS. There is still evidence of dependency in this area with, for example, some respondents saying that they could do nothing about the issue of opioid substitution therapy in arrest houses unless something came ‘from the top’. Although there is an element of truth in this, in that policy change is likely to require joint ministerial action across the Ministries of Social Affairs, Justice and Interior, NGOs are well-placed to influence such action through lobbying and advocacy efforts.

- *Human resource management* – it was reported that because of the short-term, project-based nature of financing, NGOs working on AIDS in Estonia employ staff on short-term contracts with limited or no benefits. As some staff have been employed on such contracts for a number of years, it is recognized that these contracts probably contravene Estonian employment law. This constitutes a significant reputational risk for these NGOs. Leading players state that they can do nothing about this unless they receive core state funding. This overlooks a number of other possibilities for addressing this issue.<sup>22</sup>

Estonia needs to further develop its NGO sector to build on the improved capacity in project planning and implementation. Although this may be achieved in part through competition among NGOs, there is also need for a stronger regulatory framework and a consistent programme of capacity and skills development. One example of the negative consequences of a weak regulatory framework for not-for-profit organizations relates to the provision of medical services. An organization that wishes to provide medical services needs a licence and not-for-profit organizations are prohibited by law from holding such licences. The rationale for this is that the regulatory framework for not-for-profit organizations in Estonia is not sufficiently robust to allow quality standards to be enforced. One practice is for the people operating not-for-profit organizations to establish private companies to provide medical services. This practice is confusing and increases transaction costs.

### ***Gaps and unnecessary practices***

There is scope for more active leadership from MOSA on the national response to HIV and AIDS. In addition, there are some areas of reform which need leadership from MOSA. These include:

- introducing and institutionalizing an effective and client-centred system of case management;
- promoting the value of social care of PLHIV and enhancing the professional standing of key staff, e.g. social workers, outreach workers, staff in harm reduction services;
- ensuring that important information on HIV transmission routes is collected and reported; and
- actively supporting the Governmental Commission to fulfil its potential to strengthen interventions and public messages about the status of the epidemic in Estonia.

### ***Strengths and weaknesses***

Table 1 briefly summarizes strengths and weaknesses related to management, coordination and organizational capacity of the response to HIV and AIDS in Estonia.

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<sup>22</sup> For example, having a reserves policy which would require the NGO to maintain a sufficient level of reserves to run the organization for a specified period and to wind up the organization, if needed. Such a policy would allow the NGO to employ staff on permanent contracts and to make them redundant if funding ended. This approach is used in many settings by organizations dependent on short-term funding sources.

Table 1: Management and coordination of response to HIV and AIDS in Estonia: Strengths and weaknesses

Strengths	Weaknesses
<p>Estonia has a strong HIV/AIDS strategy and a costed action plan</p> <p>Government Commission's expert groups played an active role in strategy development</p> <p>NIHD gained significant management experience as PR of Global Fund grants</p> <p>The model of Local Fund Agent used by the Global Fund promoted some important principles, such as scrutiny of grant recipients and their reporting</p> <p>A system for funding NGOs through/by government has been established</p> <p>Increased diversity of staff at NIHD</p> <p>NGOs have developed their project management capacity</p> <p>Some new NGOs and models of working have emerged, e.g.</p> <p>Healthy Estonia Foundation</p> <p>Systems for performance management and results-oriented delivery have been established</p>	<p>The Commission has a limited role and limited links to other issues related to HIV, such as control of illegal drugs</p> <p>Governmental Commission secretariat has limited capacity</p> <p>MOSA has limited human resources for the response to HIV and AIDS</p> <p>Key posts have been vacant for significant periods</p> <p>Other government ministries have yet to develop management capacity to respond to HIV and AIDS</p> <p>Respective roles of NIHD and MOSA not very clearly defined</p> <p>Ministries are not directly accountable to the Governmental Commission or MOSA for their response to HIV and AIDS</p> <p>Number of service providers remains low in some areas, e.g. work among sex workers</p> <p>NGO networks are relatively new, have little capacity and limited focus on HIV and AIDS</p> <p>Estonian law prohibits not-for-profit organizations from obtaining a licence to provide medical services</p> <p>NGOs have limited organizational skills, e.g. contract negotiation, public fund raising, risk management, reserve planning and management</p>

### Recommendations

3. MOSA should take a more active leadership role in the national response to HIV and AIDS, particularly in some areas, such as implementing a system of case management and ensuring reporting of information on HIV transmission routes.
4. A key priority for MOSA should be reinvigorating the Governmental Commission on HIV and AIDS. This would involve reviewing its membership and role. A key function would be to ensure accountability of government ministries for their mandates on HIV and AIDS.
5. There is need to define more clearly the respective roles of MOSA and NIHD.
6. Government should seek to create an enabling environment for the work of NGOs. In addition to provision of funding, this should also include a robust regulatory framework and measures to stimulate the emergence of new service providers.
7. NGOs themselves need to take more leadership on issues related to their organizational development, e.g. by establishing a network on HIV and AIDS and establishing a systematic approach to training and capacity development among NGOs.

## Financial flow and NGO support systems

### *Capacity of systems and organizations*

The decision by the Estonian Government to maintain funding levels for the response to HIV and AIDS at the levels recently provided by the Global Fund is widely-recognized as an historic development in the funding of NGOs responding to HIV and AIDS in Estonia. This will involve:

- MOSA financing health care services for uninsured patients and ARVs;
- Ministry of Justice supporting HIV interventions in prisons.<sup>23</sup> This will include refunding MOSA for the costs of centrally-purchased ARVs;
- Ministry of Education and Research financing prevention activities among young people (see p. 27); and
- Ministry of Defence financing prevention services among uniformed forces.

In addition to central governmental financing, some funding has been provided from municipal budgets. However, to date this has been minimal. This probably reflects that municipalities do not have statutory responsibility for these services and have widely varying financial resources available to them. There appears to be scope for greater use of municipal budgets for financing the response to HIV and AIDS.<sup>24</sup> There is a need for increased funding of essential services from municipal budgets. The financing role of counties and municipalities remains extremely weak. No major changes have been envisaged to channel additional funds through local governments to implement the national strategy and action plan on HIV and AIDS.

### *Recent capacity development*

The four years experience of implementing activities financed by the Global Fund grant helped many NGOs to improve their project management skills. They developed skills related to budgeting, contracting, reporting, monitoring and evaluation as a result of the requirements of the Global Fund. Initially, these requirements imposed a burden on organizations, but resulted in improved skills, greater capacity and an improved way of working.

A significant development is that NGOs recognize the benefit for themselves and their own work of these improvements. For example, they now recognize that monitoring and evaluation is not only for the donor but also useful for self-assessment and improving service provision.

### *Structures*

A key feature of the response to HIV and AIDS in Estonia has been the contracting of NGOs through governmental structures, particularly with finances from the Global Fund. Some details of this are examined here.

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<sup>23</sup> For more information on these interventions, see p46. Estonia's 'arrest houses' are not managed by the Ministry of Justice but by the Ministry of Interior.

<sup>24</sup> Estonia is divided into 15 counties. However, counties do not have their own budgets but simply administer parts of the state budget. Estonia has more than 200 municipalities. These vary widely in size from small rural communities to large cities, such as Tallinn. Municipalities have their own budgets and raise their own funds. The scale of these budgets varies widely. Municipalities' roles in health and education differ. Municipalities have responsibilities for education services but not health. Schools operate as state entities while hospitals operate as foundations or private companies.

NIHD has had two different types of contract with service providers, those financed by the state budget and those financed by the Global Fund. Differences are briefly illustrated in Table 2.

Table 2: Differences in contracting mechanisms

	State Budget	Global Fund
Time frame	One year	Two years
Payment method	Paid after completion of activities	Element of pre-payment

NIHD covered the period of transition<sup>25</sup> from the end of the Global Fund grant by extending the contracts of service providers within its area of responsibility.<sup>26</sup> NIHD has also introduced ‘framework for cooperation agreements’ lasting five years. These include an element of pre-payment and allow monthly payments. These agreements are appreciated by NGOs as they provide them with some degree of long-term assurance of funding, as they enjoyed while Estonia had the Global Fund grant. Such agreements should also reduce the time-lag between provision of services and payment. These good practices should further consolidate trust and continue the good relationship between purchaser and providers. However, this needs to be balanced with the need for competition among NGOs, incentives for quality improvement and opportunities for new providers (see below).

Provider payments have been made using two different methods of calculating the value of service purchased. The first and most widely-used for the Global Fund grant was based on a planned budget. The second was based on a unit cost for service. This is the method used by the Health Insurance Fund and has been used in other settings when unit costs of services were available and judged reliable, e.g. for Methadone treatment. The use of this second approach could be expanded. This could provide incentives to expand service coverage, e.g. by offering differentiated fees with higher fees in under-served areas.

### ***Gaps and unnecessary practices***

Contracts and methods of payment should include incentives to attract new providers, to promote competition, to expand coverage, to improve quality and to increase provision of services in specific regions.

### ***Scaling up***

The main issue here is to allocate finances for the response on the basis of a correct understanding of how the epidemic continues to spread in Estonia (see p. 7). This is still largely among Russian-speaking injecting drug users and their sex partners. Funding should be increasingly prioritized towards services for these groups.

### ***Strengths and weaknesses***

Table 3 briefly summarizes strengths and weaknesses related to financial flows to NGOs working on HIV and AIDS in Estonia.

<sup>25</sup> Oct-Dec 2007.

<sup>26</sup> E.g. prevention services for IDUs, sex workers and MSM.

Table 3: Financial flows to NGOs working on HIV and AIDS in Estonia: Strengths and weaknesses

Strengths	Weaknesses
<p>Strong commitment from Estonian government to finance services through NGOs</p> <p>Systems through NIHD are well-established NGOs have developed stronger project management skills</p> <p>Introduction of innovative approaches e.g.</p> <ul style="list-style-type: none"> <li>• Health Insurance Fund uses a fee for service basis to pay for Internet counselling</li> <li>• Government financing of a gay and lesbian information centre</li> <li>• Government financing of targeted medical assistance for sex workers</li> <li>• Involvement by Healthy Estonia Foundation, of private companies in financing seminars and information campaigns for employees and general population. This is innovative because it is financed by companies that receive the service. It does not rely on donor or state funding</li> </ul>	<p>Other ministries have not yet fully established their systems for financing and contracting NGOs, e.g. Ministry of Education and Research</p> <p>Unclear if all ministries can issue contracts for longer than one year and which include pre-payment</p> <p>Low levels of municipal funding for health services</p> <p>Potential of fees for service for driving service expansion not yet fully utilised</p> <p>Issues identified in WHO, 2007a, particularly that funding is fragmented</p> <ul style="list-style-type: none"> <li>• Between national public health strategies and programmes</li> <li>• Between the prison health system and the rest of the health system</li> <li>• With providers contracted by different agents</li> </ul>

### Recommendations

8. Larger municipalities should consider using their own resources to co-finance HIV/AIDS services, e.g. as is being done in Tallinn.
9. The Government of Estonia should review current contracting mechanisms for AIDS services to ensure they are maintaining the good practices established through the Global Fund grant, and are appropriate in terms of length and overall characteristics to enable strategic purchasing.
10. MOSA and NIHD should explore the possibility of greater use of provider payment methods based on fees for service as an incentive to scale up the response to HIV and AIDS.

