

Appendix No. 1 to Order No 771 of the Government of the Republic "Approval of the national HIV and AIDS strategy for 2006-2015 and establishment of the HIV and AIDS Committee of the Government of the Republic" from December 07, 2005.

**Estonian national HIV and AIDS strategy**  
**for 2006-2015**

**2005**

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## National HIV and AIDS strategy for 2006-2015

### 1. Introduction

The HI virus is a human immunodeficiency virus which, in the late stage of infection, causes AIDS or Acquired Immune Deficiency Syndrome. AIDS destroys the body's ability to fight other diseases and infections. As a result, a person could die of the supervening diseases. Up to now there is no effective treatment for destroying the HI virus in the body.

For the past several years Estonia has ranked number one in Europe in the amount of new HIV infections. The seriousness of the situation is reflected in the fact that the number of new HIV infections per 1,000,000 people in Estonia exceeds that of the majority of EU member states by dozens of times.

Estonia has pursued HIV and AIDS prevention activities for over 15 years. On the national level, HIV prevention and treatment has mostly been conducted through various public health programmes. The first National AIDS Prevention Programme was approved in 1992; the second programme—"National development plan for the prevention of HIV/AIDS and other sexually transmitted diseases"—was implemented in 1997-2001. The implementation of the third national programme was launched under the conditions of a concentrated HIV epidemic in 2002. A financing application was submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria at the end of 2002. With the approval of the application, the financing of HIV prevention and treatment activities increased many times in the second half of 2003.

The new national strategy was developed due to the epidemiologic situation of HIV and AIDS in Estonia, as well as the need to stop the further spread of HIV by involving all different levels and sectors of the country.

So far the most significant achievements in the programme implementation have been:

- the increase of HIV and AIDS awareness among Estonians, especially the young Estonians, although this has not yet had a significant effect on their values, attitudes and health behaviour;
- the provision of syringe and needle exchange and counselling services to injecting drug users in Tallinn, Ida-Viru County and Lääne-Viru County;
- the establishment of a HIV testing and counselling system financed mainly by the state;
- free access to antiretroviral therapy for people living with HIV and AIDS;
- good co-operation with non-governmental organizations, hospitals (service providers), foreign embassies and foreign organisations.

The main problems in programme implementation have been:

- insufficient involvement at the local level;
- insufficient integration of the activities into the jurisdictions of various ministries;
- lack of strong central management;
- lack of funding, due to which the amount of essential prevention activities carried out has been insufficient for producing results.

The general objective of the national HIV and AIDS prevention strategy for 2006-2015 (hereinafter the strategy) is to **achieve a permanent decline in the spread of HIV in Estonia.**

International experience has shown that in order to achieve the objective, the so-called “**Three ones**” principle must be applied:

- **One** central National AIDS Coordinating Authority
- **One** agreed HIV/AIDS Action Framework which is developed and implemented in cooperation between all partners
- **One** agreed country-level Monitoring and Evaluation System

Effective implementation of the strategy requires a contribution from, involvement of and co-operation between organizations from as many different sectors and fields as possible.

The strategy document specifies the strategic objectives and sub-objectives in the field of HIV and AIDS, as well as the principles and measures for achieving these objectives. The strategy document also describes the functions of the one national AIDS coordinating authority as well as the one agreed country-level monitoring and evaluation system, and divides the roles and responsibilities between the parties involved. Representatives of all parties (the government, different ministries, local municipalities, non-governmental organizations, private sector, and other interested parties) were included in the process of developing the strategy through open working groups and forums. The experts of various international organisations (World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS)) gave a vital contribution to the development of the strategy.

The agreed national action plan for the next 4 years is reviewed every year in co-operation with the various contributing parties, and the document is updated when necessary.

## **2. Situation analysis**

### **2.1. Brief description of the socioeconomic situation in Estonia**

According to the Statistical Office, the total Estonian population was 1,351,069 in 2004, with men making up 46% and women 54% of the population. The Estonian population decreased by nearly 12.5% between the censuses of 1989 and 2000 due to the negative natural growth in population and emigration. In 2004, 69% of the Estonian population lived in urban areas and 31% in rural areas. In 2003, Estonians made up 68%, Russians 26% and other ethnicities 6% of the population.

The unemployment rate in Estonia was 9.7% in 2004. Ida-Viru County had the highest unemployment rate of 17.9%, and Saaremaa the lowest rate, 4.1%. The unemployment rate of non-Estonians is nearly twice as high as that of Estonians. The main hindrances for landing a job are insufficient knowledge of the Estonian language and, in Ida-Viru County, local specialisation in areas that have lost their importance in the present-day economic context (incl. oil shale mining, military industry, etc.).

In 2002, 17.9% of the Estonian population lived in poverty. The unemployed are at the biggest risk of poverty. The share of families with children living in poverty is decreasing, but the share of children falling below the poverty threshold from the total number of children is still high, while poverty risk increases significantly in families with three or more children (share: 20%). The poverty risk is also high among single-parent families (share: 35.2%).

The general level of education is relatively high in Estonia. According to researchers, 99% of the population is literate. The share of people with at least a secondary education was 88% among 25-69-year-olds in 1999 (64% in the European Union). Among the biggest problems is the dropping out of schools at the elementary education level—nearly 1,000 students drop out from elementary schools every year (0.57%).

1,271,558 people had health insurance in Estonia in 2004 (94.1% of the population). Total health care expenses made up 5.4% of the GDP in 2003.

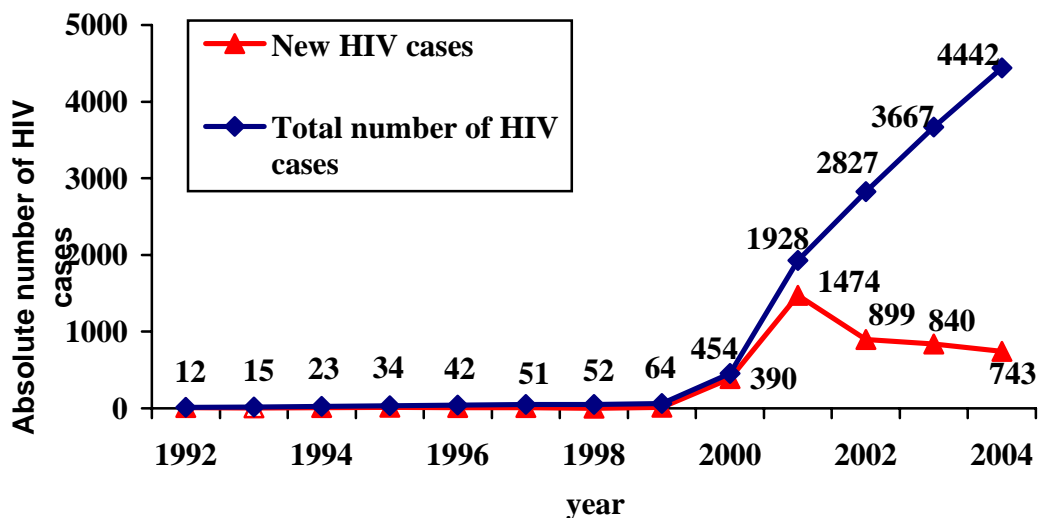
Estonian economy has developed rapidly since 1995. Between 1995 and 2003, the GDP grew an average of 5% annually.

### **2.2. Brief description of the HIV and AIDS situation**

The first case of HIV in Estonia was registered in 1988. A total of 96 HIV cases were registered between 1988 and 1999. The second half of 2000 saw a sudden increase in HIV infections among injecting drug users, which continued in 2001. The reasons for the explosive epidemic were the low awareness among the risk groups and the fact that the harm reduction measures were not in place.

The number of new officially registered cases has decreased since 2002 (see Figure 1). The first case of AIDS was diagnosed in Estonia in 1992. By the end of 2004, a total of 70 people had been diagnosed with AIDS.

Figure 1. New HIV cases and total number of HIV cases in Estonia: 1992-2004  
(Source: Health Protection Inspectorate)

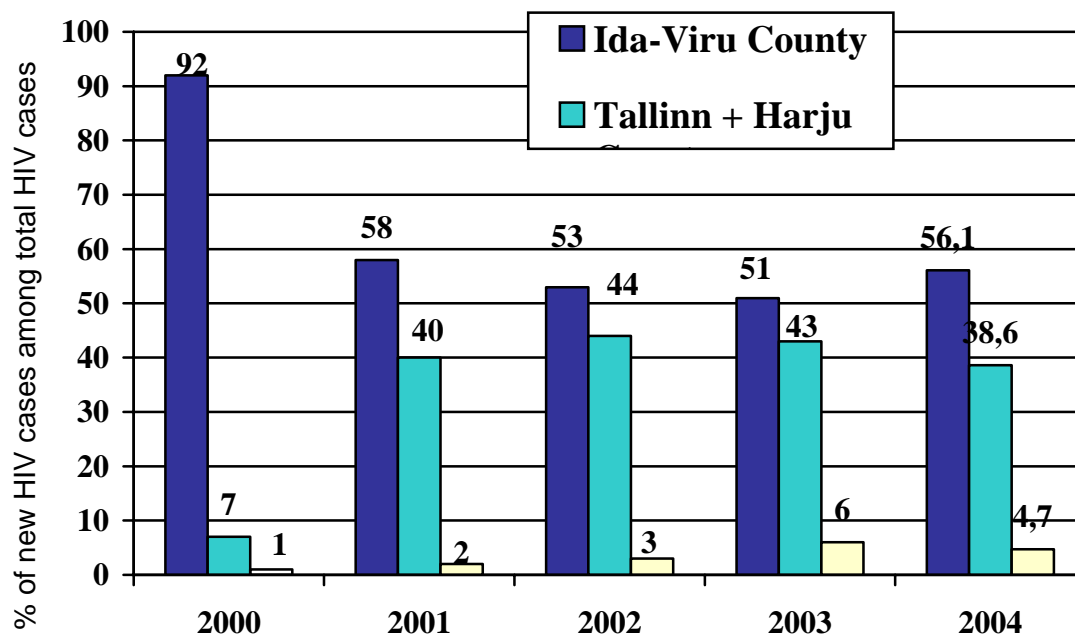


In connection with the abrupt increase in HIV infections from the autumn of 2000, the Ministry of Social Affairs announced, on 14 February 2001, a concentrated HIV epidemic, characterised by an HIV prevalence of 5% among injecting drug users, but less than 1% among pregnant women.

Over two-thirds of those registered between 2000 and 2004 as HIV-infected were less than 30 years old – i.e. most of the infected are young people. An overwhelming majority of the HIV-infected are men, but the share of women has grown in recent years. While in 2000, women made up 20% of the registered HIV cases, the percentage of women infected with the virus amounted to 32.4% in 2004. The majority of the HIV-positive speak Russian as their mother tongue. This stands to show the social vulnerability of the target group.

The year 2000 saw an explosive HIV epidemic in Ida-Viru County (above all, Narva). The HIV-infected registered in the area made up 92% of the total number of cases diagnosed in 2000. In 2001-2002, the share of HIV cases diagnosed in Tallinn decreased significantly, compared to 2000. By 2003, the share of new infections had decreased in both Ida-Viru County and Tallinn, and increased elsewhere (Figure 2). By 2003, at least one HIV infection had been registered in all counties.

