Report of a WHO/EURO Mission to
Estonia
16-19 December 2002

to evaluate Estonia's HIV/AIDS Programme

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Introduction

This report is the product of a process of observations and discussions during a mission to Estonia from 16 –19 December 2002 and is influenced by the referenced reports.
All institutions and individuals visited were extremely supportive and helpful in providing information. The assistance of Tiia Pertel, Chief Specialist, Public Health Department, Ministry of Social Affairs, Aire Trummal, Manager HIV/AIDS Prevention Programme, and Piret Laur, WHO Liaison Officer was particularly helpful.
The authors accept sole responsibility for this report drawn up on behalf of WHO/EURO.
Since a wealth of descriptive documents about the HIV/AIDS situation in Estonia and the resulting responses exists, the report will focus on the major findings and recommendations.

A. MAJOR FINDINGS

A1. Injecting Drug Users

The majority (approximately 90% in 2001) of new HIV infections in Estonia are among injecting drug users (IDUs).
Most infections are reported from IDUs in Narva, Kohtla-Järve (Ida-Viru) and Tallinn (Harju), among Russian-speaking Estonians. Many HIV infections (26% of all new cases in 2001) are among prisoners. While the HIV incidence rate in Estonia (1070.7 per million population in 2001) is the highest in the WHO European Region, the epidemic remains concentrated in Russian-speaking drug injectors in specific geographic areas. Earlier targeted (harm reduction) interventions for drug injectors would have probably averted an HIV epidemic however, there is still a window of opportunity to prevent a more generalised epidemic and to stabilise the current epidemic among IDUs.
Recommendation: Targeted (harm reduction) interventions for injecting drug users offer the best immediate solution to the current HIV crisis in Estonia.

Political commitment
Political commitment to HIV/AIDS prevention, including targeted interventions for IDUs, is demonstrated in the National HIV/AIDS Prevention Programme for 2002-2006 and in the September 2002 application to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Both documents support a comprehensive strategy consistent with the recent resolution of the World Health Organization's 52nd Regional Committee for Europe Scaling Up the Response to HIV/AIDS in the European Region of WHO, which recognises that: "*the overall strategy for the European Region is to contain the epidemic and to reduce vulnerability to HIV infection by focusing action on expanding targeted interventions for vulnerable groups, particularly injecting drug users, on enhanced prevention and treatment of sexually transmitted infections (STI), and on developing comprehensive interventions to promote and protect the health of young people, while simultaneously developing the capacity to respond to a more generalized epidemic"* (EURO/RC52/R9).

Recommendation: Estonia should continue to expand and strengthen targeted interventions, while simultaneously developing the capacity to respond to an as yet unrealised more generalised epidemic.

Range of services

National and local Government and non-government organisations provide a range of services and programmes for HIV/AIDS and drug prevention, treatment and rehabilitation and targeted (harm reduction) interventions for injecting drug users (IDUs) and other especially vulnerable groups. The range of activities being implemented and planned in Estonia is also consistent with the recommendations of the recent resolution of the World Health Organization's 52nd Regional Committee for Europe Scaling Up the Response to HIV/AIDS in the European Region of WHO: *"to promote, enable and strengthen widespread introduction and expansion of evidence-based targeted interventions for vulnerable/high-risk groups, such as prevention, treatment and harm reduction programmes (e.g. expanded needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in all affected communities, including prisons"* (EURO/RC52/R9).

National Estonian Alcohol and Drug Abuse Prevention Programme 1997-2007 (ADAPP)

Since 2000 the Estonian Centre for Health Education and Promotion (ECHEP) has been responsible for the implementation of the National Estonian Alcohol and Drug Abuse Prevention Programme 1997-2007 (ADAPP). The main priorities of ADAPP are drug prevention, monitoring and data collection and measures against drug-related crime. The current national programme for drug and alcohol prevention supports ten treatment and rehabilitation projects/activities and thirty-nine prevention projects/activities. The 2002 budget for treatment and rehabilitation was EK 297 000 (USD19 800) and EK 853 000 (USD56 867) for prevention. Funds allocated to individual projects are small, ranging from EK5 000 (USD333) to EK70 000 (USD4 667). These funds cover a wide range of activities including: information and awareness raising, leisure activities, drug treatment and rehabilitation, training materials for medical and social workers, training and study visits for prison workers, support for rehabilitation centres, treatment for young drug users and injecting drug users without medical insurance and coordination of a drug information centre. There has been little or no evaluation of these projects and they have been beset with administration and staffing problems and lack of resources. The National Alcohol and Drug Abuse Prevention Programme currently does not provide direct support to targeted interventions for injecting drug users (harm reduction projects). However in 2001 additional money was given for drug treatment and rehabilitation projects in East-Viru. (For example in 2001 the Vihmari rehabilitation-farm was co-financed by ADAPP (EEK 137 510). Ten doctors, seven from East-Viru, participated in a methadone treatment training program in Vilnius, financed by ADAPP. In the 2002 1 139 790 EEK was assigned from ADAPP's budget for drug treatment and rehabilitation projects in East-Viru, most of them dealing with IDUs. This allocation included continuing support for the Vihamri rehabilitation farm, the Sillamae Development Centre of Social Help and the Rehabilitation Centre for Alcoholics and Drug Addicts in Narva. Funds have also been allocated for the Narva methadone programme (see below). There are no national standardised drug and alcohol prevention programmes or materials although, life-skills materials are ready and currently used in schools. While ADAPP projects serve Russian-speaking clients, it is unclear whether such projects are specifically targeted at Russian-speakers, or designed to meet their specific needs. ADAPP does not produce standardised prevention materials in the Russian language. However project teams in East-Viru have prepared and provided information materials for Russian-speaking population.

Linkages between the Alcohol and Drug Abuse Prevention Programme and HIV/AIDS prevention have been weak. The National Alcohol and Drug Abuse Prevention Programme and

the National HIV/AIDS Prevention Programme have no joint activities and there was little evidence of co-operation. However from 2002 HIV specialist have become increasingly involved in district drug prevention committees. Of 15 district drug prevention committees (established in July 2001 to improve prevention activities at the local level) thirteen have HIV/AIDS specialists. District drug prevention committees are responsible for reviewing project proposals at the district level and making recommendations to the national level. The 2003 application comprised 161 proposals for a fixed amount of funds.

Recommendation: Increased funding for the National Alcohol and Drug Abuse Prevention Programme should be considered. Projects and activities supported by the National Alcohol and Drug Abuse Prevention Programme should be vigorously evaluated. National standards, prevention programmes and materials should be developed and widely disseminated. Prevention materials should be produced in the Russian language.

The National Alcohol and Drug Abuse Prevention Programme should technically and financially support targeted interventions for IDUs through collaborative projects with the National HIV/AIDS Prevention Programme

National HIV/AIDS Prevention Programme and the AIDS Prevention Centre of the Health Protection Inspectorate

Targeted interventions (harm reduction) are funded through the National HIV/AIDS Prevention Programme and the AIDS Prevention Centre (APC) of the Health Protection Inspectorate. The structural and funding relationship between the National HIV/AIDS Prevention Programme, the AIDS Prevention Centre and NGOs providing services is confusing. The National HIV/AIDS Prevention Programme covers all the costs of AIDS Prevention Centre, which does not have any funds on its own. However the APC operates in a semi-autonomous manner and in close co-operation with NGOs. Until the second half of 2002 the Gambling Foundation has been the main financer of needle exchange activities, but also some city governments have supported the activities.

AIDS Prevention Centre (APC)

The AIDS Prevention Centre (APC) was established in May 1996. Since 2000 the Health Protection Inspectorate, the government agency responsible for the surveillance system, has governed the APC. The APC is responsible for the planning and co-ordination of HIV/AIDS prevention, provision of information, anonymous testing, data collection and dissemination, and research. The APC provides some information and counselling and co-ordinates and provides technical support to NGOs involved in targeted interventions for sex-workers, marginalized youth and injecting drug users. The services provided by these NGOs include: methadone treatment, needle and syringe exchange, drop-in centres and out-reach programmes. The most important of these are the AIDS Information and Support Centre (Tallinn) and the Rehabilitation Centre for Alcoholics and Drug Addicts (Narva).

