



REPUBLIC OF ESTONIA
MINISTRY OF SOCIAL AFFAIRS

National HIV Action Plan 2017–2025

Tallinn 2017

Table of Contents

Table of Contents	2
I. Introduction	3
II. Epidemiological situation	5
1. HIV testing and diagnostics	8
2. Interventions for PLHIV	9
2.1. HIV treatment and counselling	9
2.2. Prevention and treatment of HIV-associated infections	11
3. HIV prevention	11
3.1. Prevention of HIV among key affected populations	11
People who inject drugs	12
People involved in prostitution	13
Men who have sex with men	13
People in detention facilities	14
3.2. Prevention and reduction of HIV-related stigma and discrimination in society	15
3.3. Prophylactic (biomedical) interventions	16
4. Surveillance, monitoring and evaluation	16
V. Definitions and Abbreviations	18
VI. References	20
Annex 1. Activities and Measures to Achieve a Steadily Decreasing Trend in HIV Transmission for 2017–2020 by Areas of Responsibility	23
Ministry of Social Affairs	23
Ministry of Defence	31
Ministry of the Interior	31

I. Introduction

HIV is a human immunodeficiency virus that affects the immune system and weakens the body's ability to fight against various pathogens. Estonia has had the highest rate of new HIV cases in the European Union since 2001 [1, 2]. The seriousness of the situation is reflected by the fact that the number of new HIV cases diagnosed per 100,000 population in a year exceeded the European Union's average four times in 2015 (20.5 vs. 5.8 new cases) [2].

Estonia has implemented HIV prevention activities for more than 25 years [3–5]. HIV prevention and treatment has mostly been conducted through various public health programs and strategies.

The following may be considered as the most important achievements:

1) On the outcome level:

- the awareness about HIV has increased, especially among young people;
- the rate of people who inject drugs (PWID), who do not know their HIV status has decreased due to high level of testing;
- close to 90% of PWID have used harm reduction services (needle and syringe exchange program) at least once in their life;
- sharing of previously used syringes has decreased. In addition, HIV prevalence is lower among PWID, who have injected drugs for a shorter time period, than it was 10 years ago.

2) On the system level:

- provision of government-funded harm reduction services (including syringe and needle exchange and counselling services) and opioid substitution treatment for PWID;
- provision of government-funded anonymous HIV counselling and testing in an optimal volume (including the use of rapid HIV tests and testing in community-based organizations);
- availability of free antiretroviral treatment (ART) for people living with HIV (PLHIV), regardless of health insurance coverage;
- high ART coverage in prisons.

The most significant drawbacks in implementing the current programs are:

1) On the outcome level:

- insufficient HIV testing among general population and some of the key affected populations;
- risk behaviour has not declined among young people aged 18–29 years over the past 10 years;
- high level of sexual risk behaviour and increase in the number of new HIV cases among the 30-year-olds and older;
- high level of sexual risk behaviour among PWID;
- lower ART coverage than sufficient and high rates of patients who have discontinued ART;
- high prevalence of HIV-associated infections (e.g. hepatitis C) and limited options of treatment for these infections.

2) On the system level:

- insufficient involvement of local municipalities and health care system;
- insufficient integration of the activities into the jurisdictions of various ministries;
- the lack of strong central governance;
- insufficient funding, which has led to important activities being implemented at insufficient levels to achieve the results.

Today, all HIV prevention activities have been integrated into the National Health Plan 2009-2020 (field IV “Healthy Lifestyle”, measure 7 “Prevention of New Events and Permanent Decline in the Spread of HIV”) [6]. The activities under the governance of Ministry of Social Affairs and the budget for these activities are specified in the operational program of the National Health Plan 2009-2020 named “health risk program” [6]. However, the on-going comprehensive spread of HIV in Estonia has led to a need for developing HIV-specific action plan that is governed centrally by the Government of the Republic of Estonia, which would involve all governing levels and sectors in order to constrain the spread of HIV.

The general objective of the action plan is to achieve a steadily decreasing trend in HIV transmission through necessity-based, integrated and interdisciplinary activities. Action plan identifies the strategic objectives in the field of HIV treatment and prevention and describes the activities and measures required to achieve the objectives described.

The following international declarations, which Estonia has agreed to, have been relied upon when developing the action plan:

- *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 adopted by the UN General Assembly High-Level Meeting on Ending AIDS on 8 June 2016 [7]*
- *Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia on 24 February 2004 [8].*
- *“Vilnius Declaration” on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries on 17 September 2004 [9].*
- *Tallinn charter: Health Systems for Health Wealth on 27 June 2008 [10].*

The Estonian Health Insurance Fund, Estonian Network of People Living with HIV, Estonian Society for Infectious Diseases Society, Estonian Society of Family Doctors, World Health Organization (WHO), Ministry of the Interior, Tallinn City Government, University of Tartu, Health Board, National Institute for Health Development, Ministry of Social Affairs, Ministry of Justice, Ministry of Education and Research, Ministry of Defence, Estonian Sexual Health Association, and Narva City Government were involved in the preparation of the action plan.