Figure 2: Share of new HIV cases registered in Estonia, by regions: 2000-2004  
(Source: Health Protection Inspectorate)

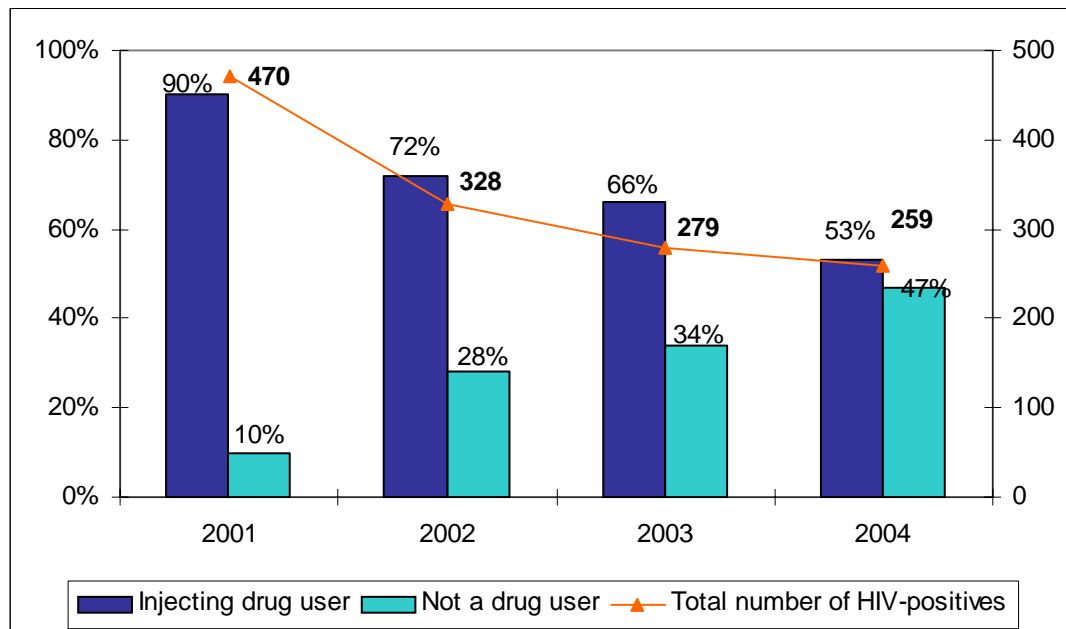


Between 1988 and 1999, HIV mainly spread in Estonia through sexual (both homosexual and heterosexual) transmission. Since 2000, the majority (over 90%) were infected through syringe sharing. Although data is insufficient, an increase in the share of transmission through heterosexual intercourse has been detected ever since 2002. According to the data gathered by AIDS consultation clinics, injecting drug users made up 90% of the HIV-positives (new cases diagnosed in the consultation clinics) in 2001, 72% in 2002, 66% in 2003 and only 52.5% in 2004 (see Figure 3). Although this data does not reflect the total number of HIV-positives, we can assume that the virus is starting to be transmitted sexually from injecting drug users to their partners, and, through them, to the general public.

The seriousness of the situation in Estonia can be seen when we compare the number of new HIV cases per one million people in Estonia to that of other countries. The respective figures for Estonia are dozens of times higher than those for the majority of EU countries. According to the World Health Organization, one out of a hundred adults (15-49 years of age) may already be infected with HIV in Estonia.

In 2003, the number of diagnosed AIDS cases per one million people increased over two times in Estonia, compared to 2002. While a total of 2.9 cases of AIDS were diagnosed per one million people in 2002, 7.6 cases were registered in 2003. This figure was 25.3 in neighbouring Latvia and 4.9 in Finland in 2003.

Figure 3: HIV cases diagnosed in AIDS consultation clinics in Estonia, by transmission channels: 2001-2004  
(Source: National Institute for Health Development)



A thorough overview of the current situation with the Estonian HIV epidemic is provided in the corresponding report of the National Institute for Health Development<sup>13</sup> and the reports prepared by the Centre for Policy Studies Praxis<sup>7</sup> and the World Health Organization<sup>3, 10</sup>.



### **3. Activity areas and management of the national HIV and AIDS strategy**

#### **Activity areas of the strategy:**

Important activity areas upon containing the HIV epidemic and alleviating the effects of the epidemic include prevention activities among various target groups, HIV testing and counselling; prevention activities designed for, treatment of and welfare of people living with HIV and AIDS; surveillance, monitoring and evaluation as well as development of human and organisational resources.

The most important activity areas for HIV prevention include increasing awareness, training and counselling, as well as, in case of injecting drug users, harm reduction. We also need to improve availability of protective equipment so as to guarantee safety of the target group representatives (incl. condoms, syringes, sterilizers, etc.). Early diagnostics and treatment of sexually transmitted diseases (STI) is an important method for preventing the spread of HIV—STIs significantly increase the risk of HIV infection. In order to prevent mother-to-child transmissions (MTCT), we need to ensure counselling of HIV-positive pregnant women and provision of the corresponding preventive health care services.

Voluntary counselling and testing (VCT) is one of the most effective preventive measures. In the course of VCT, the client receives information on the prevention of the infection, and, should the test results turn out to be positive, learns how to protect other people from the infection.

As regards people living with HIV and AIDS, we must ensure monitoring of people living with HIV, and provide antiretroviral (ARV) therapy and treatment of the supervening diseases. ARV therapy reduces the infectiousness of people living with HIV, lowering the concentration of the virus in the blood and improving the quality of life of the person infected. ARV therapy also enables to cut the expenses which would be incurred upon treating the supervening diseases (if no ARV therapy was available), and allows the person to maintain capacity for work, and continue supporting themselves or their family.

For better planning prevention and treatment, we need to get feedback on the range of the epidemic and efficiency of the activities. For this purpose, we need to develop a national surveillance, monitoring and evaluation system.

In order to develop and ensure sustainability of the prevention activities as well as the treatment and welfare system, we also need to pay attention to the continual training of various specialists, and enhancement of their competence in the field of HIV and AIDS.

#### **Priorities of the strategy:**

- A concentrated HIV epidemic among injecting drug users was announced in Estonia in accordance with the international criteria in February 2001. The fastest solution for containing the epidemic is to implement harm reduction measures among injecting drug users.
- Since over 80% of newly registered HIV-positives are less than 30 years old, and a rise has been detected in the share of sexual transmission of HIV in recent years, a focus on young people in the risk groups, and their partners will be one of our main priorities in the near future.
- The number of people who need specific HIV-related health care services (treatment of supervening diseases; antiretroviral therapy, etc.) will increase many times in the next couple of years.

The efficiency of the strategy will be guaranteed through co-ordinated activities conducted in a preset framework, the efficiency of which will be regularly evaluated. Further activities will be planned on the basis of clear-cut criteria under a uniform surveillance and evaluation system.

**Management of the Estonian national HIV and AIDS strategy:**

1. One national AIDS coordinating authority. The implementation of the national HIV and AIDS strategy is co-ordinated by the Government of the Republic (GR), which will establish a high-level multisectoral GR HIV and AIDS Committee for the purpose. The ministries involved in the implementation of the HIV and AIDS prevention activities will report to the Government of the Republic on a semi-annual basis, giving an overview of the implementation of the strategy, and any problems that occur. The respective reports will be submitted to the GR HIV and AIDS Committee. The Government of the Republic is also responsible for approving the annual priorities and activity plans. The Ministry of Social Affairs will be the secretariat of the GR HIV and AIDS Committee.
2. One agreed HIV/AIDS action framework. The HIV and AIDS prevention, treatment and welfare activities which are to be conducted on a national scale have been merged into one agreed action plan so that all stakeholders (public sector and private sector, non-governmental organizations, local governments and county governments, various financiers, etc.) would clearly understand the co-ordination and management of, and their role in the implementation of the strategy. The action plan forms an integral part of the strategy.
3. One agreed country-level monitoring and evaluation system. In order to evaluate efforts and the work carried out by the parties involved, and to assess the efficiency of the prevention activities to be conducted, a uniform surveillance and evaluation system has been established in the field of AIDS and HIV. Information on the efficiency of the related activities will be centralised in the National Institute for Health Development, which will inform the public and the involved stakeholders of both positive and negative developments in the area on a regular basis.

#### **4. General principles and ethical principles in the field of HIV and AIDS**

##### **Respect for human rights**

Global experience has shown that misconceptions about HIV and AIDS are the biggest hindrance for HIV prevention activities, development and planning of therapeutic and support services, and reduction of the negative effects of the infection. The strategy will be implemented by taking into consideration that, in order to prevent the spread of the HIV infection and reduce the negative effects related to HIV and AIDS in the society, we first need to honour, protect and promote the rights of human beings. The principal human rights also include sexual and reproductive rights as well as the right of sexual self-determination. Special attention will be paid upon the implementation of the strategy to the protection of the rights of people diagnosed with or affected by HIV and AIDS.

##### **Evidence base**

HIV and AIDS prevention and treatment must be based on modern-day social, medical and scientific positions supported by scientific research. The strategy was developed on the evidence based data gathered from all over the world, and the best global practices.

##### **Equality in health**

Prevention activities and services designed for the most vulnerable groups must meet the needs of target groups, be multifaceted and readily available to them. Equal access to minimum HIV and AIDS-related health care, welfare and other services must be ensured to all people living with HIV and AIDS.

Knowledge of how to shape health-sustaining behaviour and motivate a change in risk behaviour as well as the related information, training and services must be communicated to both Russian-speaking and Estonian-speaking people in Estonia.

##### **Harm reduction—approval and evaluation of secondary prevention activities**

Regarding the work with people in risk groups, the primary objective of HIV and AIDS prevention activities is not to change their risk group status, but to reduce the possible HIV-related harm (i.e. by providing injecting drug users with clean syringes; promoting safe sex and use of condoms among sex workers, etc.) caused to the risk group and the society as a result of their high-risk behaviour.

##### **Involvement**

Involvement of people living with or people affected by HIV and AIDS in the implementation of the strategy and in the evaluation process is of critical importance in responding to the epidemic on a national level in an efficient and ethical way. It is the only approach that makes it possible to develop activities which can affect the target groups and are based on their actual needs.

##### **Multifaceted and comprehensive approach**

Since HIV and AIDS prevention involves more than just health-related issues, adoption of a multidisciplinary, comprehensive and balanced approach is the precondition for solving the problems involved. The strategy takes a multifaceted and integral approach, involving different activities on the level of the individual, the group and the society. The strategy also combines the HIV and AIDS-related prevention activities, health care and social issues, legal and human rights issues and scientific research. It is also important, upon developing action plans, to eliminate any competition between the expenses budgeted for different fields of action (health care expenses should not, for instance, be increased at the expense of prevention activities).

## **Gender equality**

The measures to be implemented for HIV prevention and treatment as well as for welfare of the infected should be developed by taking into consideration the different status and needs of men and women as well as the possible effect of the measures on the reduction of gender inequality—equalisation of the rights, obligations, responsibilities and opportunities of men and women. Respect for the reproductive and sexual rights of men and women, as well as ensuring the equal access to sexual health education and the related information and services plays an especially important role in HIV prevention. Gender inequality increases both the susceptibility of men and women to AIDS.

## **Co-operation and partnership**

Responsibility for HIV and AIDS prevention cannot be put on a single state authority—it must be a joint effort of different levels of authority, social organisations and Civil Society. The fight against HIV and AIDS must involve state institutions, local governments, the business sector, non-governmental organizations, private initiative, the media and international partners. Prevention of the spread of HIV is associated with the prevention and treatment of sexually transmitted infections, the fight against tuberculosis, promotion of sexual and reproductive health, and prevention of drug use.

## **Consistency and sustainability**

HIV and AIDS prevention activities have, so far, been underfinanced by the state. It is vital that we budget and allocate sufficient resources for obtaining the objectives established within the framework of the strategy in a sustainable way. We also need to consistently and systematically develop human resources in the area—people are the key to efficient planning, management, co-ordination, implementation and evaluation of the strategy.

## **Transparency**

The action plan of the strategy specifies the particular measures for obtaining the goals, and establishes the indicators for evaluating the success of the activities. Information on the activities planned and conducted on the basis of a national strategy must be made available to the public.

## **Consideration of international declarations**

In addition to local legal acts, the strategy has been based on the following international declarations adopted by Estonia:

1. *The Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session on HIV/AIDS on 27 June 2001.*
2. *Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia on 24 February 2004.*
3. *“Vilnius Declaration” on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighboring Countries on 17 September 2004.*

## 5. Situation analyses, objectives and measures of the activity fields

### GENERAL OBJECTIVE OF THE STRATEGY:

**GO.** HIV-spread has permanent decline tendency

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
New HIV cases per 100,000 people	55	30	20
Share of pregnant women infected with HIV among all pregnant women	0.5%	<1%	<1%

### 5.1. Prevention activities

#### 5.1.1. HIV and AIDS prevention among injecting drug users

##### Situation analysis

There are an estimated 10,000-15,000 injecting drug users in Estonia. Injecting drug users mostly use pure heroin and amphetamine. In 2004, 73% of steady customers of needle exchange points used opiates, while 55% used stimulants. More than half of them (57%) only injected a single substance. Injected drug use is especially widespread in Narva, Kohtla-Järve, Sillamäe, Tallinn and Maardu. An increase in the number of injecting drug users in other Estonian regions has also been noticed. The majority of injecting drug users who visit the needle exchange points speak Russian as their mother tongue. 86% of them are men and 14% women (most of them are the female partners of injecting drug users). 56% of injecting drug users started injecting between the age of 14 and 20. Majority of them are unemployed and earn their income through criminal activities. Drug use, as well as the spread of HIV, is therefore high among prison inmates. Comparative analysis of preliminary and steady customers to needle exchange points in 2004 revealed that over half of both preliminary and steady customers have correct knowledge of the ways of HIV transmission. The factors that showed to contribute positively to behaviour change included distribution of a bigger amount of syringes at a time, and frequent visits to needle exchange points.