Recommendation: The responsibilities and activities of the APC should be better integrated with the Estonian Centre for Health Education and Promotion (ECHEP) and the National Alcohol and Drug Abuse Prevention Programme. The relationship between the APC, the NGOs (see below) and the National HIV/AIDS Prevention Programme needs to be clarified and rationalised.

The AIDS Information and Support Centre (Tallinn)

The AIDS Information and Support Centre (AISC) is an NGO providing targeted intervention services for IDUs and other especially vulnerable populations. In Tallinn AISC implements the Erika Street harm reduction programme. Erika Street has been at its present location since September 1998 and provides a syringe exchange scheme and methadone detoxification for seventeen clients. AISC also provides syringe-exchange from a poly-clinic and a mobile exchange unit, servicing two sites. All four sites service approximately 200 clients and

distributed about 2,500 syringes in 2001. These services cost approximately USD15000 per year and employ six "volunteer" workers. AISC receives funds from the central government and from the city/district council.

Recommendation: AISC should be better technically supported to increase coverage and better financially supported to ensure sustainability.

Rehabilitation Centre for Alcoholics and Drug Addicts (Narva)

The Rehabilitation Centre for Alcoholics and Drug Addicts (RCADA), has been in operation for 18 months and provides harm reduction and other targeted interventions for injecting drug users in Narva and the Ida-Viru District. Ida-Viru district is the region with the highest number of drug injectors and the most reported cases of HIV infection. The centre provides a wide range of services (prevention with young people, rehabilitation and harm reduction) to relatively large numbers of drug injectors (see coverage below). There are two fixed syringe-exchange sites and two mobile schemes. The whole needle exchange programme in the district works through this centre – all together 10 sites (including 7 stationary and 3 mobile schemes). Drug injectors and dealers are involved in secondary distribution. RCADA monitors and evaluates its programmes. No new HBV or HBC infections have been reported among clients and HIV incidence has declined. The Rehabilitation Centre for Alcoholics and Drug Addicts in Narva costs USD93,333 per year and is funded by central government from "gambling" funds, a levy or tax on gambling and gaming and from the National HIV/AIDS Prevention Programme from the second half of 2002. Funding has been sporadic. In July 2002 local difficulties resulted in a temporary suspension of funding. For three months the service had no condoms and syringe supplies were severely depleted. A donation from Finland replenished syringe stocks but the sixteen volunteers employed on a minimum wage were not paid for three months. Funding resumed from "gambling" funds in October 2002, but is only assured until the end of February 2003. The rest of 2003 will be covered from three sources – UNAIDS and Task Force support (through ECHEP) and national HIV/AIDS prevention programme.

Recommendation: RCADA should be better financially supported to ensure sustainability. Medium term (five year) core funding might be appropriate to ensure sustainability and continuity.

City and District Level

The city of Tallinn has a committee of Drugs and AIDS prevention responsible for the local level implementation of the National Strategy on the Prevention of Drug Dependence (2002-2012). The Tallinn strategy for drug prevention seeks to: reduce drug use (primary prevention, including alcohol and tobacco), increase treatment and rehabilitation (including methadone substitution treatment through GPs) and to reduce the supply of drugs. The priorities for 2002 were: prevention of illicit drug use; facilitating supportive environments, treatment and rehabilitation. The total 2002 budget for drug and HIV/AIDS prevention was EEK4 182 524 (USD 278 834). This funded 54 projects (prevention, counselling, training, legal aid, treatment and rehabilitation and information collection). In addition national funding supports two projects in the Tallinn children's Hospital (child protection and a day care centre for problem youth). At the district level there are few targeted interventions for HIV/AIDS prevention. A sex workers project, including syringe exchange, (Lasnamäe Health Centre) has been funded (EEK140 000 USD9 333) since October 2002. Targeted interventions for drug injectors are planned but not yet implemented. Plans include therapeutic communities, detoxification and counselling and rehabilitation. The West Tallinn Central hospital provides treatment (not ARV medicines, this is covered by National HIV/AIDS Prevention Programme) for non-insured HIV positive injectors or injectors with viral hepatitis. An outpatient methadone treatment programme for thirty clients (Kopli) is planned for 2003. There are also plans for eight syringe exchange schemes in the district. Currently 100 uninsured HIV positive patients are treated at the West Tallinn Central

Hospital Infection Centre (not ARV medicines, this is covered by National HIV/AIDS Prevention Programme).

Recommendation: HIV prevention should be considered a priority. Increased funding should be provided for targeted interventions. The outpatient methadone treatment programme should be fully supported and scaled-up in 2003.

Quality of response

The current national and district level response and, to a lesser degree, the response proposed in the GFATM application is inadequate to prevent further HIV transmission between injecting drug users and from them to their sexual partners. The GFATM application recognises the particular need to prioritise harm reduction and methadone substitution treatment programmes for IDUs, however the response proposed therein may be inadequate. It is of note that a first round application to the GFATM was referred back to the applicants with a specific recommendation to include a substantial harm reduction component. Such a component is included in the 2002 application.

Coverage

The coverage of existing programmes for IDUs is clearly inadequate. Evidence suggests that 60% of IDUs need to be reached by harm reduction programmes and 30% of IDUs need to be in methadone maintenance treatment to HIV prevent epidemics (or to slow existing epidemics). Targeted (harm reduction) interventions for injecting drug users in Estonia are, in the main, small-scale pilots that do not reach enough clients and do not provide enough sterile injecting equipment. There are currently fifteen needle exchange sites in Estonia, ten in Ida-Viru County under the Narva centre, two in Tallinn under the AISC, one in Tapa, one in Maardu under city government and one small NGO programme “We Help You” in Narva. Table 1 shows that currently between 20-30% (other less optimistic estimates suggest 10%) of IDUs are currently reached by needle exchange programmes. No information is available on retention rates (how many IDUs regularly use these services) so this estimate may be considered optimistic. The target proposed in the GFATM would increase coverage to an optimistic 50%, still short of the 60% required.

Table 1:Coverage of needle exchange programmes in Estonia

*Estimates of the number of IDUs	IDUs currently reached	Target proposed in GFATM	60% Coverage
10,000 -15,000	3,000**	5,000 – 7,000***	6,000-9,000

* Note: Estimates of the number of IDUs from the 2002 GFATM application may be considered optimistic. A “high estimate” of 30,000 IDUs is reported by UNAIDS in the 2002 Epidemiological fact-sheet. A lower estimate of 10,000 – 12,000 is presented in the National HIV/AIDS Prevention Programme for 2002-2006.

** This was estimated number of new clients visited needle exchange programs in the year 2001

*** The GFATM will be one financer for needle-exchange programmes. Additional sources of funding for programmes will include: funds already identified in the National HIV/AIDS Prevention Programme, funding from the municipalities and donor support from Germany and Finland.

Geographic differences in coverage rates complicate understanding of the situation. Estimates suggest there are more drug injectors in Narva and the rest of Ida-Virumaa (region close to Narva) (10-15,000) than in Tallinn (3-5,000). Needle syringe exchange clients in Tallinn currently number just 200 or 4-7% of the estimated IDU population in Tallinn. In Ida Viru 5,880

clients were reached between May 2001 and June 2002, suggesting a coverage rate between 39-59%.

Recommendation: Coverage of syringe exchange should be massively scaled up, particularly outside of Narva. Strategies to attract and retain more clients might include: increased numbers of fixed-site and mobile syringe-exchange schemes and outreach services for IDUs.

Table 2 shows that the current and planned number of syringes distributed is woefully inadequate. To achieve the optimal situation of a sterile syringe for every injector every day, the number of syringes currently distributed needs to be dramatically increased. It is legal for pharmacies to sell needles and syringes but there are no estimates of the number of syringes sold. Reported negative attitudes towards IDUs suggest syringe supplies from pharmacies may be limited.

Table 2:Coverage of syringes distributed in Estonia

Estimates of the number of IDUs	Number of syringes currently distributed per year	Target proposed in GFATM	*100% Coverage
10,000 -15,000	183,000 (2002)	235 000	3 650 000 – 5 475 000

625 000 syringes are planned (guaranteed) for 2003 (for Ida-Viru County and Tallinn).