## **Monitoring, evaluation and quality assurance systems**

### ***Capacity of systems and organizations***

Estonia has a well-documented system for monitoring and evaluating the national response to HIV and AIDS (Trummal and Lõhmus, 2006). This includes a number of elements:

- passive surveillance – registration of new cases of HIV infection and AIDS diagnoses;<sup>27</sup>
- active surveillance – including biological and behavioural studies among most vulnerable populations (NIHD, 2007f);<sup>28</sup>
- monitoring of actual results against those planned; and
- evaluations of activities (e.g. Drew. and Laukamm-Josten, 2006).

The system is based on indicators of different types/levels. These include:

- impact on rates of HIV transmission (incidence, prevalence) and mortality associated with HIV and AIDS;
- outcomes, such as changes in behaviours; and
- processes, including particularly the number of people reached with services.

### ***Recent trends in capacity development***

This capacity has developed strongly over the past four years largely because of the focus placed on this area by the Global Fund and the resources that have been available for evaluation and surveys within the Global Fund grant. These resources have included provision of relevant training. The Global Fund is committed to performance-based funding and requires grant recipients to set quantitative targets and monitor performance against those targets. Disbursements and grant continuation are contingent on performance against those targets.

NIHD has used contracts as an important monitoring tool (NIHD, 2007e). These include planned targets, a detailed service description, a sample reporting form and a description of a method for evaluating services.

As a result of these initiatives, service providers, such as NGOs have significantly increased their capacity to monitor the implementation of services that they provide.

### ***M&E structures***

NIHD has recently established a new Department of Surveillance and Evaluation, which will have responsibility across all areas of public health.<sup>29</sup> This is an exciting new development. In addition, the Health Statistics Department of MOSA has been placed within NIHD.

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<sup>27</sup> In Estonia, this responsibility falls under the Health Protection Inspectorate.

<sup>28</sup> Responsibility for this and the remaining bullets in this list falls under the National Institute for Health Development.

<sup>29</sup> For which MOSA has a state-level strategy. NIHD has responsibility for active, survey-based surveillance. Responsibility for passive, case-based surveillance remains with the Health Protection Inspectorate.

### ***Gaps and unnecessary practices***

There are a number of gaps or unnecessary practices in the current national M&E system. These include:

- a lack of clarity over how data will flow to coordinating bodies. According to the national strategy (Government of Estonia, 2005b), NIHD has responsibility for housing a national unit for HIV/AIDS monitoring, surveillance and evaluation. It seems clear that NIHD will continue to be able to monitor activities which it funds. However, it is less clear how this will happen for activities that it no longer funds. It is unclear how data will reach NIHD from service providers and what incentives exist<sup>30</sup> for such reporting where funding no longer flows through NIHD. One option is for contracts between ministries and service providers to specify that copies of reports should be provided to NIHD, as well as to the relevant ministry. Although this option may be a short-term solution and probably carries the least risk of damaging the system that has been established, it does not build up the role of ministries in a sustainable way and does not appear to be being implemented. A longer term aim would be to get ministries to compile their own monitoring and evaluation reports for NIHD, focused on a small set of agreed, key indicators. Such a situation is envisaged in the national strategy<sup>31</sup> with ministries and county governments submitting reports to NIHD twice per year and NGOs reporting annually<sup>32</sup> (Government of Estonia, 2005b).
- limited official data on transmission routes for HIV. Some information is available from the National Reference Laboratory.<sup>33</sup> But, this is not complete<sup>34</sup> and, as a private institution, the National Reference Laboratory is only required to provide very limited information to the Health Protection Inspectorate. It is proposed to establish an electronic, case-based reporting system<sup>35</sup> where doctors would report<sup>36</sup> details to Health Protection Inspectorate as they do for other communicable diseases. However, information from this route is not expected to be available until after 2009. It seems to be establishing a new system from scratch rather than building on the current system through the National Reference Laboratory.
- The existence of many bodies related to monitoring, evaluation and surveillance of HIV and AIDS in Estonia. These include:
  - the Health Statistics Department of MOSA<sup>37</sup>
  - the new Department of Surveillance and Evaluation at NIHD
  - the Estonian Drug Monitoring Centre<sup>38</sup>
  - the Health Protection Inspectorate
  - the National Reference Laboratory

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<sup>30</sup> A possible incentive is the availability of national data relating to the response to HIV.

<sup>31</sup> However, the strategy lacks the details of how this would be implemented and managed. It is also reported that such an approach is envisaged in the NIHD plan of action for 2008.

<sup>32</sup> In fact, contracts with government often require NGOs to report more frequently. For example, NGOs contracted by NIHD are required to report monthly.

<sup>33</sup> Through official sources, such as the Health Protection Inspectorate. More complete information is available on the website of West Tallinn Central Hospital.

<sup>34</sup> Because, for example, it collects information on reason for a test rather than likely transmission route.

<sup>35</sup> Referred to as a registry. MOSA report that this would be fully operational by 2010.

<sup>36</sup> According to the new notification form.

<sup>37</sup> Now located at NIHD.

<sup>38</sup> Located at NIHD.

- a new project entitled *Empowering the Monitoring System of Disease Surveillance and the Health Field in Estonia*. This appears to be based at Tartu University and also involves NIHD and Health Protection Inspectorate

Although it is reported that each of these bodies has a specific area of responsibility, it does seem likely that some of these functions could be effectively combined. It would be useful for there to be more discussion and validation of relevant data among these different groups.

- A lack of a publicly-available, easily-readable summary of the HIV/AIDS situation in Estonia and the main elements of the national response.
- A limited focus on quality assurance in the delivery of a variety of services. In brief, an effective quality assurance system requires the following elements:
  - an agreed set of quality standards – some progress has been made in Estonia by seeking to include such standards within contracts. However, it would be helpful if such standards were applied nationally and were not contract-specific;
  - a system of inspection or review of performance against such standards. Mechanisms for this might include surveys, supervision visits etc.; and
  - consultation with clients, e.g. through surveys. This can be helpful both in establishing quality standards and in assessing the degree to which they have been met.

### ***Scaling up***

The most important developments in the M&E system needed for scaling-up Estonia's response to HIV and AIDS would be:

- establishing robust mechanisms for determining the rate of new HIV infections and how these are occurring; and
- agreeing nationally on a method for establishing coverage of prevention programmes among most-at-risk populations.<sup>39</sup>

### ***Strengths and weaknesses***

Table 4 briefly summarizes strengths and weaknesses related to monitoring, evaluation and quality assurance systems.

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<sup>39</sup> This issue is discussed in more detail in sections related to particular services and particular population sub-groups (see p 32, p 36, p 37, p 39 and p 41). These sections review international guidance on how to measure coverage of different services. It is proposed that Estonian stakeholders should review this guidance and decide how they intend to measure coverage of these services among particular sub-populations.

Table 4: Monitoring, evaluation and quality assurance systems: Strengths and weaknesses

Strengths	Weaknesses
<p>Comprehensive surveillance system including passive and active elements</p> <p>Strong quantitative monitoring of services comparing actual against planned performance</p> <p>Response has been subject to both external evaluations and internal audit<sup>40</sup></p> <p>Global Fund grant was used to strengthen national M&amp;E system for HIV and AIDS</p> <p>NIHD has used contracts as an M&amp;E tool</p> <p>NIHD has established a new Department of Surveillance and Evaluation across all aspects of public health</p>	<p>Lack of clarity on data flow to coordinating bodies, e.g. from ministries and implementing agencies</p> <p>Limited official data on transmission routes for HIV</p> <p>There are many different players in HIV/AIDS monitoring and evaluation in Estonia. The rationale for this and their respective roles are unclear.</p> <p>Lack of publicly-available, easily-readable summary of the HIV/AIDS situation and response in Estonia</p> <p>Limited usage of research results generated in Estonia</p> <p>No quality assurance system for some services, e.g. ART, OST</p> <p>Quality assurance system for data could be stronger, e.g. for services provided anonymously<sup>41</sup></p>

### Recommendations

11. A review should be conducted of the various players in HIV/AIDS monitoring and evaluation in Estonia. This should consider whether so many different players are needed or add value to the response. It should also consider what their respective roles are and how their activities and data can be coordinated.
12. There is need to establish and agree a system for data to flow within the national monitoring system for HIV and AIDS. This should cover all agreed indicators and be based on the system outlined in the national strategy and experience gained during the implementation of the grant from the Global Fund.
13. A system needs to be established to allow Estonia to analyse and report transmission routes for HIV infection. Plans to establish a new system for doing this based on doctors reporting to the Health Protection Inspectorate are unlikely to produce robust data in the foreseeable future. MOSA should consider alternative approaches, at least in the short-term, such as establishing a mechanism to make more official use of data currently collected by the National Reference Laboratory.

<sup>40</sup> For example, the MOSA internal audit which was being conducted at the same time as this evaluation.

<sup>41</sup> This is not a unique issue for Estonia but has been a general issue for all programmes supported by the Global Fund. The Global Fund and other agencies have recently developed a data quality assessment tool. It has two versions – one which can be used by external auditors and another which can be used by national programme managers (Global Fund et al., 2007). This tool could be useful in Estonia even though the Global Fund grant has now ended.

## Healthcare systems and services for PLHIV

### *Capacity of systems and organizations*

The overall capacity of the Estonian health system has been well-documented (e.g. Jesse et al., 2004). During the 1990s, the health system in Estonia underwent a series of reforms. These began with a focus on securing and sustaining health care funding, enhancing quality of care and providing more patient choice, and ended with a focus on improving health system efficiency. Services are largely financed through an earmarked payroll tax, used to finance the Estonian Health Insurance Fund. However, 5–6% of the population are not covered by this insurance and are only eligible for emergency medical services funded by the state. Additional services are provided through special programmes, e.g. for TB and HIV. Services of these programmes are usually available to all irrespective of insurance status.