Compared to other European countries, Estonian drug users are young. The use of multiple drugs remains a problem. The number of experienced drug users is relatively small. These circumstances must be taken into consideration in planning the services. 45% of first-time visitors to needle exchange points have been injecting drugs for 2-4 years, and 20% for 5-10 years.

Counselling of drug users and needle exchange services were launched in Estonia in 1997, within the framework of the pilot projects. The state started financing the service in 2001—initially, at the expense of the Gambling Tax Fund and, from 2003, through the state programme (with co-financing provided by Finland and Germany as well as the cities of Tallinn and Tapa). Since 2004, the service is financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. As of the end of 2004, there were a total of 21 needle exchange points in Estonia, with methadone substitution maintenance therapy provided in Tallinn, Narva and Jõhvi. The amount of harm reduction services is still insufficient in Estonia, considering the number of injecting drug users.

##### Principles

Drug use is a social problem which cannot be eliminated from the society. One of the ways of alleviating the problem is to reduce the harm caused to the society and drug users themselves. In the context of stopping the HIV epidemic, the primary objective of the harm reduction programme is not to reduce drug abuse, but rather to reduce health risks caused by the use of drugs (e.g. the spread of HIV and hepatitis) both

among injecting drug users and in the society in general. The harm reduction services include syringe and needle exchange programmes, substitution and substitution maintenance therapy and counselling of injecting drug users. In the context of stopping the HIV epidemic, opioid agonist substitution and substitution maintenance therapy is used as an HIV prevention measure, and in the context of stopping drug addiction, substitution therapy can also be deemed a measure for treating drug addiction. In HIV prevention, the main objective of opioid agonist therapy is to stop the injecting, rather than treating drug addiction.

In order to stop the HIV epidemic, we need to prevent drug abuse, promote and facilitate substitution maintenance therapy, and develop an efficient outreach system to bring injecting drug users and drug users experimenting with drug injection to HIV and AIDS prevention and other health care services so as to protect themselves, their partners and peers.

Global experience has shown that single preventative activities will not lead to any results. In order to efficiently prevent transmission of HIV through drug use, we need to simultaneously implement various comprehensive prevention measures and services in order to reach injecting drug users or their needle-sharing or sexual partners.

Upon developing and rendering various services to injecting drug users, we must make sure that these services are easily accessible to children/young people and women experimenting with drugs. Injecting drug users who inject non-opioids and are multiple drug users need special attention.

The necessary HIV prevention measures implemented outside detention centres must also be made available in detention centres (e.g. substitution maintenance therapy). The harm reduction services must be rendered in accordance with the Estonian penal policy.

Drug addiction is a disease. Injecting drug users have the right to receive the same health care, psychological and welfare services with other patients/clients. Substitution and substitution maintenance therapy must be made available and accessible to both the health insured and uninsured individuals.

The services designed for injecting drug users and drug users experimenting with drug injection must be combined into an integral network focusing on prevention activities, drug addiction treatment and rehabilitation. Organisation of the latter two services is described in the "National drug addiction prevention strategy until 2012".

## **STRATEGIC OBJECTIVE 1:**

**SO 1.** Decrease in the number of injecting drug users (common goal with the "National drug addiction prevention strategy until 2012"), and permanent decrease in the spread of the HIV infection among injecting drug users

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
Number of injecting drug users*	An estimated 10-15,000; the base indicator will be gathered in 2005		
Spread of HIV among injecting drug users	62%	stable	stable

\* *Precondition:* An HIV spread base indicator and population survey will be conducted in 2005. The objectives for 2009 and 2015 will be established on the basis of this survey.

**SUB-OBJECTIVES:****SO 1.1.** Decrease in risk behaviour among injecting drug users**SO 1.2.** Increase in the number of opiate-injecting drug users subjected to substitution maintenance therapy

<i>Indicator</i>	<i>Year 2005 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of injecting drug users who have not shared needles with others in the last month	71%	Not to be calculated	75%	80%	85%
The share of injecting drug users who have used a condom in every sexual intercourse in the last month	38%	Not to be calculated	45%	50%	60%
The number of injecting drug users undergoing opioid agonist substitution maintenance therapy	400	700	840	850	900
The share of less than 18-year-old injecting drug users undergoing opioid agonist substitution and substitution maintenance therapy among all patients undergoing substitution maintenance therapy	0	10%	15%	15%	15%

Division of tasks: Primary prevention—the Ministry of Education and Research, local governments, non-governmental organizations, the private sector, etc. Syringe exchange programmes and substitution maintenance therapy—the Ministry of Social Affairs together with local governments, the police and service providers. Substitution maintenance therapy in places of detention—the Ministry of Justice and the Ministry of the Interior.

**Measures**

- **SO1-M1.** To carry out primary activities for prevention of drug abuse (the activities have been included in the “National drug addiction prevention strategy until 2012”).
- **SO1-M2.** To expand and develop geographic availability of the counselling services provided to injecting drug users and drug users experimenting with drug injection, as well as syringe and needle exchange services and single-use equipment (syringes, needles, cleaning instruments, condoms), and the accessibility of these services and equipment in low threshold centres, syringe exchange centres, pharmacies, through outreach, etc. To provide injecting drug users and their sexual partners with counselling, educating them in the ways of HIV transmission as well as teaching practical skills related to safe injecting and safe sexual behaviour. In addition to standard

counselling, we must pay more attention to educating injecting drug users through their peers.

- **SO1-M3.** To improve geographic availability of the testing of injecting drug users and their partners for HIV and other STI, by providing a bigger number of service providers with the corresponding competence. Testing is always accompanied by previous and follow-up counselling.
- **SO1-M4.** To materially increase the availability of substitution maintenance therapy services for opiate-injecting drug users (partly included in the “National drug addiction prevention strategy until 2012”).
- **SO1-M5.** To improve the quality of the rendered services by preparing a description of and instructions for the services for injecting drug users (separately for less than 18-year-old children, and pregnant women), as well as specialist training plans. To ensure training, continual in-service training and supervision of specialists working with injecting drug users on a daily basis.

### **5.1.2. HIV and AIDS prevention among young people**

#### **Situation analysis**

People under the age of 30 made up 92% of new HIV infections registered in Estonia in 2001, 87% in 2002, 84% in 2003 and 82% in 2004. Young people between the ages of 15 and 24 are the biggest risk group for HIV infection in Estonia. Injecting drug users and their sexual partners make up a significant share of the infected young people. Young people who are the most vulnerable and exhibit high-risk behaviour are especially endangered. The teen years are a period when young people are the most susceptible and vulnerable. It is a period when the majority of young people are physically mature but have yet to achieve full social and mental maturity, with their system of values and attitudes still under development.

Russian speakers make up the majority of new HIV cases. It is therefore especially important to better focus prevention activities on ethnic minorities.

An international knowledge indicator is used for evaluating young people's knowledge of the ways of HIV transmission. The indicator revealed that, in 2003, less than half of the 15-24-year-olds had accurate knowledge of the ways of HIV transmission.

HIV/AIDS and sexual education-related issues are discussed in school, above all, within the framework of human studies. Pursuant to the 2002 national curriculum, human studies are taught in school in all stages of study. The national curriculum for basic and secondary education includes HIV/AIDS as a separate topic under human studies in the “Health education” course for the 2<sup>nd</sup> stage of study. In the same stage of study, the HIV/AIDS topic also involves issues related to drugs and sexual maturity. In addition to compulsory courses, the students can take an elective course, “Social coping skills,” (includes study material for all stages of study), and three academic hours of HIV/AIDS-related courses for students in grades 4-6.

The focus group survey conducted in 2002 revealed that discussion of HIV/AIDS-related issues in school is arbitrary and unsystematic—the majority of the teachers and students were unsatisfied. In the opinion of both the teachers and students, the main problems lie in the insufficient number of human studies classes, and the lack of classes on the subject in grades 8-9 and in secondary school. The study groups are believed to be too big for such courses, and the teachers are believed to need in-service training. Availability of modern study material also gives rise to dissatisfaction.

#### **Principles**



Children's attitudes and values are shaped by their family and home, as well as acquired attitudes, mind-set and tolerance. Prevention activities must therefore also focus on parents. Young people's values are shaped by their peers, the media and the surrounding social environment.

In order to shape the health behaviour of young people, we need to implement the conception of "life skills" (referred to as "social coping skills" in the national curriculum 2002), which focus on affecting motivation and involve clearing up of the misconceptions or myths, and improvement/shaping of self-esteem. It is also important to encourage young people to postpone sexual involvement until they achieve social maturity, as well as to avoid non-regular relationships and numerous partners.

The education system must systematically teach the following life skills within the framework of the topic of HIV prevention: problem solving, overcoming peer pressure, management/comprehension of emotions, verbal and non-verbal expression of emotions, decision-making. Students must also be taught communication skills required for establishing healthy intimate relationships. In addition to teaching these skills, we must also better inform students of the infection risks, educate them in the ways of avoiding the risks, and develop health-promoting attitudes.

The conception of life skills must be implemented in "youth-to-youth" programmes designed for affecting young people's behaviour. Young people must also be involved in the process of planning prevention activities.

The principles of working with young people with special needs must be taken into consideration upon implementing HIV and AIDS prevention measures among young people who are the most vulnerable and exhibit risk behaviour.

Gender has a significant effect on a person's vulnerability to the HIV infection. This has much to do with biological differences as well as social norms and the prevailing power relations in the society. Among other things, social standards dictate the features and behaviours that are considered masculine and feminine. These, in turn, have an effect on a person's risk behaviour. Social standards are dynamic—they change over time and differ in different cultures and societies. HIV and AIDS prevention activities must be based on a gender-specific approach.

Knowledge of how to shape health-sustaining behaviour and motivate a change in risk behaviour as well as the related information and training must be communicated to both Russian-speaking and Estonian-speaking adolescents.

Young people themselves must be included in the development and implementation of prevention activities focused on the target group. Youth organisations must be strengthened and empowered.

## **STRATEGIC OBJECTIVE 2:**

**SO 2.** Permanent decrease in the number of new HIV cases among 15-29-year-olds

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
The number of new HIV cases per 100,000 15-29-year-olds	200	150	100
Spread of HIV among conscripts	The base indicators will be gathered in 2008*		
Spread of HIV among 15-29-year-old pregnant	<1%	<1%	<1%

women			
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\* The objective for 2015 will be established after the gathering of the base indicator.

### SUB-OBJECTIVES:

**SO 2.1.** Improved knowledge of safe sexual behaviour, life skills and attitudes of 10-29-year-olds, and decreased risk behaviour among 15-29-year-olds.

<i>Indicator</i>	<i>Year 2003 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of 15-29-year-olds who used a condom in every sexual intercourse with a non-regular partner in the last 12 months	44%	54%	64%	74%	84%
The share of 15-29-year-olds who did not become sexually active until the age of 15	83%	-	86%	-	90%
The share of 10-29-year-olds who have accurate knowledge of the ways of HIV transmission	45%	50%	60%	70%	85%
The share of 15-29-year-olds whose attitude towards the use of condoms is positive	The base indicators will be gathered in 2005*				
The share of 15-29-year-olds who failed to use a condom in the past 6 months due to unavailability	34%	30%	25%	20%	15%
The share of schools that teach curriculum-based life skills on a maximum level in all stages of study	The base indicators will be gathered in 2008*				

\* The objectives for 2006, 2008, 2010 and 2015 will be established after the gathering of the base indicators.

**Division of tasks:** Prevention activities in school, and work with young people with special needs; support for young people's own HIV prevention-related initiatives—the Ministry of Education and Research in co-operation with county governments, local governments, non-governmental organizations and the private sector. Prevention activities among school dropouts and the most vulnerable young people—the Ministry of Social Affairs in co-operation with local governments and service providers (non-governmental organizations). Health services designed for young people—the Ministry of Social Affairs together with local governments and service providers (non-governmental organizations, health care institutions, etc.).

### Measures

- **SO2-M1.** To implement in the education system (curricula, teacher training and in-service training, preparation of study materials, in the school environment) the health education quality standards approved by the World

Health Organization by paying special attention to preventing the spread of HIV and teaching life skills in all age categories, and to carry out periodic evaluation of the efficiency of the health education. To make sure that the HIV-related stigmatisation and discrimination issues are integrated in teacher training programmes.