* Note: 100% full coverage is based on a sterile syringe for every injector every day 10 – 15,000 IDUs x 365 = 3 650 000 – 5 475 000 syringes per year. 365 syringes per IDU per year is optimal (In England and Wales 180-540 syringes per IDU per year are distributed).

Recommendation: The number of syringes currently distributed should be dramatically increased by attracting and retaining more clients to fixed and mobile syringe exchange schemes (see above), expanding outreach and secondary distribution of syringes and encouraging pharmacies to provide syringes to drug injectors.

Table 3 shows that ten persons (between 0.06-0.1% of estimated IDUs) currently receive methadone maintenance treatment. The target proposed in the GFATM application would increase coverage to an optimistic 1%, far short of the 30% of IDUs recommended. The GFATM application proposes to involve General Practitioners (GPs) in methadone treatment and to train GPs and other health care professionals in methadone treatment.

Table 3:Coverage of methadone maintenance in Estonia

Estimates of the number of IDUs	IDUs currently reached	Target proposed in GFATM	30% Coverage
10,000 -15,000	10	50 – 100	3,000 - 4,500

Note: GFATM budget information costs methadone for 100 persons. 30 of these will receive detoxification on low levels of methadone (15mg per day). 70 persons will be maintained on 40mgs per day, which by international standards is rather low.

Recommendation: The number of injecting drug users receiving methadone maintenance treatment needs to be increased. Methadone treatment should be provided according to internationally accepted guidelines. The involvement and training of GPs and other health care professionals in methadone treatment should be encouraged.

Other treatment services for injecting drug users also do not reach a sufficient number of clients to impact on the epidemic. The number of persons seeking treatment for drug related problems has increased in recent years (from 812 in 1999, to1 431 in 2000 and 2 034 in 2002). Long waiting lists of persons seeking treatment for drug problems are reported and access to treatment services is limited. Most of those seeking treatment are young (71% of those seeking treatment in 2001 were under the age of 25 years), Russian speakers (82% in 2001). Short-term detoxification with methadone is the most widely used treatment method. There are currently three rehabilitation centres and two day centres for IDUs. Between them they see a reported 95 clients. One rehabilitation centre has seen just sixteen drug users since November 2001. Drug free treatment is available through in and outpatient treatment centres including NGOs. Several NGOs provide treatment, counselling and support. Lack of supervision, monitoring and evaluation means the value of these services is not known. Site visits suggest such services reach few injectors and at best are of limited use. The GFATM application proposed to increase the number of centres to seven in year two and the number of clients to 175 in year one and 290 in year two.

Recommendation: The capacity of treatment services should be increased to meet demand. Treatment services should be of high quality, evidenced based and subject to monitoring and evaluation.

Sustainability

Programmes are financially unsustainable. Funding is currently ad hoc, short-term, sporadic and inadequate. There is an over-reliance on donations, short-term grants and project (rather than core programme) funding. Government funding for targeted interventions is short term, often for three months to a year. Programmes reported shortage of funds and periods when funds were not available leading to shortages of syringes and condoms and, on occasions no funds for wages.

Disproportionate resources continue to be allocated to HIV/AIDS prevention in the general population (e.g. information, education and awareness), rather than on targeted interventions for IDUs. Table 4 shows that although the budget for “prevention work with risk behaviour groups” (EEK14.02 million USD935,000) represents 17% of the total budget of the National HIV/AIDS Prevention Programme for 2002-2006 (EEK83 million USD5.53 million), these funds are for a wide range of activities (programme development, monitoring, counselling, testing, de-stigmatisation) for a range of groups other than drug injectors (PLWHAs, MSM, sex workers, sexually active women, heterosexual men, persons travelling to “risk areas”, health care professionals). Resources available for direct service provision for injecting drug users are currently limited and inadequate.

Table 4: Budget in EEK of the National HIV/AIDS Prevention Programme for 2002-2006 (Ministry of social Affairs)

	2003	2003	2004	2005	2006	Total
Distribution of prevention related information among the youth	1,240,000	2,710,000	3,030,000	2,670,000	2,310,000	11,960,000
Implementation of HIV/AIDS prevention programmes of local governments	215,000	410,000	505,000	445,000	385,000	1,960,000
Prevention work with risk behaviour groups	**1,105,000**	**3,570,000**	**3,535,000**	**3,115,000**	**2,695,000**	**14,020,000**
Counselling and testing	1,075,000	2,050,000	2,525,000	2,225,000	1,925,000	9,800,000
Care and treatment of people living with HIV	5,000,000	7,000,000	7,900,000	11,100,000	12,300,000	43,300,000
Epidemiological surveillance, analysis, evaluation of prevention plans, development of prevention policy	215,000	410,000	505,000	445,000	385,000	1,960,000
Total	**8,850,000**	**16,150,000**	**18,000,000**	**20,000,000**	**20,000,000**	**83,000,000**

Table 5 shows that USD10.254 million over four years has been requested from the GFATM to increase the scale of Estonia's response to the HIV/AIDS epidemic. In the proposed budget of the GFATM application, funds for targeted interventions for IDUs are less than 10% of the total funds requested.

Table 5: Proposed budget of the GFATM application funds for targeted interventions for IDUs

	Year 1	Year 2	Year 3	Year 4	Total
Targeted interventions	258,851	245,656	250,569	255,581	1,010,657
Total funds	2,236,866	1,674,297	1,951,884	4,390,986	10,254,033
% funds for targeted interventions	(11.6)	(14.8)	(12.8)	(5.8)	(9.8)

Recommendation: Increased and sustainable funding for targeted interventions for IDUs is urgently required. Medium term (5 year) core programme funding for targeted interventions (rather than project funding) should be considered.

Behaviour change

Current rates of risk behaviour among IDUs are high. It is estimated that 50% of IDUs share injecting equipment. Targets proposed in the GTATM application (45% in year 2, 40% year 3, 30% year 4 and 20% year 5) are modest and reductions in sharing behaviour may not be of sufficient magnitude to slow the epidemic.
Recommendation: more ambitious targets for changes in risk behaviour should be set.

Especially vulnerable populations
Young Russian speakers, especially those without Estonian citizenship, are especially vulnerable to IDU HIV/AIDS. The majority of injectors in Estonia are Russian speaking, 90% of clients of services are Russian speaking. The marginalized status of Russian speakers causes difficulties. In some areas up to 45% of Russian speakers have "alien status", no health or social insurance and no access to social support, including drug treatment and rehabilitation services and HIV/AIDS treatment. This increased vulnerability is not reflected in the strategy or service delivery. "Volunteers" working in harm reduction projects currently receive a minimum wage and are under-valued and poorly trained. Many of these workers are Russian speakers, an important advantage since 90% of clients are Russian speakers. Criteria that these workers need to pass an Estonian language proficiency examination cause difficulties.
Recommendation: The vulnerability of Russian speaking injectors should be addressed through targeted interventions. Russian speaking staff should be employed and Russian language materials produced. The marginalized status of Russian speaking IDUs without citizenship requires particular attention.

While political commitment has been demonstrated, current Government support for HIV/AIDS prevention, at both the local and national level, remains inadequate. This is particularly the case regarding targeted (harm reduction) interventions for injecting drug users (IDUs) and other especially vulnerable groups. Opposition to targeted interventions (particularly to harm reduction) remains at all levels of Government, medical and welfare professions, in both Government and non-government organisations, and the general public.

A.2 Young People

The evaluation of the HIV/AIDS programme in relation to young people concentrated upon services and support structures for prevention and health promotion activities directed at this population group, rather than upon clinical or other health care related provision. This emphasis therefore, entailed discussions with several service providers ranging from educational provision, health promotion programmes, training and skill development initiatives, counselling services, infrastructure development and coordination mechanisms. General recommendations have therefore, been made, which do not relate specifically to individual service providers but to possible steps to improving coverage, management and coordination.