II. Epidemiological situation

The first case of HIV in Estonia was registered in 1988. In total, 9,492 people have been diagnosed with HIV over the years [11]. Largest number of new cases per year were diagnosed in 2001 when the number was 1,474 (105.8 cases per 100,000 population). In 2016, 229 new cases of HIV were diagnosed (17.4 cases per 100,000 population). Over the last ten years (2007–2016), the number of new cases has decreased by almost two-thirds (Figure 1) [12].

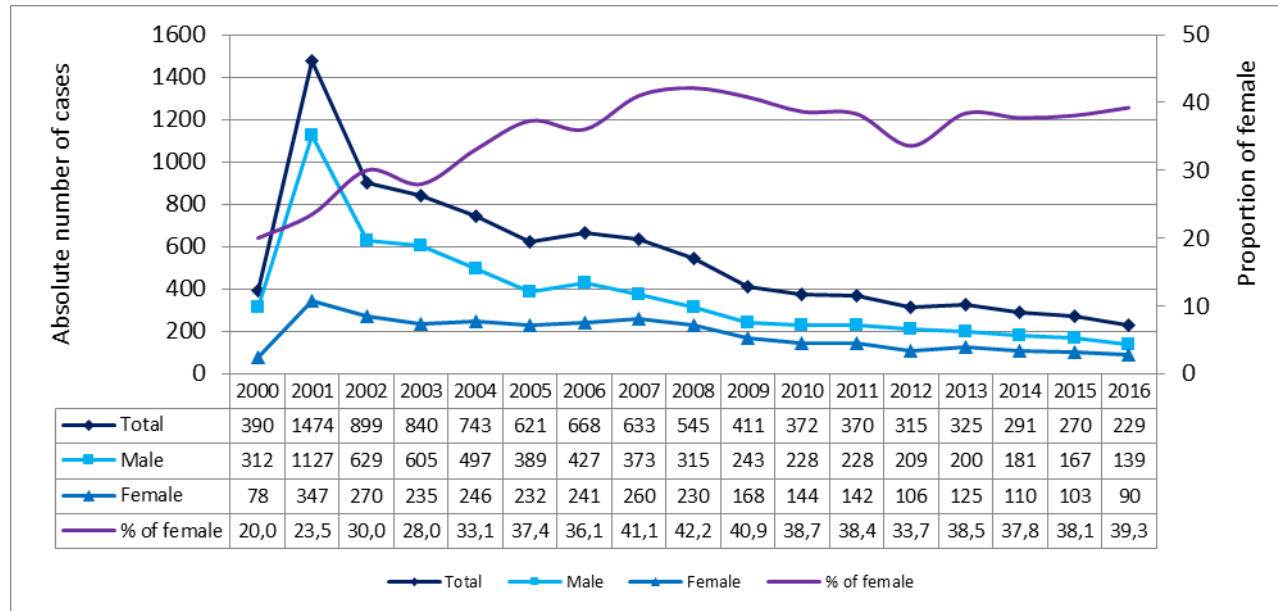


Figure 1. New HIV cases by gender (n) and the proportion of females (%), 2000–2016.

The exact number of PLHIV in Estonia is unknown. In the beginning of the epidemic (from 2000–2008) anonymously diagnosed cases were also registered as new HIV cases, thus it is likely that many of the cases may have been duplicated. In addition, the exact number of PLHIV who have died (with the exception of AIDS-related deaths) is unknown. There is also a reason to believe that HIV is underdiagnosed as indicated by the high number of late diagnoses (in 2010–2016, 4% of newly diagnosed HIV cases were diagnosed with AIDS within three months after receiving HIV diagnosis) [12]. The assessment made by the Estonian Centre for Applied Research Centre using SPECTRUM modelling indicated that the number of PLHIV in Estonia in 2015 was between 6,108–10,110 (median 7,900) and 7,762 based on a more realistic assessment [13].

In the last five years, the rate of HIV transmission has stabilised, but it remains at a high level (Figure 1). Over time, the average age of people diagnosed with HIV has increased among both men and women. In the early years of the epidemic, HIV was more likely to spread in the age group of 15–24, but nowadays, new HIV cases are related to the age group of 25–35 and above. In addition, the proportion of women among newly diagnosed HIV patients has risen to 40% (Figure 1). The positive trends are the reduction in new HIV cases among children and young people, and the very low vertical transmission rate of HIV (there was no cases registered in 2015 and 2016).