- **SO2-M2.** To improve sexual health, reproductive health, HIV and AIDS-related prevention activities and life skill teaching among young people who exhibit risk behaviour and are the most vulnerable, by involving in the prevention activities organisations that work with young people who exhibit risk behaviour and are the most vulnerable.
- **SO2-M3.** To work out youth-to-youth training standards and to set up a national youth-to-youth sexual education network. Special attention must be paid to the development of a youth-to-youth outreach network so as to also reach school drop-outs. To involve young people in the development and implementation of prevention activities.
- **SO2-M4.** To offer youth-friendly health services—incl. voluntary counselling and HIV testing—to young people, by ensuring availability of and access to the services to the majority of young people. To promote the use of condoms among young people and ensure availability of high-quality condoms to the target group. To create and exploit user-friendly HIV and AIDS information forwarding channels designed for young people (Internet portals, movies, TV and radio shows, publications, help lines, etc.) by paying special attention to the Russian-speaking target group.

### **5.1.3. HIV and AIDS prevention among sex workers**

#### **Situation analysis**

Similar to the spread of HIV, prostitution is an extensive social problem involving gender inequality, violence, poverty, unemployment, spread of HIV and STI, drug addiction, crime and many other phenomena. In Estonia, aiding prostitution involving a person of less than 18 years of age by mediation or provision of premises is punishable by law. At the same time there is no consensus, no common point of view or attitude towards this issue. The issues related to the possible legalisation of prostitution, or criminalisation of the purchase of sex are discussed every once in a while.

In Estonia, sex workers mostly operate in Tallinn (apartments, brothels, streets, night clubs, etc.). It is difficult to estimate the number of female sex workers in Estonia. Experts believe the number could total 3,000–5,000.

The poll conducted among sex workers by the AIDS Information and Support Centre revealed that a little less than 80% had used a condom in every and 20% in almost every sexual intercourse with a client in the past month. 23% of first-time visitors to the support centre and 20% of the regular visitors had used illicit drugs in the past 6 months. The regular visitors' knowledge of the ways of HIV transmission was 20% better than that of first-time visitors.

The first major prevention project designed for sex workers—"Meritäht" ("Starfish")—was carried out in 1996-1999 with the help of Finnish financing and in collaboration with a similar project conducted in Helsinki. Since 2004, the services designed for sex workers have been funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. No state funds were allocated for such activities prior to 2004.

#### **Principles**

As regards sex workers, the HIV and AIDS epidemic has conditioned the need to operate on all three levels: to prevent entry in the sex industry; to protect the health

of sex workers; and to help sex workers leave the sex industry. All of the above stages must be implemented on the level of the individual, the community and the general policy. A distinct political standpoint must be taken on human trafficking on all levels. Estonia will not legalise prostitution. In order to reduce sex tourism and prostitution in general, the purchase of sex must be made punishable, similarly to the sales of sex. HIV and AIDS prevention activities designed for sex workers must be based on broader health promotion principles that enable sex workers to tighten control over their own health. We must pay more attention to sex workers who use illicit drugs. Male and female sex workers must receive equal attention in the prevention activities.

In order to reduce demand for prostitution, we must develop responsible sexual behaviour in the society and promote health-sustaining attitudes.

### STRATEGIC OBJECTIVE 3:

**SO 3.** Zero increase in the spread of the HIV infection among sex workers; decrease in the spread of STI

<i>Indicator</i>	<i>Year 2005 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
Spread of STI among sex workers	The base indicators will be gathered in 2005.-2006		
Spread of the HIV infection among sex workers*	The base indicators will be gathered in 2005.-2006		

- *Precondition:* An HIV spread base indicator survey will be conducted in 2005 among sex workers. The objectives for 2009 and 2015 will be established on the basis of this survey.

### SUB-OBJECTIVES:

**SO 3.1.** Improvement in sex workers' knowledge of the ways of HIV transmission and life skills for demanding the use of a condom; decrease in their risk behaviour.

**SO 3.2.** Increase in the share of sex workers subjected to free STI diagnostics and treatment as well as the related counselling services

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of sex workers who used a condom in every sexual intercourse with a client in the past month	77% of the first-time users of the VCT service	82%	87%	90%	90%
The share of sex workers with accurate knowledge of the ways of HIV transmission	45% of the first-time users of the VCT service	60%	70%	80%	85%
The share of sex workers who did not fail to use a condom at the demand of a client in the past month	The base indicators will be gathered in 2005.-2006*				

\* The objectives for 2006, 2008, 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: Provision of prevention and treatment services—the Ministry of Social Affairs in co-operation with local governments and service providers (non-governmental organizations, health care institutions, etc.).

### **Measures**

- **SO3-M1.** To make HIV, AIDS and STI diagnostics and treatment services as well as social and legal services available to sex workers. In order to reduce prostitution-related health problems we must explain the methods for safe sexual behaviour, enhance availability of condoms and lubricants, teach sex workers how to use them, and improve negotiation skills. To enhance the outreach so as to include new sex workers in the HIV and AIDS prevention activities. To develop sex workers' knowledge of and skills in the field of HIV prevention through training their peers.
- **SO3-M2.** To include the topic of human trafficking and prostitution in the training of social workers, youth workers, police officers, health workers and teachers, and to provide the specialists who work with sex workers on a daily basis with the training, continual in-service training and supervision.

#### **5.1.4. HIV and AIDS prevention among the general public**

##### **Situation analysis**

Collection of data on the sexual behaviour of adults (16-64-year-olds) started in Estonia in the year 2000. The most recent data reveal that, although 90% of the adults are aware that HIV can be transmitted through the use of used syringes and through sexual intercourse without a condom, only 19% of those polled had used a condom every time they had intercourse with a non-regular partner in 2000 and 25% in 2002. This has mainly been conditioned by consumption of alcohol—non-regular coitus between young people often takes place under the influence of alcohol.

The first prevention campaigns were conducted in Estonia in 1992-1993 and focused on informing the general public of HIV, the ways of transmission of HIV, and AIDS. In the end of 1990s, the "STOP AIDS" event series were conducted in different Estonian county centres. More systematic prevention campaigns were launched in the year 2000. HIV, AIDS and drug addiction prevention campaigns have been held for young people every year since 2000. Most of these campaigns have involved various media publications—outdoor media surfaces, TV clips in different TV channels, posters in schools, flyers, etc. In addition, we have tried to organise campaign-supporting events in night clubs, schools, etc.

The development of systematic regional HIV and AIDS prevention work was launched in 2002, when most of the counties prepared their multi-annual HIV and AIDS development plans and started implementing these plans with the support of the national programme.

##### **Principles**

HIV prevention and the promotion of health-sustaining behaviour must be based on at least five intertwined activities—raising debate in the society/community, keeping the related issues salient and promoting discussions on the topic, providing information and training, reducing HIV-related prejudice and discrimination, and promoting the services and measures.

Since the results of various surveys reveal a mutual connection between different risk behaviours—e.g. people who use drugs (alcohol) also exhibit a more risky behaviour in sexual life—the connection between different risk behaviours must also be taken

into consideration upon formulating a policy on alcohol and illicit drugs. A respective strategy has been approved by the Government of the Republic in order to prevent drug addiction. This strategy is being implemented by the state. An increase in taxes and limitation of availability and advertising of alcohol are the most efficient measures for reducing alcohol consumption.

In order to reduce prejudice and discrimination, we need to implement preventive measures in the prevention work (so as to reduce social labelling), in the services designed for risk groups (so as to improve the quality of the health care, social and other services as well as to change the attitude and positions of opinion leaders) and in the judicial area. The knowledge of, information and training in the field of shaping health-sustaining behaviour and motivating a change in risk behaviour must be equally communicated to both Russian-speaking and Estonian-speaking people in Estonia. We must also keep in mind that parents serve as an example to their children.

Co-operation between public and private sectors is also important, enabling to increase the share of organisations that are actively involved in HIV and AIDS prevention activities and also implement the corresponding programmes within their own organisation.

As regards the local level, we need to ascertain and solve local problems in co-operation with the different sectors. The local opinion leaders (politicians, etc.), county governments, local governments, non-governmental organizations, congregations, local establishments and local organisations are the key. The provision of services and primary measures to high-risk areas and the expansion of network management and case management is the most efficient on local level.

#### **STRATEGIC OBJECTIVE:**

**SO 4.** Increase in the knowledge of the ways of HIV transmission and the skill of assessing the risk of infection among general population; decrease in negative attitude towards people living with HIV or AIDS

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of 16-64-year-olds with accurate knowledge of the ways of HIV transmission	91%	92%	93%	94%	95%
The share of 16-64-year-olds with no negative attitude towards people living with HIV and AIDS	28%	35%	45%	55%	65%
The share of major companies and institutions which have implemented HIV and AIDS prevention programmes	The base indicator will be gathered in 2008*				

\* The objectives for 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: the national level—the Ministry of Social Affairs in co-operation with the private sector and non-governmental organizations; the regional and local level—county governments and local governments in co-operation with the private sector and non-governmental organizations.

#### **Measures**

- **SO4-M1.** To enhance availability of services and measures as well as information and knowledge on the local level, thus facilitating health-sustaining choices.
- **SO4-M2.** To work out a communication strategy in co-operation with the specialists in the field, the sociologists and media specialists, and to ensure implementation of the strategy on different levels (local and national level) in co-operation with the different sectors (public sector, non-governmental organizations and private sector).

### 5.1.5. HIV and AIDS prevention among inmates

#### Situation analysis

The first case of infection with HIV was registered in a place of detention in May 2000. An average of 20-30% of new HIV cases is discovered in prisons. The majority (89%) of inmates infected with HIV are men between the ages of 15 and 24. Approximately 12-13% of all inmates of Estonian prisons were infected with the HI virus as of 2004. HIV testing is recommended for all those who have been arrested or convicted for the first time. The HIV test is conducted on the inmate's consent, and remains confidential.

The Ministry of Justice is responsible for organising and financing health care and social services in prisons. With the Regulation of the Ministry of Justice from 2002, the HIV/AIDS prevention plan was established for the institutions operating within the jurisdiction of the Ministry of Justice for 2002-2006 (RTL 14.04. 2004, 38, 621).

HIV-positive inmates are held in places of detention pursuant to general procedure—i.e. they are not separated from other inmates. Further examination and treatment is carried out on the basis of the patient's medical condition. Condoms have been made available in the health care departments of prisons, and disinfectants in toilets. No syringe and needle exchange services or substitution maintenance therapy is currently provided in Estonian prisons.

#### Principles

From the point of view of HIV and AIDS prevention, a place of detention plays an important role. The necessary HIV prevention measures implemented outside the prison must also be made available within the prison (e.g. substitution maintenance therapy). The Estonian penal policy is taken into consideration in the provision of harm reduction services. We must also ensure consistency of the provision of HIV-related health care and social services in and outside places of detention. Consistency is facilitated by the development of a case management system.

If a person was subjected to substitution or substitution maintenance therapy in freedom, the same services must be made consistently available to the person in a jail and prison. Therapy is provided in jails in co-operation with the centres that render the corresponding services and provide jails with the means for continuing the therapy. Jails must create the conditions necessary for continuing the therapy.

In prisons, psycho-social support services must be made available through support groups to persons living with HIV.

### STRATEGIC OBJECTIVE 5:

**SO 5.** Zero spread of the HIV infection in places of detention (incl. jails).

<i>Indicator</i>	<i>Base indicator</i>	<i>Year 2009</i>	<i>Year 2015</i>

The share of suspects and convicts deemed HIV negative with repeat tests	The base indicators will be collected in 2006	100%	100%
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#### **SUB-OBJECTIVES:**

**SO 5.1.** Increase in the convicts' knowledge of the ways of HIV transmission

**SO 5.2.** Increase in the number of people with access to health care and social services

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of convicts with accurate knowledge of the ways of HIV transmission	47%	52%	57%	62%	67%
The share of suspects and convicts administered an HIV test upon their imprisonment	80%	80%	82%	84%	85%

Division of tasks: The Ministry of Justice and the Ministry of Internal Affairs in co-operation with the service providers (non-governmental organizations, etc.). Antiretroviral medicines—to be procured by the Ministry of Social Affairs; the need for and the budget for other prevention, treatment and psychosocial support services is to be planned and provided by the Ministry of Justice.

#### **Measures**

- **SO5-M1.** To make harm reduction services available to inmates who are injecting drug users, and reduce the demand for drugs in prisons. To enhance availability of high-quality counselling as well as HIV and other STI diagnostics and treatment in places of detention.
- **SO5-M2.** To ensure availability of condoms, lubricants, disinfectants and other single-use equipment in places of detention. To ensure a safe working environment for people working and operating in places of detention, and a safe working and living environment for inmates through guaranteeing availability of protective equipment.
- **SO5-M3.** To provide inmates with the training and information material on prevention of the spread of HIV, as well as hold conversations in the form of individual or group work. To train prison staff in the ways of and prevention of HIV transmission, prevention of prison violence and respect for the rights, dignity and well-being of inmates.
- **SO5-M4.** To ensure availability of health care, psychological, social, legal and welfare services to inmates with HIV and AIDS.