Education provision

1.1 The formal school sector addresses the issues of HIV/AIDS education through the formal curriculum and within the context of the health education curriculum. The curriculum covers

many aspects of health, both through the giving of information and skill development. It is an integrated programme covering aspects such as human studies, health education, family education and psychology. The curriculum is formulated and disseminated by the Ministry of Education, where curriculum designs are agreed and guidance on delivery drawn up. Tartu University is engaged by the Ministry of Education in designing curricula as well as providing training for teachers in the development of skills and approaches to teaching and learning styles. The National Curriculum will be revised in 2004 and health education will be part of this revision.

1.2 There appears to be a general skills deficit in schools in Estonia in the delivery of training and of teacher education in health education, including sex/HIV/AIDS education. Although Tartu University coordinates an excellent, effective life skills based education programme for teachers, based upon the WHO, UNICEF, UNFPA training of trainers programme 1999, this initiative is small in scale.

1.3 The health promoting schools, although an active programme in the country since 1993, has been unable to develop beyond a few participating schools. Two different HPS networks exist, one incorporated into the Estonian Centre for Health Education and Promotion`s Children and Young people's programme, the other under the umbrella of the European Network of Health Promoting Schools. These programmes would be much enhanced if the health promoting school approach was adopted as a national programme for school health development.

1.4 The Health Insurance Fund provides funds for the health promotion projects (Health Promotion Fund).The Fund supports health promotion activities, identified through a bidding process. Agencies and NGOs, such as the FPA, have regularly been granted funds from the HP Fund which, initiate activities in various sectors, including education. The FPA is developing programmes in sex education through the Fund and is now engaged upon the development of quality indicators for sex education. A major concern about the engagement of the Ministry of Education in sex education development was expressed during several discussions, as, without the lead from the Ministry, it is found to be difficult to engage schools in teacher training and skill development in teaching and learning methodologies for sex and HIV/AIDS education.

1.5 Much health input for schools is provided by NGOs. The Education Minister explained that much reliance is put on NGO's by the education sector for the development and delivery of health education training programmes These organisations can, at worst, be unregulated, but tend to be uncoordinated in their programming and delivery. Many produce materials that are sometimes not scrutinised by the Ministry of Education, who provides such a service. The consistency of messages and mode of delivery can be compromised by the lack of monitoring, meaning quality control is absent.

Recommendations 1 (Young people):
The creation of a coordination mechanism for national health education development and delivery, using the health promoting school initiative. The health promoting school has been found to be one of the most effective approaches in developing national strategies for health development within the education system. A well coordinated and strategic health promoting school initiative in Estonia will help to ensure the consolidation of experience so far gained by the various HPS initiatives already in place and the effective coordination of teacher education, programme planning and curriculum development. Recent research outcomes such as the Health Behaviour in School Aged Children survey and the ENHPS evaluation undertaken by Tartu University (December 2002.) can be used to guide policy, indicate priority areas for action and ultimately inform practice if they are built into a health promoting school approach.

A participatory approach to the revision of the health education curriculum. This might ensure the curriculum is informed by the experiences of schools involved in health promoting schools programmes.

The strengthening of teacher education programmes to engage schools and build the skills of schools and teachers in the design of activities and delivery of sex/HIV/AIDS education programmes in the most effective ways.

A service provided to schools to inform them of the range of organisations able to offer appropriate support, linked to a national health promoting school strategy, to enable schools to be more systematic in the planning, design and development and monitoring of their health education programmes. This will also act as a means of quality control.

Provision of services to young people out of school

2.1 There is clearly some excellent work taking place that is strategic, developmental and well coordinated. The work of the Health Insurance Fund funded Youth Counselling Centres coordinated by FPA might be highlighted as a good example to site.

2.2 The Centres, with a budget 2002 of 3.5 million Kroons, are working to a 5 year programme with funding secured up to 2006. Discussions have been initiated on what happens after 2006, but nothing has been agreed. The Centres, staffed by doctors, nurses, midwives, psychologists and social workers, are developing youth friendly approaches in terms of developing environments that provide greater accessibility to the youth age group up to 24. All staff are encouraged to attend training on the development of YFS approaches. Services of free VCT, STI prevention and drug prescription are available. The FPA objective for 2003 is to increase coverage to Russian speaking communities so the FPA is actively working to increase provision to Russian speaking youth.

2.3 As an effectiveness measure, the HIF will be seeking an evaluation of this 5 year programme in the 4th year and setting the objective of an attendance rate of 23,000 visits in 2003.

2.4 As yet, although the HIF supports the work of the FPA Centres, they are not linked to the HIV/AIDS strategy. The FPA itself receives funds form a variety of sources, including HIF, UNFPA, IPPF, but not all of this is secure, resulting in a lack of sustainability.

Recommendations 2 (Young people):
Succession planning to begin in the near future to decide on the future of funding for the FPA programme post 2006

Coordination of activities in specific areas, such as peer education, with other service providers, to ensure consistency and even coverage.

Monitoring and evaluation of services could be strengthened to aid planning and objective setting.

Links between service providers, coordination and collaboration, monitoring and evaluation.

3.1 Many service providers are active in the field of developing programmes for young people around HIV/AIDS prevention. Most of them are from the NGO sector with additional activity

from international agencies, government funded centres and ministries. This situation is clearly a strength as it demonstrates a willingness to address what is now widely accepted as a serious issue. However, it is apparent that there were major gaps and overlapping activities which, through a more deeper analysis, could be better coordinated and resources more evenly distributed.

3.2 One major concern was the clear need to concentrate activities and resources at the population groups where there was clearly greater need. The Russian speaking population of young people were highlighted by many as such a group. It was noted in the UN Agency report of 1999 that this group were often better informed about HIV/AIDS than others in the country as the Russian speaking media broadcast messages more frequently that others. However, from the demographics of the epidemic, it is clear that greater attention is needed to be paid by all the service providers to the area of the country where Russian speaking youth live.

Recommendation 3 (Young people):
The FPA has identified 2003 as the year for greater concentration of activities for Russian speaking young people, particularly in relation to reproductive health and young men. More coordinated action in this direction should be developed to provide health promotion/prevention programmes through Ministry of Social Affairs- Ministry of Education collaborative activity in developing guidance and strategic planning and sponsored programme development.

4.1 Coordination of services together with quality control was also an issue that was raised in several discussions. It was pointed out that schools in particular had serious complaints about the quality of some services provided by NGOs. Ministry of Education provides services for NGOs to have their materials for schools scrutinised and approved. In some cases this service was underused.

4.2 Several service providers, such as those developing peer education programmes, were developing good ideas and involving young people in effective and empowering initiatives. Again, there appears to be a lack of coordination, information exchange opportunities, resulting in duplication and thus less effective use of valuable resources. The reach of peer education activities in particular might be looked at in detail through a more thorough objective setting process.

Recommendations 4 (Young people):
Consideration needs to be given to the creation of a coordination mechanism for programmes and activities being offered to schools and others Coordination between service providers might be considered, to include sharing of information on methods and approaches, resources, target groups, time tabling. More effective coordination might be developed between the HIV Strategy and service providers for young people, between, for example, the Living for Tomorrow project and Red Cross activities in HIV/AIDS.

A more systematic method for assessing the consistency of methodologies and content is recommended, including the quality control of services.

Partnership development could enhance programme delivery.

5.1 The monitoring and evaluation of services does not appear to be a priority for service providers. Programmes targeting schools did not appear to include follow up programmes and little advice on monitoring of programmes in schools was evident. Quality indicators are being

developed for the FPA counselling centres and good practice such as this might be used more proactively in support of other initiatives where monitoring and evaluation is weak.

Recommendation 5 (Young people):
Several models for monitoring and evaluation are available, including the current WHO/HQ M&E programme. The introduction of a common process for monitoring and evaluation for programmes and projects should be considered. This will provide consistency in programme development and delivery, more coherent planning by agencies and greater engagement by agencies with their partners and clients.

Other observations

The Estonian Family Planning Association established Tartu youth clinic. Totally in Estonia are operating 14 youth clinics. They are covering population from 14 to 24 years old. (Clinics are mainly funded by Estonian Health Insurance Fund) and (also) from Municipal health programmes. For this purposes project proposal are submitted to The Estonian Health Insurance Fund and Municipality every year (there is general agreement between Ministry of Social Affairs and Estonian Health Insurance Fund that this is long-term programme, it means that youth-friendly clinics will get sustainable funds). The Tartu youth clinic is the biggest, the main activities of clinic are prevention and lectures for young people.