Most of the new HIV cases are still being diagnosed in Ida-Viru County and Tallinn (nearly 90% of all new cases) [12]. The highest number of new HIV cases per one city has been diagnosed in Narva in 2014 when 20% of the new HIV cases were diagnosed in that city. In 2016, 15% of the new HIV cases were diagnosed in Narva. Overall, in 2000–2016, 2,369 new cases have been diagnosed in Narva, representing 25% of all new HIV diagnoses made in this period [12].

HIV is a higher risk for some population groups because of factors like their risk behaviour and social vulnerability. WHO has identified five key population groups that are disproportionately affected by HIV in almost all regions of the world [14]:

- PWID, because the probability of HIV transmission among PWIDs is 22 times higher than in the general population [14]. In 2015, 5% of all new HIV cases diagnosed in the European Union were registered among PWIDs, while in the eastern European region of the WHO this figure was 26% [2];
- People involved in prostitution (PIP), because HIV prevalence among PIPs is on average 12% based on the WHO global estimates [14];
- men who have sex with men (MSM), as the percentage of MSM among new HIV cases was 42% in the European Union and EEA countries in 2015 [2];
- people in detention facilities, because the prevalence of HIV, hepatitis B and C and tuberculosis is estimated to be 2–10 times higher among people in correctional facilities than in the general population [14]. Since prostitution and drug use is punishable in some form in many countries, there is high probability that people who belong to these key population groups have spent some time in detention facilities at some point in their life [15];
- transgender people.

Regarding HIV prevention in Estonia, it is important to pay particular attention to the first four key affected populations. The prevalence of HIV among PWID in Estonia is high but stable (in the range of 48–66%) [16–18], and the proportion of new HIV cases attributable to injecting drug use has gradually decreased over time (90% in 2001, 14% in 2016) [12; Health Board, unpublished data]. The prevalence of HIV among PIP is 8–13% (in 2011 and 2016) in Estonia and the vast majority of PIP infected with HIV have injected drugs during their lifetime [19, 20]. It is estimated that the prevalence of HIV among MSM is between 2–3% [21]. In recent years, the percentage of MSM among new HIV cases has shown a rising trend, reaching 4% in 2016 [12]. According to the Ministry of Justice, the overall number and the percentage of PLHIV in detention facilities in Estonia have been stable in recent years with the number being 482 and 422 in 2013 and 2015, respectively and the percentage being 16% in both years (unpublished data).

III. Objective of the action plan

In 2015, the United Nations adopted sustainable development goals covering 17 different areas. These included health and wellbeing targets with one of the sub-goals being to end the AIDS epidemic by 2030. Other sub-goals also include the enhancement of drug prevention and treatment and the universal access to sexual and reproductive health [22].

On 14 February 2001, the Ministry of Social Affairs of Estonia declared a concentrated HIV epidemic in Estonia and this situation has not changed until now. According to the UN and WHO definition, in case of a concentrated epidemic, HIV predominantly occurs among key affected populations (HIV prevalence is consistently over 5% in at least one of the key population groups but is less than 1% among pregnant women) [23]. HIV prevalence is less than 1% among pregnant women in Estonia [5, 12], but is more than 10% among PWIDs and PIPs [12, 19, 20]. The warning signal of the possible expansion of the epidemic is coming from Ida-Viru County, where the prevalence of HIV among pregnant women has been more than 1% already since 2001 [5]. Since 2001, the number of new cases of HIV per 100,000 population in Estonia has exceeded the average of the European Economic Area by at least three times, reaching 20 times the number in 2001 [1, 2].

The main goal of this action plan is to end the widespread transmission of HIV infection in Estonia. The widespread transmission is considered to be over when the number of new HIV cases per 100,000 population corresponds to the average for the European Economic Area by 2025. This means that by 2025 the overall number of new HIV cases registered per year must be below 100 (in 2016 the number was 229).

In addition to the reduction of new cases, the goal is to also target the 90-90-90 goals for the year 2020 set by the UNAIDS Program and the WHO [24]:

- 90% of PLHIV know their HIV status;
- 90% of diagnosed people receive ART;
- 90% of ART patients are considered as virally suppressed (have viral load below the specified level).

The objectives and indicators of the action plan are presented in Table 1.

Table 1. The objectives and indicators of the action plan

Indicator	Baseline (2016)	2020	2025
Number of new HIV diagnoses per 100,000 population	17.4 ¹	15	The average of the European Economic Area
Percentage of PLHIV, who know their HIV status	Currently unknown	75%	90%
Percentage of PLHIV, who know their HIV status and receive ART	72% ²	70%	90%
Percentage of people receiving ART whose viral load is below specified level (<1,000 copies/mL)	80% ³	85%	90%

¹ The overall number of new HIV cases registered in 2016 was 229. Based on the objectives of the action plan, this number should be decreased under 100 new HIV cases per year by 2025.