#### **5.1.6. Prevention of mother-to-child transmission of HIV**

##### **Situation analysis**

As of the end of 2004, a total of 15 children had been infected with HIV by their mothers in Estonia. While in 2003, the share of HIV-positive children born to HIV-positive mothers was 4.8% (i.e. 3 children out of 62 were HIV positive), the respective indicator for 2004 was already 9% (i.e. 6 children out of 66). In 2004, HIV-positive pregnant women made up 0.5% of all pregnant women tested for HIV.



All pregnant women are medically insured in Estonia from the 12<sup>th</sup> week of pregnancy, and are thus eligible for free health care services. All women who register themselves as pregnant are advised to test for HIV (in addition to other tests) on their first doctor's appointment. Pursuant to the pregnancy monitoring instructions of the Estonian Gynaecologists' Society, all women who opt for an abortion are also advised to test for HIV.

The main problems in the area involve women in risk groups (actively injecting drug users) who, for various reasons, seek out a health care establishment either to give birth or in a late stage of pregnancy.

### Principles

More and more, there is talk of prevention of parent-to-child, rather than mother-to-child, transmission of HIV—the planning, birth and upbringing of a child is the future parents' joint decision. This strategy focuses on the mother-to-child transmission, above all, from the point of view of prevention work.

The choice of an individual with respect to giving birth to a child is highly personal, and should not be influenced by whether or not the person is HIV positive. At the same time, the state must ensure availability of reproductive health services to people living with HIV so as to facilitate the making of the choice. Reproductive health services should include informative and neutral counselling, free-of-charge and voluntary access to safe abortion and optimal HIV treatment during the pregnancy.

Prevention of mother-to-child HIV prevention on the local level must be based on co-operation between different specialists under the case management principle, so as to ensure prevention activities among women in risk groups; so that they could be referred to specialists early, if necessary; prenatal monitoring of the mother and the foetus and postnatal health monitoring of the mother and the child. All women must have access to high-quality counselling in the issues of interest. The state must, through different measures, try to prevent mother-to-child HIV transmission due to lack of financial resources or due to social difficulties. It is also important to provide HIV-positive mothers and children born to such mothers with prenatal and postnatal prophylactic treatment.

## STRATEGIC OBJECTIVE 6:

### SO 6. Decrease in vertical HIV infection

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of vertically infected children among all children born to HIV-infected mothers	9%	<2%	<2%

### SUB-OBJECTIVE:

#### SO 6.1. Prophylactic treatment of all HIV-infected pregnant women and their children

<i>Indicator</i>	<i>Base indicator</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of HIV-positive pregnant women who have been subjected to prophylactic treatment against the spread of HIV during their pregnancy	The base indicators will be gathered in 2006	100%	100%	100%	100%

The share of children who have been born to HIV-positive mothers and who have been subjected to HIV prophylactic treatment	The base indicators will be gathered in 2006	100%	100%	100%	100%
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Distribution of tasks: Health care services—the Ministry of Social Affairs (in places of detention: the Ministry of Justice and the Ministry of the Interior). Prevention work, case management and network management on a local level—local governments. Training and service development—the Ministry of Social Affairs in co-operation with medical specialists' associations.

## Measures

- **SO6-M1.** To carry out primary prevention work (educate people as to their family planning rights and opportunities as well as how to prevent the spread of the infection from mother to child) among risk group women and their partners. To develop services designed for risk groups (incl. low threshold centres, etc.) and co-operation between different establishments so as to provide risk group women with health care services early on.
- **SO6-M2.** To prevent unwanted pregnancies among HIV-positive women by ensuring availability of high-quality reproductive health services. To ensure availability of mother-to-child HIV transmission-related health care, psychological and welfare services to HIV-positive women during the pregnancy as well as during and after delivery (preventive antiviral therapy; formula feeding of the infant; psychological and nutritional counselling; social problem solving, etc.) through the case management service system. To integrate infant HIV prevention services in existing prenatal monitoring clinics and other reproductive health services.
- **SO6-M3.** To ensure training and in-service training of different specialists in order to prevent mother-to-child HIV transmission, as well as HIV-related discrimination and stigmatisation among risk groups. To include the above topics in the training plans of health care workers, social workers and future teachers. To develop HIV testing and counselling instructions for health care workers who deal with reproductive health counselling and pregnancy monitoring.

### 5.1.7. HIV prevention among men who have sex with men (MSM)

#### Situation analysis

According to the Estonian Gay League, there are approximately 8,000-15,000 homosexual men in Estonia (usually 3-6% of adult men in a country). These men are tested and counselled similarly to other population groups. As the Estonian homosexual men have been united by the Estonian Gay League, we have had the opportunity to organise prevention activities through the particular organisation.

In 2004, the Gay and Lesbian Information Centre was established in Estonia with the funding of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Information materials for various target groups have been prepared over the years. Availability of extra-strong condoms and lubricants is more limited than that of standard condoms.

#### Principles

To include target group representatives in the development and implementation of MSM-oriented prevention activities by strengthening and empowering sexual minority organisations.

Homosexual relations are treated equally with heterosexual relations.

## STRATEGIC OBJECTIVE 7:

**SO7.** Zero increase in the spread of the HIV infection among MSM

<i>Indicator</i>	<i>Base indicator</i>	<i>Year 2009</i>	<i>Year 2015</i>
Spread of HIV among MSM*	The base data will be gathered in 2006		

\* *Precondition:* An HIV spread survey will be conducted among MSM in 2006. The objectives for 2009 and 2015 will be established on the basis of this survey.

## SUB-OBJECTIVES:

**SO 7.1.** Increase in the MSM knowledge of the ways of HIV transmission and positive attitude towards the use of condoms; decrease in their risk behaviour

**SO 7.2.** Increase in the availability of condoms and lubricants to MSM

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of MSM who used a condom every time they had anal intercourse with a non-regular partner in the past 6 months	35% of all MSM who use gay portals	5% growth	5% growth	5% growth	5% growth
The share of MSM with accurate knowledge of the ways of HIV transmission	53% of all MSM who use gay portals	63%	73%	83%	90%
The share of MSM with a positive attitude towards use of a condom in anal intercourse	The base indicators will be gathered in 2005*				

\* The objectives for 2006, 2008, 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: the Ministry of Social Affairs in co-operation with non-governmental organizations and local governments.

## Measures

- **SO7-M1.** To develop the MSM knowledge of and skills in the field of HIV prevention through training their peers, ensuring availability of information materials and promoting safe sexual behaviour. To ensure availability of extra-strong condoms and lubricants to the target group, and promote their use.

## 5.1.8. HIV prevention among people living with STI

### Situation analysis

The level of sexually transmitted infections is decreasing: while in 1999, there were 58.2 cases of syphilis and 76.3 cases of gonorrhoea per 10,000 people in Estonia, the respective indicators for 2003 were 17.2 and 34. Infections with anogenital herpes and anogenital warts increased to some extent in the same period—while in 1999 there were 24.4 cases of anogenital herpes and 31.2 cases of anogenital warts per 100,000 people, the respective indicators for 2003 were 31.5 and 32.4.

The number of new cases of hepatitis B virus and hepatitis C virus has decreased in recent years. The actual spread cannot, however, be objectively determined as no

regular hepatitis screening surveys are conducted among risk groups. It is still important to vaccinate risk groups (injecting drug users, MSM, inmates, sex workers, etc.) against hepatitis as much as possible. As regards STI treatment, the risk groups' (incl. injecting drug users, sex workers, etc.) access to treatment services is currently limited.

## **STRATEGIC OBJECTIVE 8:**

**SO 8.** Decrease in the spread of STI among the population

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
Number of main STI cases per 100,000 people:			
- syphilis	13.6	12	10
- gonorrhoea	38.3	35	30
- chlamydia	198.8	170	150

## **SUB-OBJECTIVES:**

**SO 8.1.** Increase in the number of people having themselves tested for STI. Improved availability of STI counselling and testing services, and enhanced quality of the consequent treatment and counselling

<i>Indicator</i>	<i>Base indicator</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of 16-49-year-olds who have had themselves tested for STI in the past 12 months	The base indicators will be gathered in 2006*				
The share of STI testing clinics, where testing is accompanied by the corresponding counselling and, if, necessary, treatment	The base indicators will be gathered in 2008*				

\* The objectives for 2008, 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: the Ministry of Social Affairs together with medical specialists' associations, county governments, local governments and service providers.

## **Measures**

- **SO8-M1.** To promote safe sexual behaviour (promotion of the postponing of sexual involvement, reduction of the number of sexual partners and/or the use of condoms) and inform people of establishments which provide STI treatment and diagnostics.
- **SO8-M2.** To improve availability of STI diagnostics and treatment (to train family doctors, to enhance provision of the respective service in the establishments that render services to HIV risk groups, etc.). To integrate HIV testing and counselling in the implemented STI prevention, STI treatment, sexual health and reproductive health programmes.

## **5.1.9. Prevention of the spread of HIV in the course of professional activities**

### **Situation analysis**

There have been no cases of HIV transmission in the course of professional activities. Still, the number of cases subjected to prophylactic treatment has increased every year. The Estonian Society of Infectious Diseases has developed instructions for HIV infection diagnostics and treatment, including instructions for preventing transmission of the infection through blood and other bodily fluids as well

as prophylactic treatment after coming into contact with the virus in the course of professional activities.

## Principles

The risk group includes people who are liable to come into contact with potentially infectious bodily fluids and the transmitting agents in the course of performance of everyday work tasks (health care workers; police officers and rescue workers; syringe exchange centre professionals, social workers, security officers, prison officers, teachers, people who administer first aid and emergency aid, etc.). Protection of professionals plays an important role in the prevention of discrimination of people living with HIV. Employees can aid others better when they feel protected. On the one hand, we need to ensure availability of efficient protective equipment and measures. On the other hand, the equipment and measures need to be used properly.

Employers are obliged to ensure occupational safety and sufficient regular training of their employees (in accordance with the valid regulations). Employers must guarantee confidentiality of any contact event. In the case of a potentially infectious contact event which is not related to performance of work tasks, prophylactic treatment is provided at the person's own responsibility.

## STRATEGIC OBJECTIVE 9:

**SO 9.** Zero cases of HIV infection in the course of professional activities

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
Number of people infected with HIV in the course of professional activities	0	0	0

## SUB-OBJECTIVE:

**SO 9.1.** Availability of the required protective equipment to professionals exposed to the risk

<i>Indicator</i>	<i>Base indicator</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of professionals with access to the required protective equipment	The base indicators will be gathered in 2008				95%

\* The objectives for 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: state instructions and registration system as well as training of working environment representatives and inspectors—the Ministry of Social Affairs in co-operation with specialists in the field. Ensuring of general protective measures in work stations, registration of contact events and staff training—employers.

## Measures

- **SO9-M1.** To work out uniform instructions and create an integral system for contact event registration and post-contact prophylactic treatment, and to bind these with the existing work accident and occupational disease registration system.
- **SO9-M2.** To ensure that the professionals exposed to the risk are provided with high-quality professional training, and regular high-quality follow-up training by the employer—i.e. primary and additional safety instruction.

- **SO9-M3.** To ensure availability of general preventive measures in work stations (single-use materials and equipment, organisation of utilisation, etc.), and their implementation (staff training, availability of the respective instructions, contact event registration and prophylactic treatment system, etc.). To enhance efficiency of the related surveillance. To educate employees in the field of HIV testing and counselling opportunities.

## **5.2. HIV testing and counselling**

### **Situation analysis**

Six AIDS consultation clinics currently provide free-of-charge anonymous voluntary counselling and testing services: two in Tallinn and one each in Kohtla-Järve, Narva, Tartu and Pärnu. Their work is co-ordinated and financed by the National Institute for Health Development from the resources of the national HIV/AIDS prevention programme. In addition, HIV tests can be taken at youth consultation centres all over Estonia, as well as at the family doctors' and specialist doctors' offices. Outpatient reception and examination (incl. HIV tests) conducted by family doctors and specialist doctors will be covered by health insurance if the patient is insured, and mostly by the patient himself/herself, if the patient is uninsured. A small number of bigger local governments also fund general outpatient treatment of uninsured persons (incl. HIV testing in case of symptoms).