The clinic staff in Tartu is following: 3 General practitioners, 2 Gynecologists, 2 midwifes and one nurse. Doctors are working part time, and they all have a special day for visits in the clinic. Clinic is working 5 days per week, from 9AM till 5 PM. Prior to the testing, all young patients are getting counselling on sexual health. The testing in clinic is free of charge for the youth. However, the funds for these activities are limited. As an example, for the year 2003 they got budget enough for testing of 2,000 patients. Budget for counselling is a little bit higher (5,000 patients). Testing for youth does not includes HIV. For this purposes they are sending patients to the nearest Policlinic. The clinic has in plan to move to the new building in March 2003. They are hoping to get bigger space for their offices and as a result will try to open cabinet for procedures and start take blood samples for HIV testing. During the period from July to September, clinic had registered 2 022 visits, 546 came for testing purposes.

Clinic is also implementing health education activities. They are inviting young people from the different schools of Tartu (5-10 grade school children), and providing 2 hours lectures on different topics of sexual health. The lectures for the boys and girls from lower grade (5-8) are conducted separately. During the working hours clinic is rendering also service of telephone counselling. Youth clinic has a license only for provision of preventive services, for treatment patients have to see doctors in their clinics.

A.3 Other targeted interventions (Sex Work, STI, prisons, MSM)

Sex Work

Work with sex workers started in 1994. The number of sex workers remarkably increased during 1995-1997, now there are probably 3,000 sex workers in the capital. The NGO AIDS Information and Support Centre implemented the first project in 1995 with financial support of Open Estonia Foundation, then followed by Helsinki Diaconess Institute 1996-1999, Sozialpädagogische Institute Berlin, “SEASTAR” with HIV/STD prevention among migration prostitutes in boarder regions and later in 2000 by the DAPHNE-initiative, KVINNOFORUM, Stockholm, “Training & Capacity Building Against Trafficking in Women & Girls in Baltic Sea Region”. From April 2002, the center is implementing the second phase of SEASTAR project

which is financially supported by Family Health International (FHI). Under this project the following activities are currently implemented: Voluntary testing on HIV/STD, medical consultations, safer sex promotion, drop-in services, peer education of sex workers, outreach work, work with mass media, work with others service providers and governmental structures, intervention campaigns in Narva and Pärnu. Responsible for the implementation is the project coordinator, one outreach worker (medical nurse), and one doctor (dermatologist-venerologist).

Otherwise contradicting information about prostitution and sex work was obtained, varying from "prostitution is illegal", "is tolerated", "not visible", more call-girls settings exist, brothels are raided by police from time to time" to "NGO interventions are possible and are ongoing at a small scale, prostitution is a topic for politicians before elections, etc."
The coverage of the programmes seem to be insufficient and it remains unclear how effective intervention programmes can be implemented in such an environment without political support or e.g. clarifying the situation with police. There seems to be a general consensus that in order to prevent major outbreaks of sexually transmitted HIV infections sex work has to be made safe.
Recommendation: In order to run more effective and large scale interventions among sex workers the issue of sex work has to be discussed among various actors, including Ministry of Interior, Police, local government, NGOs, etc.

STI

Despite the well established integration of STI case management obstetricians, gynaecologists and family doctors prefer to refer patients with syphilis and sometimes even Gonorrhoea to STI specialists. Some case management standards used by doctors may not be up to the national standards. It is generally recognised that quality of STI case management could be improved especially in family medicine settings. Syndromic case management is not popular in Estonia.
The project "Improvement of the prevention and control of STIs in Estonia", which is funded by Government of Sweden through the Task Force of CBSS has developed new national guidelines on "STI Patients Treatment Standards". The guidelines were prepared according to European and CDC guidelines. The standards were reviewed by all STI-related professional societies of Estonia.
Recommendation: Disseminate the new guidelines among non-STI doctors and provide training on the new guidelines.

In the nearest past there was an increase in congenital syphilis in Estonia. STI specialists are not confident whether it was a true increase. There is high doubt about the quality of performed laboratory tests for congenital syphilis diagnosis and clinical management of the detected cases of congenital syphilis. This is also relevant with regard to increasing number of Chlamydia trachomatis infections, which might also be determined by the low quality of lab diagnosis. It is another example of existing needs in improving the case management quality not only in family medicine but also in obstetrics/gynaecology institutions. Leading STI specialists in cooperation and collaboration with obstetricians, gynaecologists, urologists and other medical specialists started this process trough the joint professional association as well as through professional contacts. Along with that new STI case management guidelines has been prepared and are currently undergoing the final editing.
Recommendation: That the STI and reproductive health services become more prominently involved in HIV/AIDS prevention activities. Improving the integration should increase synergy between various low level interventions to prevent sexual transmission of HIV.
Further interventions are needed to improve STI counselling, particularly among private sector practitioners, a comprehensive approach to the improvement of STI case management and surveillance must include private sector STI health care providers.

To improve data collection and surveillance, including STI prevalence and behavioural surveillance surveys.

The Ministry of Internal Affairs, the police and the defence forces have started HIV/AIDS/STI and VCT activities as part of work safety. A proposal for international funding for testing military staff has been prepared, proposing mandatory testing. There is a lack of communication with other key players and exchange of best practice knowledge. Supply of condoms is unresolved, issues of safe sex work and police practices in this area need to be discussed at all levels (see recommendation sex work).

Recommendation: Police and armed forces should be represented in the CCM and respective working groups. Unlinked anonymous testing of cohorts of recruits could be considered in close collaboration with other surveillance activities in the country.

Prisons

The Ministry of Justice presented a well-designed action plan for activities in the prison. According to this plan (Activity 3.1.) house-hold bleach is provided in small quantities to each cell, provision of condoms has started, however, remains controversial in some prisons.

During the mission the Central Prison Hospital in Tallinn was visited. Due to the ongoing changes in the system, the central Prison in Tallinn is closed and the central Prison Hospital will be moved to Viljandi during 2003. During 2002 it has continued to function as the main health facility for the penitential system. The Hospital comprises 4 different wards: surgical, internal medicine, pulmonary and psychiatric ward. There are two outpatient clinics, one in Tartu and another in Tallinn Remand, which provides medical screening for all newly admitted prisoners as well as routine medical care for inmates. Approximately 2,235 prisoners were screened at the establishment in 2002.

Prisoners who belong to risk-groups (IDU, prisoners with hepatitis B/C, tuberculosis and STI, homosexual males and sex workers) undergo HIV testing at entering the prison. VCT is provided to all prisoners Adult male and female prisoners are tested in Central Prison and adolescents in Maardu Juvenile Prison. IDU and prisoners who had accidents involving danger of exposure to HIV undergo retesting after 3 months. Testing is free for prisoners covered by Ministry of Justice. Testing is confidential and anonymous. Prison medical authorities are informing prisoners about the risks and how to avoid HIV infection through a training program. Prison medical authorities are responsible for the counselling and testing activities in prison. In 2002 the National AIDS Prevention Centre conducted special training courses for the prison staff including guards and medical personnel and inmates. Literature and leaflets for distribution among the prisoners was also provided. A pilot project on Methadone was introduced in Central prison. For the beginning 7 prisoners were offered a Methadone maintenance treatment. Based on the results a decision will be made about continuation and extension of this project.

Recommendation: Continue to train prison officers and prison staff and inmates. Knowledge and attitudes of prison staffs towards HIV/AIDS should be improved in order to decrease their fear with regard to HIV transmission through inmates, and to diminish the potential risks of discrimination.

Train HIV counsellors and medical staff in all prisons in Estonia on voluntary and mandatory HIV-tests, pre-test and post-test counselling, availability of services for medical care and community resources.

The reference laboratory (West Tallinn Central Hospital) should regularly supervise performance of testing procedure in prisons.

Improve existing educational programs for inmates and staff by more input from external, community-based organisations or experts, and by peer education.
Make condoms and water-based lubricants easily and discreetly accessible to inmates. Regularly check on the availability of household bleach in each cell.
Pilot projects for needle/syringe exchange and free drug areas in prisons.