Responding to the consequences of the HIV epidemic has been recognized as one of the major challenges facing the health system. Many of those challenges relate to the fact that most of the people infected with HIV in Estonia to date are injecting drug users. They often do not have health insurance and require a range of services, e.g. ART, TB and STI treatment and opioid substitution therapy, which are still provided in an isolated way by different organizations in different places<sup>42</sup> (see Table 5 and Box 1)

Table 5: Providers of HIV-related services in Estonia

Service	Provider(s)
Primary testing and counselling services	NGOs, prisons, blood centres, family doctors, outpatient specialists and hospitals
General health care services for PLHIV (outpatient)	Family doctors, dermatovenereologists and other specialists
Health monitoring of PLHIV	Infectious disease specialists in five cities of Estonia
Health care services for PLHIV (inpatient)	Four hospitals with infectious diseases departments
Drug treatment services, e.g. OST	Psychiatrists <sup>43</sup>
Long-term care	Nursing homes and home nursing units
Social care and community services	NGOs

In addition, there are a number of areas where capacity appears to be limited. For example:

- The hospital in Narva reported that it was at full capacity in terms of staff available to provide ART. This is a major disincentive to trying to identify more people in need of treatment.
- Some hospitals lack support services. Again in Narva, the doctors interviewed reported the need for a psychologist. However, they reported that the hospital administration had

<sup>42</sup> It is recognized that some of these challenges are not specific to IDUs and/or HIV/AIDS. For example, it is reported that similar problems affect other aspects of health care in Estonia, e.g. mental health.

<sup>43</sup> Although there is no longer a category of ‘narcologist’ in Estonia, many of the psychiatrists providing OST in Estonia were originally trained as narcologists under the old Soviet system. This training had a different, more punitive approach to drug treatment than modern approaches to drug dependence treatment. However, all these psychiatrists have received additional training in modern psychiatry since Estonia’s independence.

declined to appoint one. There seemed to be no clear reason<sup>44</sup> for this decision or system for making such requests.

- Capacity for providing social services to PLHIV is much more limited than for medical services. For example, it was reported that there is only one social worker for Narva.<sup>45</sup> Most of the social services for PLHIV are provided by NGOs with little or no connection to the health care providers. Health workers tend to see social issues as not their concern and only call social workers/NGOs when social problems are very severe. Concerns over confidentiality are cited as one reason for not involving NGOs more.

### **Box 1: Barriers to Accessing Health Services: The Perspective of a Drug User**

In December 2007, Sergey<sup>1</sup> an HIV positive, opiate user, in his mid 20s, started to have epileptic seizures. He was very scared by this new health condition as he did not understand what was happening. As all HIV positive people have to seek treatment for all their general health conditions at the infectious diseases hospital, Sergey went to see the infectionist there. However, during the initial examination, he was told that he would be accepted by the hospital, but only if he brought his own anti-epileptic medication. In order to receive this, Sergey had to seek an appointment with a neurologist, for which he had to enroll on a waiting list. He also had to go to social services to receive a letter guaranteeing that the costs of the medication would be covered by the local municipality.

However, after the consultation with the neurologist, the required drugs were not provided directly to Sergey. He was told that the neurologist had to write a recommendation to Sergey's GP, so that the GP could prescribe the drugs to Sergey. After the recommendation had been issued, Sergey visited his GP, who prescribed drugs, recommended by the neurologist. Still, even after he received the drugs, he could not go directly to the infectious diseases hospital. He had to be seen by his infectionist again and referred to the hospital. As the infectionist only sees patients once per week, it proved difficult for Sergey to organize his appointment. At the time he spoke to the team, he had still not concluded the process but was looking forward to seeing the infectionist and finally getting into hospital. However, he admitted that the whole procedure had taken a lot of his energy and he only persisted through all the steps because the condition was so frightening.

<sup>1</sup> Pseudonym used to preserve anonymity

### ***Gaps and unnecessary practices***

A key need is for greater integration of services and this is discussed in detail elsewhere in this report (see p. 39).

In addition, employment of more social workers and nurses would allow task shifting from doctors to nurses and from nurses to social workers. This is happening to some extent, e.g. patients on ART coming back routinely may see a nurse and only see a doctor if there are

<sup>44</sup> One possible reason is that such an appointment would be seen as an additional expense. However, it is reported that the Health Insurance Fund does have a category for paying for psychologist's services. So such an appointment would also represent another potential revenue stream.

<sup>45</sup> This figure was reported to the team by staff at Narva Hospital. It appears to be at variance with official figures which report that there eight 'specialists' in Narva. The reason for the difference in these figures is unclear. One possible explanation is that the one social worker is for Narva Hospital.

specific issues. However, this could be done more. Potential barriers to this include regulations<sup>46</sup> and the pricing system used by the Health Insurance Fund.<sup>47</sup>

IDUs report being very reluctant to go to health services as a result of the stigmatizing attitudes and discriminatory practices of health staff. Greater use could be made of peer volunteers to accompany IDUs, especially young injectors, to the relevant health service. Services and providers need to adapt to the needs of clients, so that they are seen as more 'user-friendly' and less judgmental.

### ***Coverage and barriers to access***

In 2002, when Estonia applied for funding to the Global Fund, it reported having 44 people on ART (CCM, 2002). As of September 2007, reports to the Global Fund (NIHD, 2003–2007) indicate that this number had risen to 679. A significant development was to use Global Fund resources to finance health monitoring, including ART, for uninsured patients.

However, targets have not been fully met. Many, who need the services, are not receiving them. Of these, the majority are active injecting drug users. In addition, those who do come for services often come late with advanced disease. For example, one hospital reported that more than one third of patients (38%) developed AIDS within a year of diagnosis. Another reported that only 20% of those found to be HIV positive attended for medical screening. There is, however, no shared understanding of the reason for this. Health staff largely blame the IDUs for not caring about their own health, while IDUs and their advocates identify problems with the provision of services.<sup>48</sup> In particular, stigma and discrimination towards IDUs still seem to be major contributors to the existing problems of inadequate access to care and treatment.<sup>49</sup> A recent report of qualitative research among PLHIV concluded that '*stigma in the medical setting was shown to affect standards of care, including cases where treatment was denied, provided insensitively or conducted without regard to confidentiality.*' The same report showed greater problems in accessing general health services than those specifically for PLHIV and greater problems with attitudes of nurses and receptionists than those of doctors (UNDP, 2007).

Nevertheless, there is still no consensus as to ways in which the issue of late presentation by PLHIV to services can be addressed. Medical staff are proposing to conduct provider-initiated testing of all users of health services, based on CDC guidelines, in order to detect PLHIV earlier.<sup>50</sup> However, this will result in a huge number of negative tests and may not increase early

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<sup>46</sup> Which might specify that a particular activity has to be done by a particular category of health worker rather than based on competency.

<sup>47</sup> For example, in hospital there is no price list for a nurse visit.

<sup>48</sup> Some of these problems include provision of different services by different providers in different locations and the cost, time and energy required to access these services (see Box 1). There is also some evidence of anxieties among potential clients about the sustainability of ART now that the Global Fund grant has ended and this treatment is now to be funded exclusively from the state budget.

<sup>49</sup> For example, in one location, it was reported that IDUs would rather travel to other towns for services because of the negative approach of the local infectionist.

<sup>50</sup> There have already been some changes in this direction. The number of people tested each year for HIV increased from 84 633 in 2000 to 119 296 in 2003 but remained stable, at around 120 000 from 2004–2006 (Rüütel & Lõhmus 2007). A number of initiatives were then taken to increase testing, particularly the increasing use of testing in health care settings. As a result, the pattern of testing has changed away from anonymous cabinets to hospitals or primary care doctors. The number of HIV tests conducted in 2007 rose considerably to 184 075. There are some concerns about the adequacy of pre- and post-test counselling offered in such settings.

diagnosis if IDUs already know their HIV status<sup>51</sup> but avoid using services until they become seriously ill (see Box 1). An alternative approach would be to seek to encourage earlier attendance for services by reducing stigmatizing attitudes and discriminatory practices among health service providers, improving confidentiality practices, better integration and linkage of targeted interventions, and increased uses of outreach approaches, self-help groups etc. For example, closer links between hospitals and self-help groups of PLHIV could encourage greater trust between health services and particularly affected communities which might result in people seeking health services earlier.

In addition, the rising cost of ARV treatment is already placing pressure on Estonia's state budget. This will increase even more in the near future as more people receive treatment unless the unit cost of ART can be reduced.

Issues relating to provision of ART in prisons and arrest houses are considered elsewhere (p 45).

### ***Scaling up***

In the absence of more integrated services, a case management system might improve rates of take-up of services. However, such a system has yet to be fully established. It is reported that there are widely divergent views of how such a system should function. NGOs, particularly associations of PLHIV, would like to see peer-led approaches with PLHIV employed as case managers. NIHD has produced a concept for case management which would involve a wide range of professionals coordinating with each other, with one of them acting as case manager.

### ***Quality of services***

Independent quality assurance schemes for services are incomplete or not yet established. In order to improve quality of services provided, the emergence of hepatitis C as a serious public health issue has to be addressed. Currently, hepatitis C is only treated if the patient has health insurance. This is problematic because most cases of hepatitis C occur among IDUs. The majority of IDUs are not covered by health insurance (Uusküla et al., undated).

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

- prescribing practices, such as the percentage of those receiving standard first-line or second-line regimens;
- patients lost to follow-up twelve months after starting ART;
- patients still on first-line therapy twelve months after starting ART;
- percentage of patients picking up all their prescribed ARVs on time;
- percentage of patients keeping their appointments;
- pill count/adherence; and
- continuity of drug supply and avoidance of stockouts.

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<sup>51</sup> Survey results from 2005 suggest that more than two thirds (68%) of IDUs had been tested for HIV in the previous 12 months. This would seem to suggest that accessing HIV testing is not the major barrier but that IDUs who are tested and found to be positive do not then attend for medical services until they are seriously ill.

WHO recommends forming a national committee or working group on HIV drug resistance. This could include MOSA officials and experts responsible for HIV surveillance, HIV care and treatment and HIV drug resistance laboratory. Specific action points for this group are included as Annex 4 (p73).

### ***Strengths and weaknesses***

Table 6 briefly summarizes strengths and weaknesses related to healthcare systems and services for PLHIV.

Table 6: Healthcare systems and services for PLHIV: Strengths and weaknesses

<b>Strengths</b>	<b>Weaknesses</b>
<p>Functioning, national health insurance fund covering 94–95% of population</p> <p>Some services provided to uninsured people, including through national programmes, e.g. on TB and HIV</p> <p>HIV recognised as major challenge for health system</p> <p>Expansion in number of people receiving ART in last five years from 44 to 679</p>	<p>Most IDUs<sup>52</sup> do not have health insurance</p> <p>Health services, provided by many providers in different locations, are difficult for IDUs to access</p> <p>Stigma and discrimination towards IDUs and PLHIV are widespread among health providers</p> <p>Many PLHIV present late for health services</p> <p>Limited availability of social services and these are not well-integrated with health services</p> <p>Case management system not yet fully established</p> <p>High cost of ARVs risks putting pressure on budget for response to HIV</p> <p>Hepatitis C treatment not available for uninsured people</p> <p>System for monitoring emergence of drug resistance not yet established</p>

### **Recommendations**

14. There is a pressing need to address the stigma and discrimination experienced by PLHIV and IDUs from health providers. Reluctance to attend health services, as a result of this, is a major cause of late attendance by IDUs and PLHIV.
15. Ideally, health and social services should be provided in a more integrated manner, i.e. with PLHIV/IDUs able to access services quickly and easily at a convenient location. Failing this, introduction of a case management system could improve access to services.
16. The Government of Estonia should explore ways of making treatment for hepatitis C available to uninsured people.
17. MOSA should establish a system for ARV resistance monitoring

<sup>52</sup> Including those in the Russian-speaking minority.