All those subjected to medical examination with suspicion of tuberculosis are offered the opportunity to test for HIV. According to the data of the tuberculosis register, a person suffering from tuberculosis was diagnosed with HIV for the first time in 1997. As of the end of 2004, 44 people living with tuberculosis had been diagnosed with HIV. The average number of people living with tuberculosis is 45 in Estonia, with men making up two-thirds. HIV is thus currently spreading in age groups that differ from those of tuberculosis. Still, as HIV-positives are especially vulnerable to tuberculosis, Estonia must prepare for a double epidemic of HIV/TB.

In Estonia, donor blood is tested for HIV, hepatitis B and hepatitis C as well as other infectious agents. An HIV test with a 14-day window is applied for examining donor blood. A total of 72 donors were diagnosed with HIV between 1989 and 2004. No HIV cases have been diagnosed in Estonia after donor blood/organ/tissue transfer.

Annex 1. Situation analysis: HIV testing and counselling services.

### **Principles**

Expansion of the HIV testing and counselling services must be accompanied by access to integrated HIV prevention, treatment and welfare services. It is crucial to pay attention to health promotion strategies and adherence to human rights in rendering HIV testing and counselling services. HIV verification tests are funded centrally through the state budget.

HIV testing must be confidential, conducted together with the counselling and on the client's informed consent. Informed consent means that the client has been informed of the important data related to HIV testing and volunteers to test for HIV. The entire HIV prevention and treatment must be voluntary—it helps to protect human rights and achieve permanent results in population health indicators. Tests may be conducted without consent only in extreme cases when the patient is unconscious, has no parent or guardian, and ascertainment of the HIV status is required for deciding the correct treatment.

The provision of voluntary counselling and (if necessary) testing services to target and risk groups must be integrated in the existing system so that it would be rendered as a part of the natural service in the course of various voluntary and mandatory prophylactic tests.

Establishments that offer testing and counselling services must closely co-operate with organisations that render other related services. At the same time, the data on the person must be kept confidential.

Donor recruiting and selection must be carried out among low-risk population groups, and be co-ordinated by the state. We need to promote donorship, educate and motivate donors, as well as constantly recruit new donors and maintain existing donors.

Donor blood must be tested for bloodborne infection pathogens in accordance with the national and international instructions. In order to ensure that the blood is safe, we must develop national instructions and blood testing activity plans, and update these on a regular basis.

#### **STRATEGIC OBJECTIVES 10 AND 11:**

**SO 10.** Increase in availability of HIV testing and counselling

**SO 11.** Guaranteed safety of donor blood/organ/tissue transfer to recipients

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
The share of 16-49-year-olds who have planned to test, and actually tested for HIV in the past 12 months	The base indicators will be gathered in 2006*		
The share of recipients who have not been infected with HIV through donor blood/tissue transfer	100%	100%	100%

\* The objectives for 2009 and 2015 will be established after the gathering of the base indicators.

#### **SUB-OBJECTIVE:**

**SO 10.1.** Availability of high-quality testing and counselling services to all interested parties

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of HIV consultation clinics, where testing is accompanied by counselling in accordance with the standards	The base indicators will be gathered in 2008*				

\* The objectives for 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: Donor blood and tissue safety—the Ministry of Social Affairs. HIV testing and counselling—the Ministry of Social Affairs, the Ministry of Justice. Service promotion—the Ministry of Social Affairs in co-operation with county governments and local governments, non-governmental organizations, the private sector, employers, etc.

#### **Measures**

- **SO10-M1.** To develop counselling and HIV testing instructions, separately specifying the instructions for screening surveys to be conducted among specific target groups (donors, pregnant women, children and youngsters, people affected with STI, tuberculosis patients, etc.).
- **SO10-M2.** To expand provision of high-quality testing and counselling services in health care establishments and establishments that render services to risk groups. To continually train health care officials and social workers as well as psychologists in how to render high-quality pre-test and post-test counselling services. To decrease HIV and AIDS-related negative



attitudes and discriminatory behaviour through raising the service providers' awareness (especially in health care establishments).

- **SO10-M3.** To ensure consistent provision of high-quality testing and counselling services in existing centres and clinics in accordance with the clients' needs (opening hours), and to implement regular measures for inspecting the quality of various HIV testing and counselling services.
- **SO11-M1.** To increase the donors' HIV and AIDS-related awareness.
- **SO11-M2.** Depending on the objective, to implement modern high-quality methods for HIV diagnostics (ensuring donor blood safety, initial HIV testing, verification of the HIV infection, etc.) and to ensure staff training and in-service training in order to implement these methods.

### **5.3. Prevention, treatment and welfare services for people living with HIV and AIDS**

#### **Situation analysis**

The health condition of people living with HIV and AIDS is monitored in Estonia under the supervision of infectionists. If a person's HIV test turns out to be positive, the doctor who took the blood sample will direct the person to an infectionist. Infectionists operate in 5 cities—in Tallinn, Kohtla-Järve, Narva, Tartu and Pärnu.

In 2003, the Estonian Society of Infectious Diseases worked out the instructions for HIV infection diagnostics and treatment. High-quality three-component antiviral therapy is available in Estonia at the Merimetsa Centre for Infectious Diseases of West Tallinn Central Hospital, Tartu University Hospital and Ida-Viru Central Hospital since the 2004, and Narva Hospital since 2005. Therapy was previously provided only in the Merimetsa Centre for Infectious Diseases. In 2004, 10 people were subjected to antiretroviral (ARV) therapy in Estonia. According to the estimates of the Merimetsa Centre for Infectious Diseases, the number of people who need this sort of therapy will rise to approximately 250 by the end of 2005. Antiretroviral medicines are supplied centrally, and are free of charge for all patients. One of the medicines (Retrovir) is compensated to the insured from the budget of the Estonian Health Insurance Fund, but we plan to start supplying the medicines centrally in the future.

The sub-type of the Estonian HI-virus (CRF06\_cpx) differs from the standard HIV-1 subtype B virus of Western Europe and North America. In addition to Estonia, the Estonian HI-virus subtype is only known in some West African countries. We must therefore enhance studies into drug resistance in Estonia so as to ensure successful ARV therapy in Estonia.

*Health care services for the HIV infected who are insured.* The purpose and essence of outpatient health care services is to regularly monitor the condition of the HIV infected so as to administer ARV therapy on time. The services include a specialist doctor's appointment, and the required medical tests. Outpatient health care services are mainly provided by infectious disease doctors. Inpatient health care services are provided to the HIV infected on the beds of different profiles, depending on the pathology of the disease: on the beds for infectious diseases, oncology, intensive care, internal diseases or, in case of supervening tuberculosis, the beds for tuberculosis. The services are rendered by active care hospitals which provide services in the respective medical area. The cost of the health care services designed for people living with HIV who are insured is covered by the Estonian Health Insurance Fund.

*Health care services for the HIV infected who are not insured.* The cost of outpatient health care services designed for the HIV infected who are not insured is covered by the Global Fund to Fight AIDS, Tuberculosis and Malaria. The availability of outpatient health care services designed for the HIV infected who are not insured was poor (practically unavailable, considering the social status and income of the majority of the target group) until the second half of 2004 when the Global Fund to Fight AIDS, Tuberculosis and Malaria concluded with Estonian hospitals the first agreements for financing these services. The purpose of regular outpatient reception is to monitor the condition of the HIV infected so as to timely administer ARV therapy. The problem lies in that the majority of the target group members fail to see a doctor after learning of their diagnosis. Their condition cannot be thus regularly monitored. Due to the lack of regular monitoring of the immunostatus and health condition, the infected often see a doctor upon symptoms and/or complications declaring themselves. The administering of the treatment is thus delayed. This, in turn, does not have a good effect on the progress of the disease. If ARV therapy is delayed, the

services that the patient needs will be much more expensive (intensive care, treatment of complications).

Due to the lack of regular monitoring of the majority of the target group, we do not have an overview of the actual need for the services in the near future. Inpatient health care services (hospital treatment) are made available to the HIV infected who are not insured only in case of emergencies. The services are financed from the state budget (the emergency treatment funds for the uninsured).

## **Annex 2. Health care services for people living with HIV and AIDS.**

The first support group for people living with HIV was established in Estonia in 1993. The first group was mainly intended for people infected through sexual intercourse, and is still running. The first support group for former injecting drug users who are HIV positive was established in 2002. Approximately 400 HIV-infected used the support group services as of the end of 2004—this constitutes less than 10% of the registered HIV-infected in Estonia.

### **Principles**

The customer-oriented approach is based on the mutual co-operation between different specialists. In order to better cope in the society, people living with HIV and AIDS need integrated health care, psychological and social counselling, welfare and legal services that correspond to their needs. People close to the people living with HIV also need to be supported. The case management approach is known to have been used for developing a service network that supports independent coping and is based on the person's needs. In addition to the specialist network, the HIV-infected are also supported on a daily basis by their “sponsors”—i.e. an individual who is chosen by the HIV-infected person to learn additional skills on how to support the person infected with HIV in daily problems.

It is extremely important to involve people living with HIV and AIDS in practical prevention work as well as in the HIV and AIDS-related decision-making process. For instance, people living with HIV and AIDS can do much to decrease HIV-related prejudicial attitudes and discriminatory behaviour in the society, but it is difficult for them to do it alone. We therefore need to support the establishment of self-help and support groups for the people living with HIV, and to empower them.

In order to avoid infection, post-contact prophylactic HIV treatment must be made available.

We also need to pay attention to the prevention and treatment of double (HIV/TB) and triple (HIV/HCV/TB) infections.

In case of epidemics, the Estonian legal acts must not prove to be a hindrance to sufficient treatment. Medicines must be supplied centrally, by applying all possible measures for procuring high-quality medicines at the best possible price so as to ensure availability of high-quality specific antiviral therapy to all people who have HIV or AIDS and need the therapy. We must also take into consideration that the administration of ARV therapy is also important from the point of view of HIV prevention—it reduces the infectiousness of the people living with HIV in the society. If ARV therapy fails, we need to ascertain the patients' HIV resistance mutations and the subtype of the virus in order to improve the efficacy of the therapy, avoid complications caused by side-effects and prevent the spread of the resistance to a particular medicine among the general population.

## **STRATEGIC OBJECTIVE 12**

**SO 12.** Improvement in the quality of life of the people living with HIV and AIDS

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
The share of people living with HIV and AIDS who consider their quality of life average or better than average	The base indicators will be gathered in 2005*	5% growth	5% growth
Number of new AIDS diagnoses per year	27	Not more than 500	Not more than 200
Number of deaths among people living with HIV, and the number of deaths from AIDS among people living with HIV per year	31/3	Not more than 200	Not more than 50

\* The objectives for 2009 and 2015 will be established after the gathering of the base indicators.

**SUB-OBJECTIVE****SO 12.1.** Increase in the share of people living with HIV and AIDS subjected to psychological and social counselling as well as health care and welfare services

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2006</i>	<i>Year 2008</i>	<i>Year 2010</i>	<i>Year 2015</i>
The share of first visits of the HIV-infected to an infectionist among all new cases diagnosed in the past 12 months	The base indicators will be gathered in 2006*				
The share of people living with HIV and AIDS subjected to regular (minimum of once per year) specific health monitoring among all registered cumulative cases	The base indicators will be gathered in 2006*				
The share of uninsured people living with HIV and AIDS subjected to regular (minimum of once per year) specific health monitoring among all registered cumulative uninsured cases	The base indicators will be gathered in 2006*				
The number/share of people living with HIV and AIDS subjected to health monitoring who need and are subjected to antiretroviral therapy	100 people/ 100%	Forecast /100%	Forecast /100%	Forecast /100%	Forecast /100%
The number/share of people living with AIDS subjected to health monitoring who need and are subjected to infection prevention and treatment	The base indicators will be gathered in 2006*	/100%	/100%	/100%	/100%

The share of people living with HIV and AIDS who have needed and have been subjected to psychological and social counselling and welfare services	The base indicators will be gathered in 2005*				
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\* The objectives for 2008, 2010 and 2015 will be established after the gathering of the base indicators.

Division of tasks: Medicines and health care services—the Ministry of Social Affairs. Psychological and social counselling, welfare services and case management—the Ministry of Social Affairs in co-operation with county governments, local governments and non-governmental organizations. Legal aid—the Ministry of Justice.