MSM

It is estimated that there are 5,000 "active" or "out" men who have sex with men (MSM) in Estonia. The number of HIV cases reported from this group remains low, but MSM are a potentially vulnerable group. Legislation enacted in 1991 decriminalised male-to-male sex. Male-to-male sex is tolerated by the police and in society as a whole. In April 2001 the first sauna was opened in Tallinn. It provides condoms, lubricants and HIV/AIDS information (in English). Clients are mainly Estonian (including Russian speaking Estonians), however during the summer 40/50% of clients are from abroad, including from Latvia, Finland, Sweden and Russia (St. Petersburg). The Estonian Gay League is an NGO representing the interests of MSM and is a member of the GFATM CCM. "Active" or "out" MSM have a good self-support system and network. There is some concern for heterosexual and bisexual men and for the small group of young often Russian speaking men who provide "escort" services. Currently there is little or no overlap between MSM and IDUs, however there is a potential for mixing to occur between these two groups.
Recommendation: The current response is adequate for the current situation, however the proposed response in the GFATM should be supported because of the potential vulnerability of this group.

A.4 Care and Support, ARV treatment, TB, Blood safety

Antenatal Care

The first HIV positive pregnant woman was detected in 1993. In the year 2002 there were 72 officially registered HIV pos pregnant women and 32 of them gave birth; in the year 2001 there were 49 officially registered HIV pos pregnant women and 26 of them gave birth. Number of women decided to gave birth is increasing – it has been doubled within last 2 years. By now 5 newborns were tested pos. In accordance with official statistics in 2001-2002 there is increase in number of HIV infection among people of most active reproductive age (number of 15-19 years old people has been more than 4fold increased in 2001-2002 in comparison with 19987-1999; number of 20-24 years old has been more than doubled. Female male ratio has been increased from 1:8 in 1987-1999 to 1:2,27 in 2002).
Antenatal care (ANC) is covered by insurance. Contents of ANC package is divided to 6 periods and includes 6 complexes of examinations. At the moment it envisages among others one HIV test performed at the time of the first visit, 2 tests for Syphilis (at the time of the first visit and another one - within the 3rd complex of ANC at the 20-36 week of gestation). ANC also includes tests for Gon, CT, HCV, Tv, BV, Pap. Not tested pregnant women can be tested at the time of delivery. Babies born by HIV pos mothers can be tested in the maternity houses just after birth.

Testing for HIV is free but not anonymous. Testing is voluntary – patients have a right to refuse, but often blood samples are taken without informed consent. Counselling usually exists provided by obstetricians/gynaecologists but quality of counselling is mostly poor. Even people providing counselling recognise the necessity of its improvement. Regarding the attitude toward HIV pos patients it should be mentioned that some resistance of the medical personnel still exists. Mostly this is well recognised by obstetricians, gynaecologists, paediatricians and the necessity to cope with that is acknowledged.

Besides the almost universal access to ANC care there is a contingent of people who does not have it. They belong to the most vulnerable group of population (as usual they are IDUs) and thus are at high risk of HIV infection. Even the part of the population having access to ANC care often come very late or only by the time of delivery. Low awareness of the population on the existing opportunities of ANC contributes to that.

ARV treatment

There is universal access to ARVT. Most of existing ARV are registered and available in Estonia. Retrovir is covered by insurance, others by the HIV/AIDS Programme. National guidelines are prepared and will be published in the nearest future. Treatment is started on CD4 counts 350 or below and viral load 10,000 and above. HAART costs 100,000 EK (appr 6,500$) per patient/year. At the moment approximately 50 patients are on ARVT (42 adults, 4 children).
ARVT is prescribed and HIV positive patients are treated by infectiologists, which has caused sometimes treatment delays, especially in newborns and pregnant women.
Recommendation: Obstetricians, gynaecologists should be actively involved in HIV/AIDS case management and trained appropriately to ensure high quality of care. Counsellors at needle exchange points have to pay attention to women-IDUs and provide mandatory information about methods of avoiding unwanted pregnancy and HIV prophylaxis among newborns.

Monitoring of treatment is done by the West Tallinn Central Hospital. At the moment only this clinic has lab capacity. Lab monitoring is not covered by insurance for non-insured people nor by the HIV/AIDS Programme. Currently only financial support provided by the Tallinn Municipality makes it possible for non-insured people. Leading specialists are willing to expand lab capacity to other regions by lobbying for the purchase of the necessary equipment.
For social care of PLWHA there are special commissions, which examine the ability to work. Based on the results the financial support is provided covered by insurance – appr. 1,000 EK per month. At the moment there are not enough NGOs or institutions providing social support for PLWHA.

Recommendation: The high importance of extending treatment access should be stressed, especially to the high prevalence regions where most of PLWHA will live in the near future (this should include access for treatment and health care services, since most of HIV-pos are non-insured IDUs, who also need counselling and social support before ARV-treatment). The respective departments in the MoSA have to address ARV treatment issues as well and not leave this to the PH department alone. The opportunity of ARV treatment should exist even if CD4 count and viral load measures are not available[1]. A public health approach to HIV/AIDS care should be promoted.
WHO treatment guidelines should be adopted and published (Estonian guidelines for treatment have been developed).
Other stakeholders have to become involved in the fight against HIV/AIDS: ARV treatment should become the responsibility of all hospitals and eventually made available at the level of private specialists and private practitioners. The Pharmaceutical Policy Department of the MoSA and others responsible for drug purchases should become involved in the negotiations for cheaper ARV. It could be considered to do this across the three Baltic States.

[1] See page 25 of Scaling up. Antiretroviral therapy in resource-limited settings. Guidelines for a public health approach., WHO, June 2002; accessible at http://www.who.int/hiv/pub/prev_care/pub18/en/

Voluntary Counselling and Testing (VCT)

According to the "National HIV/AIDS Prevention Program for 2002-2006", one of the objectives is to ensure counselling and HIV testing to all persons interested. For this purpose 5 special anonymous testing cabinets were established in Tallinn, Tartu, Pärnu, Narva and Kohtla-Järve. During the evaluation mission, two of those cabinets (Tallinn and Tartu) were visited. As an example the Tallinn anonymous testing cabinet, established by the AIDS Prevention Centre is described here. Until the beginning of 2002, the cabinet was located in one room of the AIDS centre. Then the cabinet was moved to a new building, in front of the AIDS centre, now the centre has 3 rooms: one for registration and counselling, another for blood collection, and one as waiting room. Staff of the centre consists of two persons, administrator and nurse. The cabinet is open daily, except Saturday and Sunday, 3 days from 8-11 am and two days from 3-6 pm. There is no appointment system and all the patients are seen the same day.

It was impossible during this mission to assess the quality and content of counselling itself. However, it seems difficult to cover all issues during a counselling session of only 5-6 minutes (including data collection and registration in the register books). No written policy on confidentiality was available. Blood samples are labelled with a code that can be linked to personal identifying information, then it is sent to West Tallinn Central Hospital Laboratory. After the blood sample is taken, clients receive condoms, and some printed information on HIV/AIDS prevention.

Clients are asked to call back to the Anonymous Testing Centre to get the results, which are available in 48 hours. If the test is negative, the results are given by phone. If the test is positive, than client is asked to come personally to the AIDS centre. Then in the centre, the specially appointed doctors are informing clients about the positive test and referring them to West Tallinn Central Hospital. This hospital is the main and only health facility, which is responsible for HIV+ patients. However, information on how this referral is working in reality is not available, as the cabinet staff does not receive any information from West Tallinn Central Hospital. For the staff of both visited cabinets the problem of "Burnout" is very evident. There is a shortage of staff, big workload, and the work is stressful and difficult, especially when sometimes only one nurse is facing a group of IDU.

This example highlights the fact that best practice experiences are not applied (best practice would be to treat all clients alike whether positive or negative, results should be give not after 48 hours but after a confirmatory test could be done, e.g. 2 or 3 weeks which would prevent also repeated tests without behaviour change) and that additional anonymous services should be made available at West Tallinn Central Hospital, where such services could easily be integrated into existing services.