## Services for young people

### *Coverage*

A range of HIV prevention services were provided with financing from the Global Fund, including adult-led education and peer education in schools. As of September 2007, both types of programme had exceeded planned targets. A total of 88 472 had been reached through adult-led activities and 28 071 through peer-led activities. The percentage of young people aged 15–24 able to answer three questions about HIV correctly rose from 53% in 2003 to 82% in 2007.<sup>53</sup> However, consistent condom use with a non-regular partner in the last twelve months changed little<sup>54</sup> from 46% in 2003 to 50% in 2007.

It is difficult to say anything about programme coverage on the basis of these figures. Young people are a diverse group of people in Estonia with widely divergent risks of contracting HIV. Those who do not inject drugs and do not have sex with someone who has injected drugs have very low risk. Those who do inject drugs or have sex with someone who has injected drugs have significant risk. It is not appropriate to mix these two groups in coverage calculations. It is therefore not useful to talk about coverage of services for young people because it is such a heterogeneous group.

### *Problems in achieving coverage*

The main current problem relates to the transition of responsibility from the Global Fund/NIHD to the Ministry of Education and Research. Although the Ministry is continuing to support peer education activities, it has decided not to continue with adult-led HIV education in schools but to incorporate such lessons into the curriculum. Such an approach is probably appropriate given the need to sustain and systematize this education. However, it is currently problematic because the new curriculum which contains this material is not yet available. Some kind of interim measures may be needed but these should be the responsibility of Ministry of Education and Research or Municipal Education Departments to arrange. NIHD should resist the temptation to intervene directly in this area.

### **Recommendations**

18. The Ministry of Education and Research should introduce the new curriculum as speedily as possible, including plans to systematize teaching related to HIV and AIDS.
19. In the meantime, the Ministry of Education and Research and Municipal Education Departments should consider contracting NGOs and others to continue providing AIDS education to young people until such time as the curriculum is operating effectively. Although NIHD and MOSA should advocate for such provision, they should resist the temptation to finance such services directly as this would risk undermining the Ministry of Education and Research's leadership role in this area.

<sup>53</sup> Because of a change in the questions asked, these figures are not directly comparable.

<sup>54</sup> This change was reported to be not statistically significant.

## Services for sex workers

### *Coverage*

One of the objectives of the grant from the Global Fund was to expand HIV prevention services for sex workers. This was done largely through support to the provision of services through the AIDS Information and Support Service/Elulootus. As of September 2007 (NIHD, 2003–2007), it was reported that 1357 sex workers had been reached with voluntary counselling and testing. This exceeded the targets set. However, it is difficult to assess coverage from this figure because:

- it does not cover all services provided; and
- it is unclear what denominator should be used. For example, should it be the number of sex workers in Estonia or just Tallinn? And should it be the current number or the total number during the period for which figures for counselling and testing were collected?

A recent survey (Trummal, 2007b) of 227 sex workers in Tallinn produced the following data related to programme coverage:<sup>55</sup> Reported condom use was high – almost all (94%) sex workers reported using a condom during last commercial sex. More than three quarters (78%) reported always using a condom during vaginal or anal sex. Rates of condom use during oral sex were lower (51%). Most sex workers reported getting condoms from a shop (58%) or pharmacy (47%). Relatively few (8%) reported getting condoms from the AIDS Information and Support Centre.

However, it is unclear how accurate this high reported use of condoms is because more than one third (36%) of sex workers reported STI symptoms in the past four weeks. Sex workers reported most commonly going to a pharmacy for STI treatment (40%). None reported receiving STI treatment from Elulootus.<sup>56</sup> Only 13% of sex workers had ever visited the services of the AIDS Information and Support Centre.<sup>57</sup>

Almost three quarters (71%) of sex workers had been tested for STIs in the last twelve months and more than half (57%) had been tested for HIV during the same period. Of those tested for STI and HIV, most received the testing through a medical specialist (78% and 62% respectively). Others went to AIDS counselling cabinets (12 and 22%) and AIDS Information and Support Centre (5.5% and 11%).

It appears from this study that pharmacies, medical specialists and AIDS counselling cabinets are significant providers of services for sex workers. Coverage of services of the AIDS Information and Support Centre appears relatively limited.<sup>58</sup> Services outside Tallinn were not covered in this study but are likely to be more limited.<sup>59</sup> The provider of services for IDUs in Narva expressed the need for HIV-related services for sex workers in that city.

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<sup>55</sup> This was a convenience sample because of problems experienced with the attempted RDS methodology. Consequently, the sample may not be representative of all sex workers in Tallinn.

<sup>56</sup> It is possible that some sex workers did receive treatment from Elulootus but reported this under another category, e.g. dermatovenereologist.

<sup>57</sup> Which is co-located with Elulootus.

<sup>58</sup> This is disputed by the centre. However, they restrict advertising their services for fear of being inundated, which implies that coverage could be significantly expanded.

<sup>59</sup> In addition, the nature of the sample means that the study may not be representative of all sex workers in Tallinn (see Footnote 55, p. 37).

### ***Problems in achieving coverage***

The main problem relating to targeted services for sex workers is that they are limited in geographic scope. It would be ideal to expand the services to cities outside Tallinn, such as Narva, Tartu and Pärnu.

### ***Quality of services***

There is currently no systematic quality assurance system (see p. 20) for these services although NIHD incorporated service descriptions in contracts for all services.

### **Recommendations**

20. NIHD should seek to establish services for sex workers outside Tallinn

## **Services for men who have sex with men**

### ***Coverage***

One of the objectives of the grant from the Global Fund was to expand HIV prevention services for MSM. This was done largely through support to the provision of services through NGO Diversity,<sup>60</sup> including the establishment of a Gay and Lesbian Information Centre in Tallinn. As of September 2007, 17 770 contacts<sup>61</sup> had been made to the centre through visits, phone calls and emails.

A recent survey (Trummal et al., 2007) of MSM sought to recruit 400 participants. Only 59 were recruited. One factor in this low coverage was the economic activity of these men and their resultant access to health services, e.g. STI and HIV testing.<sup>62</sup> The survey did produce some data relevant to programme coverage. Respondents reported low condom use at first sex (20%). Consistent use with a regular partner was also low (20%) with higher rates reported for non-regular partners (42%). Condom use at last sex was higher – 36% for regular partners and 84% for non-regular partners. Just under one quarter (23%) obtained condoms from gay clubs and saunas supplied by the Gay and Lesbian information centre. A smaller number (12%) had visited the centre.

It appears that MSM have reasonable access to HIV-related services, such as condoms, STI treatment and HIV testing. However, many of these channels are not specifically targeted at MSM. Currently, there are no specific services for MSM outside of Tallinn. There is a strong aspiration from the Gay and Lesbian centre to open similar services in Tartu.

### ***Problems in achieving coverage***

The main problem relating to targeted services for MSM is that they are limited in geographic scope and to one provider. It would be ideal to expand the services of the gay and lesbian information centre, e.g. to Tartu.

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<sup>60</sup> Which at that time was known as the Estonian Gay League.

<sup>61</sup> These are not unique individuals but number of contacts/person times. This means that if the same person contacts the centre on two different occasions, it is counted as two contacts.

<sup>62</sup> That is the provision of these services is less of an incentive for MSM to participate in the survey than it is for other groups, such as IDUs or sex workers.

### ***Quality of services***

There is currently no systematic quality assurance system for these services (see p. 21) although NIHD incorporated service descriptions in contracts for all services.

At the Gay and Lesbian information centre, feedback questionnaires, prepared by NIHD were completed over a two month period in spring 2006. These were completed anonymously by 53 people and were aimed at those using services for at least a second time. Questions asked included how people heard about the service, how satisfied they were and what services they thought were needed.<sup>63</sup>

There are some concerns that contract-based quality standards can be too prescriptive, e.g. limiting activities to narrow HIV prevention activities and not broader activities focused on the stigma and discrimination endured by MSM in Estonia. Given the extent of stigma and discrimination faced by MSM in Estonia, tackling these would seem to be a legitimate use of financing focused on addressing HIV and AIDS.

### **Recommendations**

21. NIHD should consider supporting the establishment of a Gay and Lesbian Information Centre in Tartu

## **Services for IDUs**

### ***Availability of services***

In Estonia, government<sup>64</sup> and NGOs are providing a range of services for IDUs. These focus on both HIV and drug use and include services focused on prevention, treatment and rehabilitation. They include specialized services for IDUs<sup>65</sup> and general services from which IDUs also benefit.<sup>66</sup> IDUs also come into contact with other government agencies on a regular basis, e.g. police and prisons. The range of services being implemented<sup>67</sup> is broadly consistent with international and European recommendations for universal access to HIV prevention, treatment and care for IDUs (Donoghoe et al., 2008). Particular support for the development of these services came from the Global Fund. This support was of critical importance because of the controversial nature of these interventions and the associated difficulties in securing funding. However, services for specific groups of IDUs are more limited. Such groups include women, young injectors<sup>68</sup> and amphetamine injectors.<sup>69</sup>

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<sup>63</sup> Respondents praised the friendliness of staff and the quality of information provided. More people received information on rights of sexual minorities (44%), spending leisure time (34%) and getting acquainted (36%), than about HIV/AIDS (26%) or safe sex issues (16%). Additional activities requested included movie evenings, meetings with similar organizations in other countries, seminars/trainings/information events, something for spending leisure time and something for parents (Lõhmus and Trummal, 2006b).

<sup>64</sup> Both national and local.

<sup>65</sup> Such as needle and syringe programmes, drug treatment programmes, low threshold centres etc.

<sup>66</sup> Such as hospitals, shelters, social services etc., in addition, to medical and social services.

<sup>67</sup> Including needle and syringe programmes (NSP); drug dependency treatment, notably opioid substitution therapy (OST) and access to antiretroviral therapy (ART).

<sup>68</sup> The importance of preventive interventions among young people, including occasional and experimenting drug injectors and non-injecting drug users, has recently been increasingly recognised. Such services aim to either stop drug use, or avoid initiation into injection.

Effective provision of services requires providers to work cooperatively together. There is some evidence of that, e.g. on joint advocacy for government funding to continue activities started with Global Fund financing.