## Measures

- **SO12-M1.** To implement a case management and network management-based prevention, health care and welfare service system in accordance with the needs of people living with HIV and AIDS. To ensure availability of psychological and social counselling and welfare services to people living with HIV and AIDS, and protect their human rights. To expand and develop the network of services designed for people living with HIV and AIDS (nutritional, psychological and legal counselling, HIV testing and counselling, home care, palliative care, etc.).
- **SO12-M2.** To ensure free-of-charge monitoring of the health condition of all HIV-positives, and, if necessary, the availability and quality of antiretroviral therapy and treatment of HIV-related diseases (incl. testing of drug resistance if necessary). To work out a multi-annual pan-Estonian plan for antiretroviral therapy and treatment of HIV-related diseases, and to organise the central procurement of high-quality HIV and AIDS medicines and other equipment at the best possible price. In order to better plan the antiretroviral therapy, other treatment services and resources as well as to assess their quality, a confidential HIV and AIDS register will be established for storing data in encoded form.
- **SO12-M3.** To work out activity instructions for HIV screening among people living with tuberculosis and tuberculosis screening among people living with HIV, as well as instructions for treating HIV-positive people living with tuberculosis (incl. by taking into consideration the additional medical needs—e.g. opioid agonist substitution maintenance therapy).
- **SO12-M4.** To train people living with HIV and AIDS in the provision of counselling and support services. To facilitate establishment of support and self aid groups for people living with HIV and AIDS.
- **SO12-M5.** To provide different specialists who render services to people living with HIV and AIDS (health care workers, social workers, psychologists, nutrition specialists, etc.) with HIV and AIDS-specific training, in-service training opportunities and supervision, and to integrate the HIV and AIDS topic in the training programmes for future health care and social workers.

## **5.4. Surveillance, monitoring and evaluation**

### **Situation analysis**

As regards gathering of HIV and AIDS data in Estonia, passive infection surveillance data is available for the longest period of time. The current system collects anonymous data on HIV-positives and people living with AIDS by sex, age and region. In addition, data is collected on the ways of HIV transmission, but the method used for registering the information does not enable unambiguous interpretation—only general conclusions can be drawn on the trends of the spread of HIV. As regards active infection surveillance, no regular surveys have been conducted on infection trends evident in different risk groups. Surveys are planned among injecting drug users and sex workers in 2005 in order to assess the population, the spread of HIV, and the level of risk behaviour.

As regards behavioural surveillance, significant developments have occurred in the last few years. By today we have succeeded in collecting information on the primary behaviour, knowledge, and other characteristic indicators on the most important target groups (injecting drug users, sex workers, young people, etc.).

Positive developments are also evident in the implementation of evaluation activities in the field of HIV and AIDS. We have started to promote the need for evaluation—above all, to compare the planned results and the actual results, to ascertain whether our intervention activities have reached a sufficient number of people in the target group, and whether the desired changes can be seen in the target group. There are still areas which have not received notable attention—e.g. evaluation of the economic impact, cost-efficiency analysis.

Development of the surveillance and evaluation activities has been facilitated by the importance placed on the monitoring and evaluation by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and sustainable financing of evaluation activities. It is extremely important to extend the practical experience gathered within the framework of the above programme to all other national HIV and AIDS activities, and to further develop a uniform system for collecting, analysing and distributing data.

### **Principles**

In order to be able to efficiently plan resources for HIV and AIDS, and to prevent possible new outbreaks of the infection, we continually need new information on the situation in the target groups, and the efficiency of our intervention activities. The surveillance system is used for collecting data on the spread of the HIV infection in population groups and on the general changes in risk behaviour. The monitoring and evaluation system is used for collecting data on contacts with the target group and efficiency of the activities designed for influencing the target group. The latter also uses the surveillance system data for evaluating long-term results and effects.

The monitoring and evaluation system monitors whether or not the desired changes are achieved through the activities. The purpose of the system:

- to give an overview of the accomplishments achieved through the activities, and to provide early verification of the efficiency of the work;
- to ascertain the problems and to assist in making the adjustment and improvement of the activities a part of the natural working process;
- to provide transparent and objective information to the public and the financiers;
- to serve, on all levels, as a management tool for the establishments who execute the strategy.

Measuring of the implementation of the activities, and documenting of the success of these activities helps to ascertain the best possible services and activities, and to better direct resources.

While the monitoring and evaluation system depends directly on the activities, the surveillance system with its main components must be independent from the volume of the activities.

It therefore proves necessary to agree on the common principles for and methods for implementing the surveillance, monitoring and evaluation system. The system must be set up in a way which enables comparative and additional analysis of the important data gathered from various sources. It is also vital to make regular forwarding of information on both the positive and negative developments in the HIV and AIDS area a part of the system. We must gather, analyse and distribute data which can be directly used and is necessary for improving efficiency of the activities. Inevitably, we also need to develop the skills of activity planners and co-ordinators so as to use the data gathered through the surveillance, monitoring and evaluation system for enhancing efficiency of the activities.

### **STRATEGIC OBJECTIVE 13:**

**SO 13.** Enhanced use of verifiable data for the planning

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
The number of objectives of the national activity plan which are based on data collected through surveys and analyses	The base indicators will be gathered in 2006*		90%

\* The objectives for 2009 and 2015 will be established after the gathering of the base indicators.

Division of tasks: co-ordination of HIV and AIDS-related surveillance, monitoring and evaluation—the Ministry of Social Affairs (National Institute for Health Development). Evaluation of the process and results of the implementation of the measures of the strategy—implementing authorities (ministries and their divisions, county governments and local governments, non-governmental organizations, the private sector, various financiers, etc.). Evaluation of the results and effect of the strategy—the Ministry of Social Affairs (National Institute for Health Development).

### **Measures**

- **SO13-M1.** To work out and implement a national HIV and AIDS infection and behavioural surveillance system (incl. HIV database and risk group surveys). To work out and implement a uniform HIV and AIDS activity monitoring and evaluation system by paying special attention to the economic effect of an epidemic, and the analysis of the cost-efficiency of prevention activities. To ensure continual distribution of information to the parties involved, and use of the results of the analysis for enhancing efficiency of prevention activities.

## 5.5. Development of human and organisational resources

### Situation analysis

Upon developing human and organisational capabilities, we need to pay attention to enhancing the different specialists' skills and knowledge of HIV and AIDS as well as other areas (STI prevention and treatment, fight against tuberculosis, promotion of sexual and reproductive health, drug prevention). Administrative and general skills (work and time management, budgeting and accounting, monitoring and evaluation, etc.) are also required for enhancing efficiency of the work.

HIV and AIDS professionals must be subjected to professional training before starting work, as well as continual in-service training and supervision. Provision of psychological supervision is especially important for specialists working daily with risk groups.

Since stigmatisation and discrimination are the biggest hindrance for planning and implementing efficient prevention, treatment and welfare services, human rights and the protection of these rights as well as prevention of HIV-related stigmatisation and discrimination must form an integral part of an HIV and AIDS-related training programme.

### STRATEGIC OBJECTIVE 14 AND 15:

**SO 14.** Increase in competent organisational and human resources actively involved with HIV prevention

**SO 15.** Increase in the number of services rendered on the basis of the service description approved by the specialists in the field

<i>Indicator</i>	<i>Year 2004 (base indicator)</i>	<i>Year 2009</i>	<i>Year 2015</i>
The number of competent organisations and people actively involved in HIV prevention	The base indicators will be gathered in 2006*		
The number of services for which the specialists in the field have approved a service description	The base indicators will be gathered in 2006*		

\* The objectives for 2009 and 2015 will be established after the gathering of the base indicators.

Division of tasks: Mapping, co-ordinating and consulting—the Ministry of Social Affairs. Specialist training—scientific research and development institutions, different ministries within their jurisdiction. Lifelong training and supervision—employers.

### Measures

- **SO14-M1.** To create a central database of people and organisations involved in HIV and AIDS-related training, and to map the training need in the area by different levels (national, local) and regions. To develop (in the scientific research and development institutions) a training system for trainers in the field of HIV and AIDS. To include the field of HIV and AIDS in the professional standards of various specialists, and the relevant topics and materials in their training programs so as to ensure the required competence.
- **SO15-M1.** To work out and regularly update HIV and AIDS prevention, health care and welfare service criteria and requirements for provision of services.



To develop a quality management system for the service and prevention activities (together with lifelong study and supervision).

## **6. Organisation of the implementation of the strategy**

### **6.1. Management and co-ordination of the strategy**

The national HIV and AIDS strategy is to be implemented under the management of the Government of the Republic (GR) which will establish a highly qualified multisectoral GR HIV and AIDS Committee for the purpose. The ministries involved in the implementation of the HIV and AIDS prevention activities will report to the Government of the Republic on a semi-annual basis, giving an overview of the implementation of the strategy, and the occurring problems. The respective reports will be submitted to the GR HIV and AIDS Committee. The Government of the Republic is also responsible for approving the annual priorities and activity plans. The GR HIV and AIDS Committee is the counsellor of the Government of the Republic in HIV and AIDS-related issues. The Ministry of Social Affairs is the service unit of the GR HIV and AIDS Committee.

The GR HIV and AIDS Committee will include deputy secretary generals of ministries, local governments, representatives of HIV-positives and specialists of permanent work groups established with the Ministry of Social Affairs for the development and implementation of the HIV strategy.

### **6.2. Implementation and funding of the strategy**

The Ministry of Social Affairs is the authority who converges and co-ordinates the activities undertaken by the parties involved in the implementation of the strategy. Specialist work groups will be formally and informally established with the Ministry of Social Affairs in order to discuss the issues related to the implementation of the strategy.

Every year, the ministries will work out and adjust the HIV and AIDS activities for the following 4 years in accordance with the areas of responsibility agreed in the strategy, and the priorities approved by the Government of the Republic. Information on these activities will be forwarded to the Ministry of Social Affairs which will prepare a uniform activity plan for the following 4 years and submit it to the Government of the Republic. Specialist work groups will be involved in the preparation of the activity plan, if necessary.

The Public Health Act stipulates a list of health services the provision of which is mandatory for local governments. These services include counselling, outreach, syringe exchange and support groups for people living with HIV and AIDS. The services are financed from the state budget, with the local government obliged to provide and maintain the premises.

The county level involves local information forwarding, organisation of health promotion and disease prevention events, co-ordination of the activities of local governments and, if necessary, supervision of the services organised by the state.

HIV and AIDS-related activities will be funded, until 2007, mostly by foreign aid (the Global Fund to Fight AIDS, Tuberculosis and Malaria). It is crucial that we ensure at least the same amount of funding of the activities after 2007 as well—either from the state budget or through local governments or other funds. The funding of the HIV and AIDS strategy has been planned in accordance with the state budget strategy, and the funding of the strategy is based on the state priorities.

All HIV and AIDS-related permanent services—HIV testing and counselling, substitution maintenance treatment of injecting drug users, antiretroviral therapy, treatment of HIV –infection-related diseases, etc. must be funded sustainably either from the state budget or through other funds. Antiretroviral medicines must be procured centrally, or from the state budget, or through other funds, and made

available to all those in need, incl. insured individuals. Health care services for the insured individuals who have opportunistic diseases must be funded from the health insurance budget. Health care services for those who are not insured must be financed either from the emergency aid budget or, on the basis of a similar scheme, directly from the state budget.

The private sector and its resources will be further involved in the activities. For this purpose, we will establish a fund to fight HIV and AIDS in Estonia. The resources of the fund will be used directly for financing the activities and projects of this strategy. The activities financed from the fund resources will be conducted under the management of experts and state officials who are independent of the national HIV and AIDS strategy. The fund will be used based on the principle of transparency—public procurements will be held for the implementation of the activities; the reports on the results will be made public. The transparency of the use of the funds will be ensured via a web-based project database which will contain information on all projects for which funding has been applied as well as projects which will be and have already been funded. The project database will also contain information on the projects funded from various foreign aid sources. The database will enable to get an overview of the HIV and AIDS-related activities in Estonia so as to better co-ordinate these activities.

The private sector can contribute to HIV prevention itself, or through other organisations (e.g. non-governmental organizations, local governments, etc.). Still, in order to avoid overlapping of activities, the co-ordinating authority—the Ministry of Social Affairs—must be informed of any such initiatives. Non-governmental organizations or private organisations will be the main executors of the strategy (under the co-ordination of the different levels of the public sector). The state will not establish extensive state structures for the implementation of the strategy and, above all, will plan the activities so as to strengthen and expand non-governmental organizations. Non-governmental organizations are the state's equal partners in the implementation of the strategy. Now better organized, their activities help shape public opinion and increase awareness of HIV and AIDS by providing various services for preventing the spread of the HI-virus.

In order to guarantee sustainability of non-governmental organizations, the state will set up a system of long-term framework agreements and base financing (in accordance with the Public Procurement Act). Under the system, the state will base the purchase of services from non-governmental organizations on previous partner experience, and ensure continual financing of the activities of the long-term contractual partners in the next period, provided that there have been no problems with the organisation and implementation of the activities.