Anonymous testing is not sufficiently available in Estonia despite of the number of cabinets for anonymous testing. There is a strong necessity to evaluate their function, aiming to improve the quality for anonymous counselling and testing and increasing accessibility, affordability and acceptability. Thus enabling them to fully meet the needs of the most vulnerable of Estonian society. Questions such as the appropriate number of VCT sites, staffing, as well as their location, working hours, etc. should be decided based on the local needs, on the current epidemiological situation, size of population at high risk, recent behavioural data and all other important related issues. Also other existing opportunities should be used to expand access to testing, e.g. in the STI Clinic. The first HIV positive case in Estonia has been detected in this clinic in a syphilis patient. In 2002 (11 month) 2,362 patients were tested for HIV, 24 HIV positive cases were detected. All cases have been reported but no feed-back received. Neither counselling nor preventive activities are currently performed. The STI clinic as well as STI services in general are not participating in HIV prevention and control activities. In Estonia with highly experienced dermato-venerologists, their active involvement in HIV/AIDS control would be very much beneficial (see recommendation STI).

Recommendations: Establish policies, standards and strategic plans regarding VCT with consensus on respective roles of participating agencies.

Increase training of counsellors/nurses to provide VCT services and monitor quality of such services.
Increase number of staff working at VCT centres by designating more institutions as VCT centres.

TB

The TB programme is a well functioning programme, which is both vertical as well as integrated into the primary care level. The DOT (Directly Observed Therapy) programme involves General Practitioners and nurses. The programme is internationally recognised as one of the model programmes of its kind.
The GFATM proposal mentions to link the HIV/AIDS programme with the TB programme, however, in practice such links are still weak. Areas for collaboration of both programmes exist in prisons, TB wards, VCT centers, and ARV treatment schemes in hospitals or at home and not only at the level of co-infected patients.
Recommendation: The TB programme should take an active role to develop joint activities with the HIV/AIDS programme in the various areas where opportunities for collaboration exist (see above). TB representatives should be members of the CCM, the HIV/AIDS programme board and HIV/AIDS representatives in the TB board. Funds for collaboration should be made available.

Blood Safety

The Estonian Blood Transfusion Service is in full process of reorganisation, with a new law under discussion in the Parliament. There is an outstanding programme for blood donor education and recruitment and blood is 100% tested for transfusion transmissible diseases.
Starting with January 2003, the Estonian Blood Transfusion Service will be assisted for restructuring by the Netherlands, in the framework of the MATRA project. Critical issues remaining are the lack of a centralised donor registry and inappropriate storage of fresh frozen plasma (See also the report by Dr Valentina Hafner, WHO/EURO).
Recommendation: Proceed rapidly with the reorganisation of the blood transfusion services, which is supposed to lead to better management of donors and blood safety. Prioritise improvements, starting with a better donor selection and central registration, reduction of clerical errors, appropriate storage, and central management of blood supplies. Introduction of PCR technology for routine screening seems not a priority under the current conditions.

A.5 Surveillance, Monitoring and Evaluation

Surveillance

STI and HIV surveillance are integrated with other communicable disease surveillance in the Health Protection Inspectorate and the system provides good data on STI and HIV transmission. Currently the HIV reporting form is under revision and a more detailed form has been proposed. Weaknesses include integration of behavioural surveillance in the areas of drug use and sex work and STI prevalence surveys (currently the percentage of IDU among all HIV infections is only known from a sub-sample which varies between 10-50%).
Recommendation: Rather than relying on more detailed reporting forms a better sentinel surveillance system for risk assessment and prevalence surveys should be established

Monitoring and Evaluation (M & E)

The current M&E activities are inadequate and a comprehensive M&E plan does not exist. Furthermore responsibilities for M&E are ill defined between various actors. The National plan, as well as other project documents, is not designed to facilitate M&E. Measurable outputs, outcomes or indicators are missing.
Therefore the mission was only used to demonstrate where assistance could be found once the M&E unit would have been set up. Various existing UNAIDS, WHO documents, guides and handbooks have been provided on a CD. It is hoped that the material could provide the base for a strong M&E unit and its plan in the near future.
The Estonia Center for Health Education and Promotion (ECHEP) is currently responsible for M&E of the programme, supervision of the AIDS Prevention Center (APC), and for reporting and planning. Since the APC is not the only actor in the programme it is unclear who evaluates e.g. surveillance activities or hospital care. Other major areas of work of the ECHEP include e.g. Drug prevention committees in local governments, surveillance and mapping activities, behaviour surveys, needle-exchange support. This diverse and partly overlapping or conflicting with other institutions' work does not create an environment for M&E of the national programme. Mentioned situation is a result of the restructuring which started in the beginning of 2002 by changing the leading institution of the national programme. APC and ECHEP together form the staff of the same programme (both financed by the programme). In this situation APC has continued its ongoing activities and some new developments and activities (like starting with cooperation in county government level, starting with the development issues of a better (behavioural) surveillance system and mediating foreign funds for needle exchange). These issues have not been overlapping, they are new issues, but division of roles between APC and ECHEP have been unclear.
Recommendation: a separate, strongly staffed and equipped unit for M&E should be created. See recommendations about structural reforms.

The document "National HIV/AIDS Prevention Programme for 2002 – 2006" needs restructuring and improvements to allow better management and monitoring and evaluation of the programme. The budget in chapter 5 does not tally with the objectives in the narrative part, objective 3 'Blood safety' is missing.
Recommendation: prepare operational plan for the national programme, e.g. in form of a logframe with detailed figures for funding and indicators to allow monitoring and evaluation.

The only budget documents for the national plan that were presented (1. for 2002; 2. proposed budget for 2003) are not sufficient for M&E.
Recommendation: A more detailed budget down to the level of activities has to be prepared. For each recipient the Ministry should maintain detailed budgets and indicators for M&E.

The evaluation reports of the HIV/AIDS programme 1997-2001 (by Praxis and State Audit Office) have already raised very similar concerns about performance, M&E and management problems.

A.6 Coordination, Management, Structure

The current HIV/AIDS programme is scattered among several institutions and most activities are of low scale and uncoordinated among several actors. Basically a centralized national HIV/AIDS programme does not exist. The lack of overall leadership, which is mentioned in several reports and evaluations of the past, is due to this currently dispersed structure of the

programme. On the other hand the problems encountered are very common during the transition from the stage where various actors respond to the new HIV/AIDS threat until a well planned and coordinated programme is set up. A common reaction is to blame insufficient financial resources for the mismanagement instead of improving leadership and making structural changes that will create synergy and mobilize already existing resources. The lack of coordination and supervision seems to be particularly evident. The M&E function seems extremely weak, in fact there are no coherent activities that would currently justify the name 'M&E unit'. A comprehensive reorganisation seems to be expected by all stakeholders, however, the communication about the nature of necessary changes and possible structures seems not to have been very successful.
In general the communication among different actors in the programme is not well structured, there is a lack of understanding and discussion on the possible alternatives for the leadership and management of the programme. A particular communication gap seems to exist between the MoSA and the APC.

A possible coordination and management structure, which was proposed by several actors, could look like this:

1. Level: Ministry of Social Affairs
Public Health Department
HIV/AIDS Unit
Advisor, Strategic Planning/Reporting Group
Coordination of other ministries
Supervision of Health Development Institute and HIV/AIDS Programme

2. Level: Health Development Institute (to be founded)
5 Public Health (Institutions) Programmes
National Alcohol and Drug Abuse Prevention Programme 1997-2007 (Drug Prevention Programme)
HIV/AIDS Prevention Programme for the years 2002 - 2006
National Program of Research and Development in Public Health for the Years 1999–2009 (Research Programme)
Programme on tuberculosis treatment of Estonia 1998 – 2003 (/PH and Social Education Center)
Youth and Children Health Programme 2000 – 2005 (Youth/Child Programme)

3. Level: HIV/AIDS Prevention Programme - "AIDS Prevention Centre"
Programme Manager
6 Coordinators (for each area of work)
Areas of Work
1. Adolescents and Youth
2. Targeted Interventions (Vulnerable Groups: e.g. IDU, sex work, STI, prisons, MSM)
3. Care and Support for PLWHA
4. Blood Safety, VCT, Occupational Safety
5. Local Level, Community and NGO Support
6. Monitoring and Evaluation, Surveillance*

(*actual surveillance activities will remain in Health Protection Inspectorate)

4. Level: Partner Organisations

Each coordinator of the 3. level will guide and coordinate in the respective area either directly supervised activities, e.g. the 5 anonymous cabinets for VCT, or the activities of other partners such as hospitals, laboratories, VCT centres of local governments, NGOs, etc.