### *Coverage of services*

It is estimated that there are 13 801 injecting drug users in Estonia (Uusküla et al., undated). Table 7 presents key coverage data (see WHO et al., 2008) based on programmatic and survey data.

Table 7: Coverage of services for IDUs

Indicator	2002 <sup>70</sup>		2007 <sup>71</sup>	
	No.	% <sup>72</sup>	No.	%
<i>Needle Syringe Programmes</i>				
Programme Data				
Number of new clients	3000 <sup>73</sup>	21	10 902 <sup>74</sup>	79 <sup>75</sup>
Number of IDUs 'regularly' reached <sup>76</sup>	No data	No data	5465–6329 <sup>77</sup>	40–46
Number of syringes distributed per year	183 000	13 <sup>78</sup>	1 615 604 <sup>79</sup>	117 <sup>78</sup>
Survey Data				
Percentage of IDUs who report getting syringes/needles from NSP in last 4 weeks	-	No data	-	73 <sup>80</sup>
<i>Opioid Substitution Therapy</i>				
Number of IDUs receiving methadone maintenance therapy	10	<0.1	654 <sup>81</sup>	4–6 <sup>82</sup>

<sup>69</sup> Use of amphetamines has particular characteristics of relevance to HIV-related services. These include much higher frequency of injections, more sexual activity, lack of effective drug treatment and higher co-morbidity with mental problems.

<sup>70</sup> Data from WHO, 2002.

<sup>71</sup> These figures are the most recent available, provided by NIHD for the evaluation team.

<sup>72</sup> All percentage calculations in this table use the current denominator of 13 801 unless otherwise stated.

<sup>73</sup> This figure was new clients for 2001. As a round number, it is likely that it was estimated.

<sup>74</sup> These figures are for the period of the Global Fund grant (Jan 2004 to Sep 2007).

<sup>75</sup> This figure almost certainly over-estimates coverage because it counts clients 'ever reached' with services and compares these with a denominator from a fixed point in time (rather than all the people in Estonia who injected drugs during the specified time period).

<sup>76</sup> Currently, there is no shared understanding internationally of what 'regular' means in this context. Forthcoming WHO/UNODC guidance (WHO et al., 2008) suggests that this should be defined as at least once a month in the past year.

<sup>77</sup> These figures are an estimation of the number of clients attending at least twice in the second quarter of 2006. They are based on measurements of the number of clients with client cards attending at least twice during that period (2476). However, it is known that many of the clients of NSPs do not have client cards. Nevertheless, since the number of visits to NSPs by clients with and without client cards is known, this figure has then been scaled up based on that information. The range presented represents 95% confidence limits for that calculation. If the parameters are changed to attending at least once per quarter, the number rises to 9,125-10,461, representing coverage of 66–76%.

<sup>78</sup> Number of syringes per IDU per year.

<sup>79</sup> These figures are for 2006 and refer to syringes distributed with needles. In addition, a further 601 269 separate needles were also distributed.

<sup>80</sup> 2005 data.

Overall, for needle and syringe programmes, coverage is very good<sup>83,84</sup> and comparable to the best achieved in other European countries. The number of syringes distributed per IDU per year (117) is close to reaching levels (140 per year) which have been shown to be effective elsewhere (Donoghoe et al., 2008). This figure underestimates the total number of syringes and needles available to IDUs, because it does not include those purchased from pharmacies. In addition, it does not consider variations in coverage from one area to another. For example, the Low Threshold Centre in Tallinn reported that, in 2007, it distributed 12 823 syringes to just over 2,200 IDUs. This is 5.8 syringes and needles per IDU per year.<sup>85</sup> Geographical spread of NSPs is uneven. Most services are in three counties in North-East Estonia. Although this can be explained by the high HIV prevalence among IDUs in these counties, there is a need to ensure that these services are also available in other areas of Estonia.

Although the number of IDUs receiving opioid substitution therapy in Estonia has increased since 2002, overall coverage remains low<sup>86</sup> (4–6%). This falls far short of the 40% recommended by WHO and UNODC and levels achieved in other European Union countries. Availability of other forms of drug treatment services is also reported to be limited.

Coverage of ART among HIV positive IDUs appears to be low. For example, although the vast majority<sup>87</sup> of all HIV infections in Estonia have been among IDUs, only 30–35%<sup>88</sup> of those receiving ART in Narva are reported to be IDUs. The problem does not seem to relate to access to HIV testing. Coverage of HIV testing among IDUs appears to be good. For example, in 2005, more than two thirds of IDUs (68%) reported having had an HIV test in the last year. However, relatively few of these then attend for medical services.<sup>89</sup>

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<sup>81</sup> This figure appears to include some IDUs receiving methadone for detoxification purposes and excludes some IDUs (around 110) receiving OST from other sources, i.e. not funded by NIHD.

<sup>82</sup> The coverage is 4.7% if the total number of IDUs (13 801) is used as denominator. If the denominator is restricted to the estimated number of IDUs who are primarily opioid users (11,178), the coverage rises to 5.9%. This difference is minor in Estonia because most IDUs are primarily opioid users. However, it is unclear whether the denominator here should be all opioid users (i.e. including non-injectors) or only opioid injectors. It is also unclear whether the denominator should be all opioid users or only those who are dependent.

<sup>83</sup> As defined in Donoghoe et al., 2008.

<sup>84</sup> There are some difficulties in measuring the coverage of HIV programmes for IDUs at a national level. For example, the methods and measures for monitoring the UNGASS declaration of commitment on HIV/AIDS (UNAIDS, 2007) differ from those proposed for measuring progress towards achieving universal access (e.g. WHO et al., 2008; Donoghoe et al., 2008). UNGASS reporting is currently based on survey data while the proposed methods for measuring progress towards universal access are based on programme data of availability, coverage and quality of services. In addition, in Estonia, there are problems with the client card system used to identify unique individuals, and information available from different sources is not always consistent (e.g. see footnote 79).

<sup>85</sup> One reason for this is that the centre is operating under legal restrictions which prevent it from distributing needles and syringes at its premises. However, there are other reasons why outreach services do not distribute as many needles and syringes as other programmes. These include not having IDUs working as outreach workers as is the practice in other programmes.

<sup>86</sup> See UNODC, 2007.

<sup>87</sup> There are currently no official figures for the percentage of HIV infections occurring in Estonia as a result of injecting drug use. As a result, this figure is controversial and disputed. Informal estimates vary from 60–85%.

<sup>88</sup> Again, there are problems because there are no official figures on the percentage of those on ART who are current and/or former IDUs. Figures supplied by an NGO indicate that the percentage of those on ART who inject or injected drugs could be as high as 85%.

<sup>89</sup> In Narva, it was reported that only 20% of those testing HIV positive attended for medical follow-up.

There is also evidence of changes in injecting behaviour among IDUs. For example, in 2002, half (50%) of IDUs reported sharing injecting equipment. More recent data showed just over one quarter (29%) of IDUs sharing syringes in the previous four weeks (Uusküla et al., undated).<sup>90</sup>

### ***Access barriers***

Although barriers to access to some services, e.g. NSPs, have been largely overcome, they remain significant for other services, e.g. OST and ART. Some of these barriers are briefly reviewed here:

- stigmatizing attitudes and discriminatory practices towards IDUs, including among health service providers. Health service providers generally blame IDUs themselves for failing to access services, e.g. ART, rather than recognizing systemic barriers to access;
- the majority of IDUs are poor, unemployed, Russian-speaking and uninsured;
- limited cooperation between providers of services for IDUs. A particular concern is the absence of linkages between drug dependence services, such as provision of OST, and HIV/AIDS treatment services, such as ART;
- concept of case management has been developed but not applied fully in practice. There is no real understanding of the benefits that might be gained by seeking to provide IDUs with a 'one stop shop'<sup>91</sup> for all services;
- very negative perceptions of OST among service providers and IDUs;<sup>92</sup>
- human resource development related to services for IDUs is not systematic, e.g. there is no state educational programme to train drug specialists in Estonia and some roles, e.g. outreach worker are not professionally recognized. 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 protect workers' rights;
- a legal environment in which drug users are frequently arrested and convicted for possession of small quantities of illegal drugs;
- role of police in HIV and drug-related prevention and treatment services is very limited, e.g. drug prevention education in schools and provision of ART in arrest houses; and
- many IDUs have spent time in prison. Lack of access to services, e.g. OST there means that services started in the community are interrupted and stopped (see p. 35).

### ***Quality of services***

International scientific literature on development of drug services places increasing focus on issues of quality of services (WHO et al., 2008). Aspects of quality include:

- the scope, completeness, effectiveness, efficiency and safety of interventions
- client satisfaction with the intervention
- human rights orientation

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<sup>90</sup> Care is needed in interpreting these findings because differences in methods and questions may mean that the findings are not comparable. It would help such comparability if same methods and questions were used over a prolonged period.

<sup>91</sup> Integration and co-location of HIV/AIDS and drug treatment services have been argued for by a number of authors (e.g. Sylla et al., 2007; WHO, 2007b).

<sup>92</sup> One reason for this is the widespread perception of methadone as a 'toxic' substance.

- friendliness of services
- community involvement and empowerment.

Some important elements of quality of programmes for IDUs have been identified.<sup>93</sup> Discussions with IDUs identified a number of service elements which they viewed as particularly important components of quality of NSPs, including proximity of services, convenient opening times, wide range and good quality of needles and syringes, and friendly programme staff.

NIHD built a good foundation for an efficient quality management and monitoring system during the time that it managed Estonia's Global Fund grant (Drew and Laukamm-Josten, 2006). This operates through a system of service descriptions contained within contracts (NIHD, 2007e). It is expected that this approach will continue in future. A remarkable improvement in quality of NSP services since the last evaluation has been possible because of the introduction of a new procurement and supply management system. This allows sub-recipients to procure a wide variety of syringes and needles of different brands directly from the wholesaler on a monthly basis. However, this improvement has not yet occurred in relation to condom provision and programmes are not able to provide a full range of materials, such as cookers, filters and water for injections.

A recent review (UNODC, 2007) identified great variation in the quality and philosophies underlying the principles and operational practices of OST programmes in Estonia. Two distinct approaches exist. The first focuses on using OST to achieve abstinence among small numbers of highly-motivated IDUs. The second sees OST as a harm reduction method, relevant to the majority of IDUs. The first approach appears to dominate in Estonia.<sup>94</sup> This has negative implications for both access to OST and quality of services.

Some observations on the quality of the services visited include:

- there are wide variations in quality including location, range of services and degree of user-friendliness;
- involvement of peers in service provision and design improves service quality and results in higher uptake of services;
- services are perceived as better when staff are able to communicate with IDUs in their primary language, which in most cases is Russian; and
- the requirement that programmes meet targets in terms of number of returned syringes is not in line with most up-to-date evidence base (Bluthenthal et al., 2007).