### **6.3. Surveillance, monitoring and evaluation of the strategy**

The National Institute for Health Development will set up an HIV and AIDS prevention surveillance, monitoring and evaluation unit, assigned with the task of developing the data collection system (in co-operation with various ministries and establishments), data collection, data analysis and regular publishing of information on the trends in the HIV and AIDS area, and efficiency of state activities:

1. The HIV and AIDS data (surveys, etc.) will be converged on the level of the ministries and county governments, and forwarded to the surveillance and evaluation units of the National Institute for Health Development.
2. The standard activity reports will be converged on a semi-annual basis from the jurisdiction area to the ministries and from the local governments to the county governments, who will submit the consolidated reports through the Ministry of Social Affairs to the surveillance and evaluation unit of the National Institute for Health Development.

3. Private organisations and non-governmental organizations and various financiers should, advisedly, inform the Ministry of Social Affairs or the National Institute for Health Development of the their HIV and AIDS-related activities on a regular basis by submitting, once a year, the activity report agreed in the strategy development process.

## 7. Terms and definitions

**HIV** — human immunodeficiency virus

**AIDS** — acquired immune deficiency syndrome

**Antiretroviral (ARV) therapy** — the purpose of the therapy is to stop replication of the virus and the resulting progress of the HIV infection (maintaining and restoring the functions of the immune system). As a rule, the therapy combines three or more different medicines which affect different stages of virus replication. In addition to the above, the therapy aims at improving the quality of life, decrease HIV-related incidence and mortality, as well as, indirectly, reduce the spread of the virus and avoid the supervening infections and tumours. Since medicines also affect (harm) other human cells beside the virus, certain criteria have been developed for starting the treatment. Most of the infected start needing the therapy years after being infected.

**Discrimination** — unfair treatment of an individual, based on prejudicial assumption on his/her potential HIV status.

**Life skills** — in health education, the conception of life skills stands for the training of psychosocial and communication skills, ascertainment of values and misconceptions, and development of positive self-esteem so as to pursue healthy behaviour. Through active studies, various life skills—problem solving, overcoming the pressure of peers, decision-making, conflict solving without losers, emotion management, etc.—are taught by integrating these in the topics of HIV, AIDS and sexual behaviour, smoking, alcohol-use and drug-use prevention, violence management and nutrition.

**Prevention activities** are divided, on the basis of the target groups, into primary, secondary and tertiary prevention activities. Primary prevention activities include prevention of the infection of healthy people living with HIV (e.g. prevention activities among young people and general population). Secondary prevention activities include activities in the HIV risk groups (e.g. syringe exchange among injecting drug users, HIV and STI diagnostics and treatment for sex workers, etc.). Tertiary prevention activities include helping people living with HIV and AIDS prevent the supervening diseases (tuberculosis, pneumonia, etc.), trying to put off AIDS (antiretroviral therapy) and improve the quality of life of the people living with HIV and AIDS (psychosocial support, support of the peers, support and self aid groups, nutritional counselling, etc.).

**Mother-to-child transmission of HIV** — means transmission of the HI-virus from an HIV-positive pregnant women to the child during the pregnancy, during labour or breast-feeding. The often-used terms vertical and perinatal HIV transmission also bear the same meaning. The use of the term does not give the right to lay blame on the pregnant woman or mother.

**Mother-to-child HIV transmission prophylactics** — involves three principal methods for preventing mother-to-child transmission of HIV: (1) prophylactic ARV therapy during pregnancy, (2) Caesarean birth, and (3) breast milk substitution.

**Vulnerability** — HIV-related vulnerability may be conditioned by circumstances over which the person, for various reasons, has no direct control. Such circumstances include poverty, inequality, gender discrimination, discrimination, marginalisation and criminalisation. Vulnerable groups, firstly, have been deprived of their human rights and/or, secondly, have limited access to HIV-related information, health care services and prevention measures and equipment, and thirdly, have insufficient negotiation skills for ensuring a safe sexual life. these groups include impoverished people, ethnic groups, refugees, prisoners and children. In some groups, vulnerability is related to risk behaviour—e.g. men who have sex with men, injecting drug users, etc.

**Stigmatisation** — i.e. negative “labelling”, attributing negative features. The HIV and AIDS-related stigma can be described as the “undervaluation” of the people living with HIV and AIDS by the society.

**Human rights** — moral birthrights that apply to and protect all human beings.

**Harm reduction** — health promotion, health problem prevention, evaluation and intervention activities aimed at reducing the consequences of risk behaviour on health and society without necessarily ending the problem behaviour.

**Confidentiality** — protection of the personal data and test results of a person in order to protect the rights and well-being of the person on whom such data has been collected. Only the person himself/herself and the health workers working with him/her know which tests have been taken, and have access to the results of the analysis. This information shall not be published to third parties without the person’s consent.

**Lubricant** — a special silicone-based or water-based grease/substance which reduces friction, thus making the condom more durable.

**Low threshold centre** — consultation centre for primary support and counselling for injecting drug users. The main objective of the low threshold centre is to reduce the harm caused by the use of drugs.

**Peer** — a person belonging in the same social group with another person or group of persons. Social group belonging may be based on age, sexual orientation, profession, socio-economic situation and/or health condition, etc.

**Opioid agonist substitution maintenance therapy** — treatment of a person addicted to opiates with opiate-containing medicines which have been registered in the Republic of Estonia, so as to restore the social coping ability of the person.

**Opiate-injecting drug user** — a person who injects opiates and has been diagnosed with the addiction syndrome. Addiction — repeated use of psychoactive substances, where the user is subjected periodically or chronically to the influence of psychoactive substance(s), feels the need/urge to use the particular psychoactive substance, has difficulties in voluntarily stopping or reducing the use of the substance and is capable of behaviour that harms himself/herself or others in order to use the substance.

**Palliative care** — general care of the terminally ill or the dying, with the focus on alleviating the pain and other symptoms as well as solving psychological, social and emotional problems.

**Sex worker** — a person who is paid money or traded goods for sexual favours on a regular basis or from time to time, regardless of whether or not the person consciously considers this activity a source of income.

**Reproductive health** — a state of complete physical, mental and social well-being, not merely the lack of a disease or poor health related to the reproductive system, its functions and operation. Reproductive health thus means that the person can live a satisfying and safe sex life, and is able to have children, as well as to freely decide whether or not, when and how often he/she would like to have children.

**Surveillance** — routine or regular data collection and analysis on the basis of standard methods. Surveillance of the spread of HIV can be conditionally divided, on the basis of the collected information, into two: surveillance of the spread of the HIV infection – i.e. infection surveillance, and surveillance of the risk behaviour related to the transmission of the infection – i.e. behavioural surveillance. In turn, both of the above surveillance types can be divided, on the basis of the surveillance data collection methods, into two: passive surveillance or routinely registered data and its

analysis, and active surveillance or data gathered through surveys and its regular analysis.

**Monitoring and evaluation** — routine documenting or collection of the information on the programme, project or activities, and the episodic comparison of the achieved results and the planned results.

**Supervision** — work process-related counselling. Supervision increases the employees' motivation to develop, acquire both professional and social skills and the desire to contribute to the organisation. The employee is assigned to a position that best corresponds to his/her competence and interests. Employees thus no longer need to overexert themselves for achieving the same results.

**Injecting drug user** — a person who is, as a result of using narcotic or psychotropic substances, psychologically or physically addicted to a substance, and who administers such substances intravenously, intramuscularly and/or subcutaneously.

**Outreach** — activities focused on contacting a person or a group of persons, who are located in a particular area, and with whom no efficient contact has so far been made, or who have not been involved in the programme through existing services or traditional health education channels.

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## Annex 1. HIV testing and counselling in Estonia. Current situation

Service	Service description	Service providers (the provided service)	Financier
Initial testing, with counselling	<ul style="list-style-type: none"> <li>Nurse's reception (voluntary counselling: VCT)</li> <li>Doctor's reception for outpatients (OR)</li> <li>Initial testing (IT)</li> <li>Verification or a test verifying the positive or doubtful result of the initial testing (VF)</li> </ul>	<ul style="list-style-type: none"> <li>Anonymous clinics (VCT, IT)</li> <li>Youth consulting clinic (VCT, IT)</li> <li>Prisons (VCT, IT)</li> <li>Donor centres (IT)</li> <li>Family doctors: outpatient treatment (mainly if there are medical indications, OR, IT, VF)</li> <li>Specialist doctors: outpatient treatment (in case of pregnancy, medical indications) OR, IT, VF</li> <li>Hospitals (in case of medical indications) OR, IT, VF</li> </ul>	Global Fund (VCT and IT in prisons)
			State budget (VCT and IT in anonymous clinics and consultation clinics)
			Health insurance (OR, IT and VF of the insured)

## Annex 2 Health care services for people living with HIV and AIDS. Current situation

Health care service	Service description	Service providers 2005	Financier 2005
Outpatient treatment of HIV-positives and AIDS patients by specialist doctors	Health and immunostatus monitoring: <ul style="list-style-type: none"> <li>Regular doctor's consulting and medical examination</li> <li>Laboratory analyses (virus concentration in blood, immunostatus, infection indicators)</li> <li>Other tests (x-ray, etc.)</li> <li>ARV therapy</li> </ul>	Infectious disease doctors ( <i>42 doctors registered</i> ) Family doctors Other specialist doctors	Health insurance (services for the insured; partially ARV therapy)
			State budget (ARV therapy)
			Global Fund (outpatient services for the uninsured, ARV therapy)
Inpatient treatment of AIDS patients by specialist doctors	<ul style="list-style-type: none"> <li>Inpatient treatment by specialist doctor on infectious disease beds</li> </ul>	Tartu University Hospital, West Tallinn Central Hospital, Ida-Viru Central Hospital, Pärnu Hospital, Narva Hospital ( <i>a total of 90 adult bed with an occupancy rate of 73.2%, and 105 children's beds with an occupancy rate of 51.3%</i> )	Health insurance (services for the insured)
			State budget (emergency services for the uninsured)
	<ul style="list-style-type: none"> <li>Inpatient treatment by specialist doctor on intensive care beds</li> </ul>	All active care hospitals ( <i>186 level I beds with an occupancy rate of 61.4%; 191 level II beds with an occupancy rate of 51.4%; 116 level III beds with an occupancy rate of 75.5%</i> )	Health insurance (services for the insured)
			State budget (emergency services for the uninsured)
	<ul style="list-style-type: none"> <li>Inpatient treatment by specialist doctor on oncology beds (with supervening oncological pathology)</li> </ul>	Tartu University Hospital, North Estonian Regional Hospital	Health insurance (services for the insured)
			State budget (emergency services for the uninsured)
	<ul style="list-style-type: none"> <li>Inpatient treatment by specialist doctor on TBC beds (with supervening tuberculosis)</li> </ul>	Tartu University Hospital, North Estonian Regional Hospital, Ida-Viru Central Hospital, Viljandi Hospital, Narva Hospital, Rakvere Hospital ( <i>a total of 298 beds with</i> )	Health insurance (services for the insured)
			State budget (emergency services for the uninsured)

		<i>an occupancy rate of 74,1%</i>	
	<ul style="list-style-type: none"> <li>Inpatient treatment by specialist doctor on other beds</li> </ul>	All hospitals	Health insurance (services for the insured) State budget (emergency services for the uninsured)
Nursing care (incl. palliative care and hospice care - i.e. care for the dying)	<ul style="list-style-type: none"> <li>Inpatient nursing care</li> <li>ARV therapy</li> </ul>	Nursing hospitals (913 beds)	Health insurance (services for the insured)
			Own liability or local government (services for the uninsured)
	<ul style="list-style-type: none"> <li>Home nursing care</li> <li>ARV therapy</li> </ul>	Home nurses	Health insurance (services for the insured)
			Own liability or local government (services for the uninsured)
	<ul style="list-style-type: none"> <li>Home support for cancer patients</li> </ul>	Home nurses, doctors	Health insurance (services for the insured)
			Own liability or local government (uninsured cases)
Post-contact prophylactics <ul style="list-style-type: none"> <li>Contact events related to professional activities</li> <li>Other contact events</li> </ul>	<ul style="list-style-type: none"> <li>Specialist doctor's consulting (risk assessment; treatment plan) OR</li> <li>Initial testing IT</li> <li>Verification VF</li> <li>ARV therapy</li> </ul>	Infectious disease doctors Occupational health doctors All doctors	Health insurance (services for the insured)
			Employer (cases related to professional activities)
			Own liability (uninsured cases)
Ambulance service for AIDS patients	Emergency aid for emergency situations; transport to hospital	Ambulance	State budget (all people on the Estonian territory)