The greatest gains in economies of scale can be expected at the 2. level, which will be relevant far beyond the HIV/AIDS programme: the foundation of such a public health institution would bring together a lot of redundant and parallel Public Health activities, which are currently operating in small units with little institutional capacity and sustainability – examples include e.g. projects of the Centre for Health Education and Promotion or the Drug Monitoring Centre. Also at this level the TB programme and the HIV/AIDS programme will be structurally joined, an important prerequisite for future success in combating both infections. Re-organisations of this kind are, however, difficult to implement and may have delayed the necessary changes in the HIV/AIDS programme already. The view raised was that only the ministry could take the leadership in implementing such changes. The level of Programme Manager has to be given the appropriate weight to allow visible leadership within the programme, the MoSA and other ministries, as well as to the general public – one of the deficiencies of the current programme stated in most reports. The strong political commitment necessary to achieve this will be the prerequisite for a successful transformation of the institutional structure.

The AIDS Prevention Center (APC) has been the central institution in the past for piloting new interventions and working closely with community groups and NGOs. The achievements of this institution are commendable and have greatly contributed to the current highly visible programme areas, e.g. in IDU interventions. There is the notion of the APC actually working too closely with NGOs. Visiting the APC and the AIDS Information and Support Centre made it difficult to delineate responsibilities and engagement of individuals and institutions. Such allegations do not, however, reflect the reality of an effective HIV/AIDS response, which should by all means be as close as possible to the affected community and NGOs. Examples of NGOs that would need more support are those who deal with People living with HIV/AIDS (PLWHA) and prisoners: the current support and set-up of NGOs still seem to be too weak. On the other hand, for example, the current 5 VCT centres are sufficient to set up standards and training schemes for other integrated VCT centres to be set up at community level to react flexible to needs. Without such integration sustainability would not be achievable.
One other opinion is that only in 2002 the Prime Minister's office and other top level government institutions have fully acknowledged the HIV problem and more funding will now become available, thus current efforts and achievements may be diluted by structural changes.
Recommendation: That no current activity of the AIDS Prevention Center be re-assigned or de-centralised until there is an engagement of other institutions sufficiently funded and with qualified human resources in the new structure to at least ensure functioning at current levels.

Discussions about re-structuring the programme have obviously taken so long that some staff of certain institutions, particularly the APC, has been de-motivated and their enthusiasm severely undermined by the uncertainty of future work arrangements. Timing and demonstrated leadership is of utmost importance for changes as required in the programme.
Recommendation: To rapidly decide on the necessary structural changes and effectively communicate them to all involved to ensure ownership and support for such changes.

Structural changes as required in the HIV/AIDS programme and the public health sector in Estonia only create efficiency and sustainability if there are sufficient means to effect the change and if the people working in the structure understand them and support them. This level of commitment and understanding requires more than a short feed-back meeting by foreign consultants. It requires strong and visible leadership, as well as a broad consensus between those

providing resources, those who are acquiring new tasks and resources, and those giving up tasks and resources. Some of the recommendations are quite banal and can be implemented almost immediately. Others are complex, controversial, and difficult. These need to be extensively discussed between the MoSW and all other stake holders.

Recommendation: MoSA staff, and other interested parties to create the most favourable conditions possible for managing the transition within the public health sector from a disease-oriented vertical HIV/AIDS programme to an integrated sectoral response to HIV/AIDS. Specifically, the consensus should assure that the response to HIV/AIDS is strengthened in the transition, the suggested changes are feasible and realise all potential economies of scale and of scope, the transition reduces duplication without creating gaps by identifying activities which could be more effectively carried out by existing implementing units, the capacity of a multi-sectoral policy and co-ordinating secretariat is strengthened in the transition, and the relative merits of private sector and public sector delivery of HIV/AIDS related activities are taken into account.

B. ANNEXES

B.1.1. Persons contacted (in alphabetical order)

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B.3. Terms of Reference

10 December 2002

Mission to evaluate Estonia's HIV/AIDS programme

Mission members (focus areas): Martin Donoghoe, WHO/EURO: IDU, SW, MSM
Lali Khotenashvili, WHO/EURO: STI, PMTCT, care, SW, MSM, surveillance
Ulrich Laukamm-Josten, WHO/EURO: team leader, M&E, care, STI, surveillance
David Rivett, WHO/EURO: young people
Zaza Tsereteli, Baltic Sea Task Force: STI, young people, VCT and prisons

Duration: 16-19 December 2002
Place: Tallinn, Tartu, Narva

INTRODUCTION

Estonia has completed the strategic planning process for a national response to HIV/AIDS with the National Strategic plan formulation (National HIV/AIDS Prevention Programme for 2002-2006) and the GFATM application. This process, however, has only been finalized in the last months.

To ensure that programme managers have not overlooked any part of the response and have set the programme on a well-planned track, the Ministry of Social Affairs (MoSA) has requested an outside evaluation from WHO/EURO's STI/HIV/AIDS Programme.

It was agreed to have a short 3-days mission, which should assess the program's content, scope and coverage, together with the quality and integrity of implementation efforts. As such it would be a process evaluation of the previous major steps towards the establishment of the national program.

The MoSA and national stakeholders would provide information to help determine the links between the program efforts and resources, and the goals the program is trying to achieve. The coverage of intervention areas by different partners and their role in the national program, the functioning of the coordinating mechanisms (e.g. Country Coordinating Mechanism) will also be evaluated. The monitoring and evaluation plan for the national program will be also discussed.

TERMS OF REFERENCE

The purpose of this evaluation mission, in so far as is possible within the time constraints of preparation and implementation, is to assess whether Estonia's national HIV/AIDS programme as approved by the Government on 16 Jan 2002 is meeting the expectations of all major stake holders in terms of content, scope and coverage, together with the quality and integrity of implementation efforts. The Evaluation will ::

- assess the extent to which the national program has met the goals and core objectives set out in the Republic Order no. 33-k of 16 Jan 2002;
- examine the degree to which the objectives of the national program are realistic given its structure and mandate, and provide conclusions and recommendations on governance, management and functions that will promote improved performance; and
- review the relevance of the national program objectives and functions for the challenges of the next four years and provide recommendations on future objectives and functions of the Programme also in relation to the GFATM proposal;
- make suggestions for a monitoring and evaluation plan;

METHODOLOGY

During 16 – 18 Dec 2002 team members together with Estonian HIV/AIDS programme staff will do site visits and meet as many key informants as possible from the list provided below, according to a programme arranged by the MoSA and perform interviews, using a semi-structured questionnaire (inputs, outputs, quality of services, gaps, improvements, modifications, recommendations).
They will review the National HIV/AIDS programme document, the GFATM proposal and any other documents provided during the mission. Verbal feed-back of preliminary findings and recommendation will be provided in a debriefing session open to all stake holders on 19 December before departure. A report not longer than 20 pages will be drafted by 15 Jan and shared with the MoSA and finalized within 2 weeks afterwards, containing summary findings and recommendations.

B.4. Questionnaire

Objective #
#.1. Inputs (budget, expenditure, manpower, material, time)

#.2. Outputs (what services, to whom, when, how often, how long, in what context; distributed commodities, trained staff, service units delivered)

#.3. Quality

#.3.1. To what extent are planned activities actually realized (give % figure; what coverage of target population)?

#.3.2. How well are the services provided (does it work or not; guidelines, standards; unanticipated effects)?

#.3.3. How well are the services coordinated (how many actors, what structures)?

#.3.2. How well are the services monitored (indicators, M &E, surveillance system)?

#.4. Gaps, improvements, modifications, recommendations (objective, services, implementors)?

#.5. Institutions, organisations, persons contacted, (Title, Address, Tel, email)