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<sup>93</sup> These include geographical proximity of services; operating times; quality of prevention materials; access to information on health and other issues; attitude of program staff; access to other services not limited to syringe exchange; client-focused rules and regulations; and levels of client satisfaction.

<sup>94</sup> For example, 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 not in line with current practice and recommendations from WHO/UNODC. It was reported to the team that new guidelines have been drafted.

## **Recommendations**

22. The Government of Estonia should agree on a set of indicators to measure coverage and quality of services for IDUs both nationally and at local level.
23. Efforts need to be made to increase access to services for IDUs. These services also need to be of good quality. While maintaining and increasing provision of sterile injecting equipment, particular focus is needed on OST and ART.
24. MOSA should work with service providers to introduce national quality assurance standards covering implementation and operation of NSPs.

## **Services for prisoners**

### ***The importance of prisons and other custodial settings***

Internationally, prisons and other custodial settings are an important environment in which there is a risk of HIV transmission.<sup>95</sup> Populations most-at-risk of infection, e.g. IDUs, are over-represented and they have more limited access to prevention and other services. In many countries of the EU, use of illegal drugs in prisons is increasing (Shewan et al., 2005). However, prison management face increasing public pressure to keep prisons drugs-free and largely respond with increased security measures. Nevertheless, some are recognising that those using illegal drugs are ill and do not belong in prison (WHO et al., 2004). Some countries, e.g. Spain have begun implementing effective HIV prevention programmes, based on principles of harm reduction, in prisons.

According to official, published statistics, at the end of 2005, Estonia had 4 463 prisoners – a rate of 338 per 100 000 population, which is the highest in the EU. The number is reducing and it was reported that there were 3 400 prisoners in Estonia at the time of the evaluation. There has been massive investment in Estonia's prison infrastructure and in the provision of medical services. In addition to prisons, administered by the Ministry of Justice, there are a number of 'arrest houses' administered by the Ministry of Interior.

As in other EU countries, information on HIV infection, sexual activity and the use of illegal drugs in prisons in Estonia is not widely available. According to figures from the Ministry of Justice, in January 2008, there were 486 HIV positive people in the Estonian prison system. This constitutes 14% of all prisoners. A recent study (Lõhmus and Trummal, 2006a) showed that:

- more than one third (34%) reported using drugs while in prison
- of those, almost two thirds (63%) had injected drugs
- almost half (45%) of those had shared syringes or needles in the past four weeks<sup>96</sup>
- one in ten (10.5%) reported having had same-sex sex in the past year
- more than three quarters (76%) reported testing for HIV in prison.

### ***Availability of services***

Ministry of Justice reports that medical departments have taken action to implement comprehensive HIV/AIDS prevention, treatment and care services in prison settings. These

<sup>95</sup> And other infectious diseases, such as hepatitis B and C.

<sup>96</sup> More reported sharing water (50%) or a container (49%).

activities have had some positive benefits. For example, continuing education about HIV among prisoners is reported to have reduced stigma and discrimination experienced by HIV positive prisoners, who live together with other inmates. Evidence to support these reports was gathered during the interviews conducted during this evaluation. Respondents reported that hostile attitudes towards and discrimination against HIV positive prisoners has reduced as a result of the activities described above, and other activities, including the work of NGOs in prisons. HIV testing<sup>97</sup> is offered to all first-time offenders and is available at different stages of imprisonment. It is reported to be voluntary, confidential and based on informed consent. The costs of testing, diagnostics and treatment are paid from the state budget by the Ministry of Justice. This is part of the Ministry of Justice's role of providing all the health care and social support services in prisons (WHO, 2007a).

Particular strengths of the Estonian response to HIV and AIDS in prisons are:

- high numbers of prisoners are tested for HIV, e.g. 2 671 in first six months of 2006;
- condoms and lubricants are available for free in prisons through health care departments and NGOs. Condoms are also available for sale in prison shops;
- vaccination for hepatitis B is provided to all prisoners who are convicted for more than 7 months;
- training has been provided for prisoners and staff about HIV, AIDS, other communicable diseases, sexual behaviour and social programmes for IDUs;
- the existence of 21 support groups for PLHIV and IDUs in prison, operated by Convictus;
- provision of ART to 110 people; and
- provision of other health services, e.g. TB screening.

However, Estonia's national HIV and AIDS strategy (see p. 10) clearly states that all HIV prevention services that have been implemented outside prisons should be equally available in prisons. This specifically includes harm reduction measures, such as needle and syringe exchange, OST and provision of condoms and lubricants. However, many of these activities are not yet being implemented in prisons and other custodial settings. Indeed, there seems to be a focus on preventing HIV transmission through improving physical infrastructure and strengthening security, to prevent illegal drug use.

Condoms, lubricants and disinfectants are currently distributed in small quantities under carefully-regulated conditions. However, it is reported that these practices are under review. For example, some respondents questioned the necessity of providing condoms to prisoners.

Previous studies (Grund, 2005; Drew and Laukamm-Josten, 2006) noted that there was a continued absence of key, proven, prevention services in prisons, particularly needle exchange and opioid substitution therapy. Little has changed since those studies were conducted. Given that many IDUs spend time in prisons and other custodial settings, the absence of these services in those contexts constitutes a major gap in Estonia's response to HIV and AIDS. Currently IDUs on OST invariably have this important treatment interrupted when they enter Estonia's criminal justice system. Other measures, such as provision of disinfectants or counselling and drug reduction programmes will not compensate for the absence of other services. In particular,

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<sup>97</sup> Confirmatory tests for those found to be HIV positive are paid from funds available under the National HIV and AIDS Strategy, administered by NIHD.

provision of bleach is not recommended as a safe disinfectant for needles and syringes in prisons because it requires detailed instructions on how to use safely and effectively.

Other problems related to delivery of services in prisons have been documented previously (Drew and Laukamm-Josten, 2006) and during this evaluation. They include:

- some negative staff attitudes towards PLHIV. Such attitudes are also seen among some prisoners.
- condoms and lubricants are not easily accessible;
- the prison health system is not able to provide daily medications, e.g. ARVs. Prisoners get their pills in their cell in a plastic bag for a week.<sup>98</sup>
- prison health staff have limited HIV/AIDS knowledge.<sup>99</sup>
- prison health care is lacking an understanding of medical ethics as prerequisite for trustful doctor-patient-relationship.<sup>100</sup>
- lack of throughcare and seamless provision of services for prisoners on leave and after they are released. For example, it is reported that only 50% of ARV-patients continue their treatment once released;<sup>101</sup> and
- some concerns that there may be some HIV positive prisoners who need ART but are not receiving it.<sup>102</sup>

Some local efforts have been made to provide OST from community programmes to arrest houses, e.g. in Narva, but these were stopped by the Ministry of Interior. An order permitting provision of OST in arrest houses has recently been developed although implementation had not started at the time of the visit. The Ministry of Justice has been discussing introducing OST in prisons for those receiving this in the community, but this has not yet started. Medical staff from Tartu prison indicated that they were ready and willing to implement such a programme if authorized to do so.

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<sup>98</sup> Although this practice was observed in one prison, the Ministry of Justice reports that this is not the practice in other prisons and that serious efforts are being made to change this. This involves changing the structure of the medical services and closer monitoring of its practices.

<sup>99</sup> Ministry of Justice reports that there have been extensive efforts to train all prison staff on issues relating to HIV and AIDS, including education of medical staff.

<sup>100</sup> Ministry of Justice reports that medical care in prisons is administered by empathetic and well-educated providers. There is reported to be a confidential relationship between prisoners and medical staff. In particular, the number of staff who know a prisoner's HIV positive status is limited and this information is treated as confidential. However, in interviews, it appears that there may be breaches in this confidential relationship when security matters are involved, e.g. use of illegal drugs. The Ministry of Justice acknowledges some challenges in this area, particularly related to the recruitment of competent staff. Efforts are being made to address this by improving pay and conditions of service of prison medical staff.

<sup>101</sup> Ministry of Justice reports that prisoners on ARVs are provided with a supply for three days on discharge. They are informed on how to continue their treatment. The infectious disease specialists who work in prisons also work in the community.

<sup>102</sup> At the time of visiting, 120 prisoners were reported to be on ART. This constitutes one quarter of those in prison known to be HIV positive.

## **Recommendations**

25. MOJ and MOI need to take effective steps to ensure continuity of critical health services, such as OST, in custodial settings. This could include working with community providers of services in arrest houses and introducing OST, initially as a pilot in Tartu prison, and then elsewhere.
26. Needle exchange pilot programmes should be considered for future implementation in prisons. This will require a preparatory programme of staff training.
27. Efforts are also needed to reach a higher proportion of HIV positive prisoners with ART. This could involve an expanded role for NGOs to provide peer support.
28. Availability of condoms should be improved. These should be available anonymously and free of charge

## **Integration of services**

Other sections of this report have focused on particular services. This section looks at the extent to which these services, particularly those for PLHIV, are integrated and coordinated

### ***Coordination mechanisms***

Estonia's national response to HIV and AIDS is based on an agreed, multisectoral strategy and is coordinated by a Governmental Commission (see p. 10). The implementation of such a multisectoral strategy has been a challenge for all partners which has required new working practices from all involved. There are still some areas that could be improved, such as sharing of roles and information within areas of MOSA, the lead ministry in Estonia's national response to HIV and AIDS. To date, lack of key staff in MOSA, changes in government and limited powers to require accountability from ministries have meant that the potential of the Governmental Commission has not yet been fully-reached. Within MOSA, responsibility is shared among two departments – public health and health care. Limited staff capacity has resulted in coordination being underdeveloped between these two departments. Also, there are two MOSA agencies mainly responsible for public health services and surveillance. These are the Health Protection Inspectorate (HPI) and the National Institute for Health Development (NIHD). HPI is mainly responsible for public health surveillance, including routine statistics on HIV and AIDS. NIHD has been implementing the national AIDS strategy, including responsibility for monitoring activities and conducting special surveys. The added value of splitting passive and active surveillance roles is unclear and there are opportunities to improve the flow of HIV-related information between MOSA agencies.

### ***Integration at service level***

Health and social services for PLHIV are described elsewhere in this report (see p. 23). Issues relating to integration of those services are briefly reviewed here:

- Many of those first tested positive for HIV do not attend for health monitoring with an infectious diseases specialist. Such health monitoring is not currently available at all the places where HIV testing is provided.
- Services are paid for in a variety of ways – through the Health Insurance Fund, through separate programmes and by local municipalities. Uninsured persons may need to obtain

proof that services will be paid for, e.g. by the local municipality, before they can be received.

- Capacity of hospitals to provide social services, e.g. through a social worker, is limited. Linkages to other providers of social services, e.g. NGOs are often limited.
- Some companies providing specialist, outpatient medical services have close linkages to NGOs. In these cases, linkages between medical and social services is stronger than between hospitals and NGOs.
- There is very limited consideration of the perspectives of clients/users of services when considering how they should be provided. In general, service providers blame potential users for non-use, particularly where these people are IDUs. Issues of importance to IDUs, such as geographical proximity of services, opening hours, staff attitudes etc. are rarely considered by providers when planning service provision.

### **Recommendations**

29. MOSA, its departments and agencies could improve coordination and information exchange through regular meetings and by introducing a system of rotation of specialists between MOSA, NIHD and HPI.
30. Client perspectives, particularly those of IDUs, need to be considered much more fully when planning HIV-related services. This is likely to involve providing more services through outreach, with extended opening hours and through trusted providers.

## Recommendations

### Overview

1. The team recognizes the need to avoid encouraging complacency among the general population of Estonia about their risk of contracting HIV and/or increasing the stigma and discrimination experience by most-at-risk populations. However, care is needed in stating that the HIV epidemic in Estonia is generalizing beyond IDUs and their sex partners. It is the view of the evaluation team that available information does not support this assertion. More detailed information about current transmission routes is required.
2. There is evidence that Estonia's HIV prevention programmes, based on harm reduction interventions among most-at-risk populations, particularly injecting drug users are beginning to be effective. In particular, targeted (harm reduction) interventions for injecting drug users, including opioid substitution therapy, still offer the best solution to the ongoing HIV crisis in Estonia. They should be continued and further scaled-up.

### Coordination and Management

3. MOSA should take a more active leadership role in the national response to HIV and AIDS, particularly in some areas, such as implementing a system of case management and ensuring reporting of information on HIV transmission routes.
4. A key priority for MOSA should be reinvigorating the Governmental Commission on HIV and AIDS. This would involve reviewing its membership and role. A key function would be to ensure accountability of government ministries for their mandates on HIV and AIDS.
5. There is need to define more clearly the respective roles of MOSA and NIHD.
6. Government should seek to create an enabling environment for the work of NGOs. In addition to provision of funding, this should also include a robust regulatory framework and measures to stimulate the emergence of new service providers.
7. NGOs themselves need to take more leadership on issues related to their organizational development, e.g. by establishing a network on HIV and AIDS and establishing a systematic approach to training and capacity development among NGOs.

### Financial Flows

8. Larger municipalities should consider using their own resources to co-finance HIV/AIDS services, e.g. as is being done in Tallinn.
9. The Government of Estonia should review current contracting mechanisms for AIDS services to ensure they are maintaining the good practices established through the Global Fund grant, and are appropriate in terms of length and overall characteristics to enable strategic purchasing.
10. MOSA and NIHD should explore the possibility of greater use of provider payment methods based on fees for service as an incentive to scale up the response to HIV and AIDS.

### Monitoring and Evaluation

11. A review should be conducted of the various players in HIV/AIDS monitoring and evaluation in Estonia. This should consider whether so many different players are needed

or add value to the response. It should also consider what their respective roles are and how their activities and data can be coordinated.

12. There is need to establish and agree a system for data to flow within the national monitoring system for HIV and AIDS. This should cover all agreed indicators and be based on the system outlined in the national strategy and experience gained during the implementation of the grant from the Global Fund.
13. A system needs to be established to allow Estonia to analyse and report transmission routes for HIV infection. Plans to establish a new system for doing this based on doctors reporting to the Health Protection Inspectorate are unlikely to produce robust data in the foreseeable future. MOSA should consider alternative approaches, at least in the short-term, such as establishing a mechanism to make more official use of data currently collected by the National Reference Laboratory.

### **Services for PLHIV**

14. There is a pressing need to address the stigma and discrimination experienced by PLHIV and IDUs from health providers. Reluctance to attend health services, as a result of this, is a major cause of late attendance by IDUs and PLHIV.
15. Ideally, health and social services should be provided in a more integrated manner, i.e. with PLHIV/IDUs able to access services quickly and easily at a convenient location. Failing this, introduction of a case management system could improve access to services.
16. The Government of Estonia should explore ways of making treatment for hepatitis C available to uninsured people.
17. MOSA should establish a system for ARV resistance monitoring.

### **Services for young people**

18. The Ministry of Education and Research should introduce the new curriculum as speedily as possible, including plans to systematize teaching related to HIV and AIDS.
19. In the meantime, the Ministry of Education and Research and Municipal Education Departments should consider contracting NGOs and others to continue providing AIDS education to young people until such time as the curriculum is operating effectively. Although NIHD and MOSA should advocate for such provision, they should resist the temptation to finance such services directly as this would risk undermining the Ministry of Education and Research's leadership role in this area.

### **Services for sex workers**

20. NIHD should seek to establish services for sex workers outside Tallinn.

### **Services for MSM**

21. NIHD should consider supporting the establishment of a Gay and Lesbian Information Centre in Tartu.

### **Services for IDUs**

22. The Government of Estonia should agree on a set of indicators to measure coverage and quality of services for IDUs both nationally and at local level.

23. Efforts need to be made to increase access to services for IDUs. These services also need to be of good quality. While maintaining and increasing provision of sterile injecting equipment, particular focus is needed on OST and ART.
24. MOSA should work with service providers to introduce national quality assurance standards (see p. 21) covering implementation and operation of NSPs.

### **Services in custodial settings**

25. MOJ and MOI need to take effective steps to ensure continuity of critical health services, such as OST, in custodial settings. This could include working with community providers of services in arrest houses and introducing OST, initially as a pilot in Tartu prison, and then elsewhere.
26. Needle exchange pilot programmes should be considered for future implementation in prisons. This will require a preparatory programme of staff training.
27. Efforts are also needed to reach a higher proportion of HIV positive prisoners with ART. This could involve an expanded role for NGOs to provide peer support.
28. Availability of condoms should be improved. These should be available anonymously and free of charge.

### **Integration of services**

29. MOSA, its departments and agencies could improve coordination and information exchange through regular meetings and by introducing a system of rotation of specialists between MOSA, NIHD and HPI.
30. Client perspectives, particularly those of IDUs, need to be considered much more fully when planning HIV-related services. This is likely to involve providing more services through outreach, with extended opening hours and through trusted providers.

## *Annex 1*

### TERMS OF REFERENCE

#### ***Background***

Today Estonia operates in a framework of the fourth national program/strategy for fighting HIV/AIDS – “National HIV and AIDS Strategy 2006–2015”. The main financial resources for implementing the strategy (and the national program before that) have been the state budget and the support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Estonia started its 4-year GFATM program on 1st of October 2003 and finished it on 30th of September 2007. Ending this program is an important turning point in fighting HIV and AIDS in Estonia since GFATM has given big amount of extra resources to increase the scale of Estonian’s response to the epidemic. Therefore there is an opportunity to reassess the national response as a whole to fight HIV/AIDS in the light of the previous implementation of GFATM program.

The aim of the evaluation is to give practical input to Estonia for developing the area of HIV/AIDS interventions in the near future. For that the evaluation needs to assess and give recommendations on two main areas: structures and systems in place, coverage and quality of services. Evaluation is ordered by the National Institute for Health Development (NIHD) and also requested by the Ministry of Social Affairs as integral part of the collaborative agreement between the Government of the Republic of Estonia and World Health Organization to support the scaling up the response to HIV/AIDS in Estonia.

#### ***Areas and key questions***

There are two closely connected areas in the national response that need to be looked at.

- 1) Structures, systems and organizational development.** The assessment of:
  - 1.1** Management and coordination systems (including structures and systems developed under the GFATM program);
  - 1.2** Financial flow and NGO support systems (as providing financial support to service providers);
  - 1.3** Monitoring, evaluation and quality assurance systems (including those developed under the GFATM program);
  - 1.4** Healthcare systems connected with services for PLHIV; and
  - 1.5** Organizational development and capacity building of coordinating institutions and service providers.

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

1. What is the capacity of the systems and organizations in place?
2. How has the capacity in the area developed in recent years?
3. Do present structures support the needs in fighting the epidemic in Estonia?
4. What are the strong and weak parts of the developed systems?

5. Are there areas that need revision/restructuring, gaps to be filled or unnecessary practices that need to be dropped?
6. What is needed to further scale up the national response?

### **1.6. Integration of services**

Questions to be answered when investigating area 1.6:

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

The levels to look at under the section one:

- state level
- level of NGOs and other service providers.

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

- 2.1.** Prevention and health care services targeted at IDUs and convicts;
- 2.2.** Services targeted at youth, SWs, MSM;
- 2.3.** Health care of PLHIV – health monitoring, ARV, relation to TB, HCV and STIs, getting PLHIV to the health care system;
- 2.4.** Psychosocial support to PLHIV and case management.

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

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

### ***Methods***

Evaluation mission will be organized in two parts: 1) mission for evaluating structures and systems in place and coverage and quality of services for PLHIV, youth, SW, MSM; 2) mission for evaluating structures and services related to interventions targeted at IDUs and prisoners.

Methods for evaluation:

- Desk review of documents, reports and other materials related to HIV/AIDS issues in Estonia. Materials will be provided by NIHD before the in-country mission.

- Interviews with key informants in chosen organizations with visits to service provision sites in Tallinn and East-Estonia. Key informants will be relevant government officials in different ministries and NIHD, representatives of NGOs, private companies and hospitals. Organizations will be chosen in cooperation of evaluation experts and NIHD.

Separate Terms of References are prepared for evaluating services for IDUs and in prison settings by UNODC.

### ***Expertise needed***

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

### ***Partnerships:***

- World Health Organization Regional Office for Europe – Ulrich Laukamm-Josten, Claudio Politi, Martin C. Donoghoe, Agris Koppel;
- Roger Drew as an independent consultant;
- UNODC – Signe Rotberga, Heino Stöver (evaluation of prison settings), Anya Sarang (evaluation of services for IDUs);
- National Institute for Health Development (NIHD) – Providing resources for the evaluation, organizing meetings, solving technical issues. First contact: Aire Trummal, analyst; and
- Ministry of Justice – organizing meetings under the domain of the ministry.

Experts involved in the first part of the evaluation: Ulrich Laukamm-Josten, Roger Drew, Claudio Politi, Agris Koppel, Signe Rotberga. Expert involved in the second part of the evaluation: Roger Drew, Heino Stöver, Signe Rotberga, Anya Sarang, Martin C. Donoghoe. The main report writer is Roger Drew and he will consolidate the reports of other experts to the overall report.

### ***Timeframe:***

First part of the evaluation:

- September-November 2007: Negotiations with partners for conducting the evaluation.

- November-December 2007: Preliminary review of provided documents, study results, etc; preparing the structure of appointments in Estonia.
- 4–7 December 2007: Site visits and interviews in Estonia with chosen stakeholders.
- December 2007-January 2008: Report writing (findings and recommendations). Draft report by 20 December.

Second part of the evaluation (IDUs and prison settings):

- September-November 2007: Negotiations with partners for conducting the evaluation.
- December 2007: Preliminary review of provided documents, study results, etc; preparing the structure of appointments in Estonia.
- 7–11 January 2008: Site visits and interviews in Estonia with chosen stakeholders.
- January-February 2008: Report writing (findings and recommendations). Draft report by 8 February, final report by 29 February.

### ***Output***

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

First mission:

- Each of the four evaluators involved write a 2–3 page long report on each area he has to cover after the mission in Estonia. When writing the report answers will be given to all questions listed in Terms of Reference and maximum 3 recommendations given for improving the situation.
- Other evaluators will send their parts to Roger Drew by 14 December who will integrate different parts to the overall report and send the first draft report to NIHD by 20 December 2007. NIHD will give its comments after receiving the second draft report after the mission in January 2008.

Second mission:

- Evaluator of services for IDUs and evaluator of services in prison settings will both write a report on the area they have to cover after the mission in Estonia. When writing the report answers will be given to all questions listed in Terms of Reference and recommendations given for improving the situation.
- Other evaluators will send their parts to Roger Drew by 22 January who will integrate different parts to the overall report and send the draft report to all evaluators involved by 29 January 2008. Other evaluators will give their comments by 1 February. Roger Drew will make changes to the report according to the comments and send the report to NIHD by 8 February. NIHD will send their comments by 22 February to Roger Drew who will make final changes to the report.
- The deadline for the final consolidated report is 29 February 2008.

## ANNEX 1A: TERMS OF REFERENCE FOR COMPONENT OF EVALUATION FOCUSED ON INTERVENTIONS AMONG INJECTING DRUG USERS

### ***Background***

At present, Estonia operates in a framework of the fourth national program/strategy for fighting HIV/AIDS – “National HIV and AIDS Strategy 2006–2015”. Financial resources for implementation of the strategy are mainly provided by the state budget and grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Estonia started its four-year GFATM program on the 1 October 2003 and finished it on the 30 September 2007. Ending this program is an important turning point in fighting HIV and AIDS in Estonia as GFATM has given big amount of extra resources to increase the scale of Estonia’s response to the epidemic. At this point it is necessary 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 towards injecting drug users. The assignment will be 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). The main objective of the 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.

### ***Purpose of consultancy***

The purpose of the consultancy is to evaluate HIV/AIDS interventions towards injecting drug users and to develop recommendations for further improvement. The report will serve as a basis for the revision of the national HIV/AIDS action plan and development of UNODC project workplan for 2008 – 2010.

### ***Specific tasks***

- assessment of structures, systems and organizational development:
  - institutional assessment of key actors involved in HIV prevention among IDUs;
  - analysis of national funding plans and resources to address HIV/AIDS among IDUs, including NGO support systems;
  - assessment of M&E system for HIV/AIDS interventions towards IDUs;
  - development of recommendations to fill in the gaps in the current structures and systems.
- assessment of coverage and quality of services for IDUs:
  - compliance with international standards of good practice for provision of HIV prevention services for IDUs;
  - accessibility to and coverage of the key interventions within the comprehensive package of services for IDUs: needle and syringe programmes, opioid substitution therapy, voluntary HIV counseling and testing, anti-retroviral therapy;

- systems and tools for monitoring and evaluation of HIV prevention services for IDUs;
- assess capacity building needs for service providers;
- prepare recommendations for capacity building, including organizational aspects for development of a sustainable national system for initial and in-service training of service providers;
- develop recommendations for improvement and scaling-up of HIV prevention among IDUs.

### ***Timeframe and expected outputs***

By 7 January 2008: desk review of background documents;

7–11 January 2008: mission to Estonia, 5 w/days;

By 22 January: working paper with findings and recommendations submitted to UNODC Regional Coordinator for the Baltic States and Roger Drew. Roger Drew will prepare and send the consolidated report of two missions for commenting by 28 January. Evaluators give their comments by 11 February. Final consolidated report of two missions will be ready by 19 February.

### ***Implementation arrangements***

National Institute for Health Development (NIHD) will provide all background documents and organize the meetings in Estonia. Findings and recommendations should be discussed with NIHD and the WHO team of experts conducting the evaluation of fighting HIV/AIDS in Estonia.

### ***Competencies and skills***

- advanced university degree or equivalent in public health, medicine or social science;
- competence and at least five years of practical experience with planning and evaluation of HIV prevention among IDUs;
- familiarity with UNAIDS, UNODC and WHO policy documents on HIV prevention and care in prisons;
- working experience in East European region; and
- excellent command of English with proven drafting skills.

## ANNEX 1B: TERMS OF REFERENCE FOR COMPONENT OF EVALUATION FOCUSED ON INTERVENTIONS IN PRISON SETTINGS

### ***Background***

At present, Estonia operates in a framework of the fourth national program/strategy for fighting HIV/AIDS – “National HIV and AIDS Strategy 2006 – 2015”. Financial resources for implementation of the strategy are mainly provided by the state budget and grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Estonia started its four-year GFATM program on the 1 October 2003 and finished it on the 30 September 2007. Ending this program is an important turning point in fighting HIV and AIDS in Estonia as GFATM has given big amount of extra resources to increase the scale of Estonia’s response to the epidemic. At this point it is necessary 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 in prison settings. The assignment will be 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). The main objective of the 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.

### ***Purpose of consultancy***

The purpose of the consultancy is to evaluate national response to HIV and AIDS in prison settings and to develop recommendations for further improvement. The report will serve as a basis for the revision of the national HIV/AIDS action plan and development of UNODC project workplan for 2008 – 2010.

### ***Specific tasks***

- Assessment of structures, systems and organizational development:
  - institutional assessment of key actors involved in management of HIV/AIDS in prison settings;
  - analysis of national funding plans and resources to address HIV/AIDS in prison settings, including NGO support systems;
  - assessment of M&E system for response to HIV/AIDS in prison settings;
  - Development of recommendations to fill in the gaps in the current structures and systems.
- Assessment of coverage and quality of services in prison settings:
  - compliance with international standards of providing HIV/AIDS treatment and care in prisons;
  - continuity of services between correctional institutions and jurisdictions, and between the prison and the community;

- accessibility to and coverage of the key interventions within the comprehensive package of services for IDUs: HIV prevention, voluntary counseling and testing, professional HIV/AIDS care, treatment and support, drug dependence treatment;
- systems and tools for monitoring and evaluation of HIV prevention services in prisons;
- capacity building needs for prison staff and service providers;
- develop recommendations for improvement and scaling-up of HIV prevention and care in prison settings.

### ***Timeframe and expected outputs***

By 7 January 2008: desk review of background documents;

7–11 January 2008: mission to Estonia, 5 w/days;

By 22 January: working paper with findings and recommendations submitted to UNODC Regional Coordinator for the Baltic States and Roger Drew. Roger Drew will prepare and send the consolidated report of two missions for commenting by 28 January. Evaluators give their comments by 11 February. Final consolidated report of two missions will be ready by 19 February.

### ***Implementation arrangements***

National Institute for Health Development will provide all background documents and organize the meetings in Estonia. Findings and recommendations should be discussed with the WHO team of experts conducting the evaluation of fighting HIV/AIDS in Estonia.

### ***Competencies and skills***

- advanced university degree or equivalent in public health, medicine or social science;
- competence and at least five years of practical experience with planning and evaluation of HIV in prison settings;
- familiarity with UNAIDS, UNODC and WHO policy documents on HIV prevention and care in prisons;
- working experience in East European region; and
- excellent command of English with proven drafting skills.

## *Annex 2*

### SCHEDULE OF PEOPLE INTERVIEWED

#### *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

Silver Salla, Financial Manager

Anne Hansberg, Head Accountant

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

Jaano Ester, Leading Auditor, Internal Audit Department

Maris Salekesin, Chief Specialist, Drug Abuse

#### *Ministry of Education and Research*

Aare Vilu, Expert, Youth Affairs Department (by videoconference)

#### *PriceWaterhouseCoopers*

Rando Rannus, Consultant

#### *West-Tallinn Central Hospital*

Kai Zilmer, Head of the Infections Centre

Tiiu Aug, Doctor-Infectionist

Olev Lumiste, Consultant AIDS Counselling Cabinet

#### *East Viru Central Hospital*

Kaljo Mitt, Chief Doctor

Oleg Ananjev, Social Worker

Anne Junolainen, Medical Nurse

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*Living for Tomorrow*

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*Association Anti-AIDS*

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*NGO Diversity*

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*Foundation Healthy Estonia*

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*Health Protection Inspectorate*

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Dimitri Jaaniste, Infectionist  
Lilia Novikova, Infectionist  
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Pavel Grjaznov  
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Vladimir Lüde, Outreach Worker  
Roman Sidorov, Outreach Worker  
Roman Mazajev, Outreach Worker  
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Clients of services

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Roman Družinin, Needle Exchange Worker  
Ija Tšerenkevitš, Needle Exchange Worker  
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Alla Tannil, Support Group Leader  
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## *Annex 4*

### PROPOSED TERMS OF REFERENCE AND ACTION POINTS FOR A WORKING GROUP ON HIV DRUG RESISTANCE

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

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

1. The Committee should take responsibility for reviewing a national approach to measures for the prevention of the development of HIV drug resistance and the development of a plan for the monitoring of 'early warning' signs related to development of HIV drug resistance, e.g. monitoring of drug prescription practices, quality assurance of ART, population adherence, survival, treatment failure, stock-out rates, etc.
2. A specialized national HIV molecular diagnostic laboratory should be responsible to provide guidelines and recommendations for HIV drug resistance genotyping and a standard QA/QC programme for Estonia's laboratories.
3. A national virologist should be responsible for the setting up of the laboratory and the performance of the HIV drug resistance testing. Appropriate training, for example through twinning with laboratories with ample experience in HIV drug resistance genotyping, could be established.
4. Conduct national studies as recommended by WHO (below).
5. Annually, a report on the assessment of HIV drug resistance in the country should be written in order to inform all stakeholders of the results. This report should also give guidance on the interpretation of the results and suggest possible action points for the national ART scale up program to further minimize the emergence of HIV drug resistance and potentially to influence national ART guidelines and policy.

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

Who recommends two types of studies to be conducted as the first step in assessing Estonia's HIV drug resistance situation:

#### **1. Surveillance of Transmission of HIV drug resistance:**

- aim: to define to what extent HIV drug resistance is currently being transmitted
- objective: to estimate the prevalence of HIV drug resistance in recently HIV-infected populations in specific geographic settings
- population for study: specimens from recently-infected populations will be collected
- study design: HIV drug resistance threshold survey
- sites: initially two sites could be selected (e.g. Tallinn, Narva)
- This threshold study to be repeated in the following year with two additional sites

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

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

Annex 5

RELATIONSHIPS AND STRUCTURE OF GOVERNMENTAL COMMISSION ON HIV AND AIDS IN ESTONIA