² ART consilium data of patients living with HIV and receiving ART registered with the infectious disease specialist.

³ E-HIV database data.

IV. Activities and interventions to end the widespread transmission of HIV

The following describes all the primary policies in the HIV/AIDS field and the current situation, challenges and corresponding measures, which are described in more detail in Annex 1. Annex 1 is structured by the governance of different ministries responsible for the activities described in this document.

There are four courses of action:

1. HIV testing and diagnostics;
2. activities targeted at PLHIV:
 - HIV treatment and counselling;
 - Prevention and treatment of HIV-associated infections;
3. HIV prevention:
 - Prevention of HIV among key affected populations (PWID, PIP, MSM, people in detention facilities);
 - Prevention and reduction of HIV-related stigmatisation and discrimination in society;
 - Prophylactic interventions;
4. Surveillance, monitoring and evaluation.

1. HIV testing and diagnostics

Current situation

In 2016, nearly 157,000 people were tested for HIV, which accounts for 12% of the population. This number has doubled since the year 2000 when 6% of the population was tested for HIV [12]. The level of HIV testing has also doubled among young people (2005 vs. 2010) [25]. However, the level of HIV testing can still be considered low in Estonia as less than one tenth of men and one fifth of women aged 15-49 years have been tested for HIV in Harju and Ida-Viru Counties and this proportion has not changed significantly over the years [26]. In addition, people are rarely tested based on the incidence of HIV indicator conditions and this has not changed significantly over the years (2012–2015) [26]. According to the guidelines for HIV-testing and referring PLHIV to care, which were established in 2012, all 16–49-year-old patients in outpatient or inpatient care in Harju County and Ida-Viru County should be tested for HIV [27].

HIV testing has remained modest, despite the fact that there are no budgetary constraints on conducting HIV testing according to the aforementioned guidelines (i.e. testing is ensured also for people without health insurance). In addition, the funding of HIV testing carried out by primary health care specialists is organised outside of their usual therapeutic fund. However, only barely 1% of primary health care patients in Harju and Ida-Viru counties are tested for HIV [26]. Meanwhile, nearly three quarters of all adult PLHIV visited primary health care specialist at least once during the period of two years prior to HIV diagnosis, and about one third of them had an HIV indicator condition documented in their medical history during that time period [28].

High priority measures

- HIV testing and linkage to care according to the aforementioned guidelines;
- Providing anonymous and voluntary HIV testing and counselling;
- Providing community-based HIV testing and counselling;
- Ensuring high-quality laboratory HIV screening and diagnostics.

Indicators

Table 2. Indicators for HIV testing and diagnostics

Indicator	Baseline (2016)	2020	2025
The proportion of late diagnoses (either CD4<350 or AIDS during the first visit after HIV diagnosis)	50% ⁴	40%	<30%

2. Interventions for PLHIV

2.1. HIV treatment and counselling

Current situation

According to WHO recommendations published in 2015, HIV diagnosis must be followed by the package of services that support linkage to care and patient’s adherence to treatment [14, 23]. This includes, for example, the availability of case management and peer counselling services and raising awareness among healthcare professionals. Although it is important that patients are referred to care immediately after receiving HIV diagnosis (linkage to care), these people are often not linked to care in Estonia and go missing for the health care system. This can be tackled by implementing the guidelines for HIV-testing and referring PLHIV to care, which were established in 2012, but these guidelines have not been fully implemented in the health care system. According to WHO, this is most probably due to the lack of appropriate training and financial resources [29].

ART and other outpatient services provided by the infectious disease specialist are free of charge for all PLHIV (regardless of health insurance coverage) and only a standard visit fee is applied for these services. Starting from 2015, it is recommended to start with ART immediately after receiving HIV diagnosis, because people with suppressed viral load are minimally contagious [14]. As of the end of 2016, 5,439 HIV-positive patients were registered with infectious disease specialists, of whom only 3,941 (72%) received ART. The main reason why PLHIV registered with a doctor do not receive ART is the discontinuation of treatment. The proportion of persons who have recently started ART, but have discontinued treatment has been consistently high among treated persons being in the range of 5–12% in the period of 2011–2016. This proportion is even higher among the treatment-experienced patients (i.e. those who have been receiving ART for more than one year) being in the range of 12–16% in the period of 2011–2016 (ART council, unpublished data). Thus, low adherence to treatment resulting in discontinuation of ART is a common problem.

Free treatment is provided for all women and infants in need in order to prevent HIV transmission from mother to child. Because of that, the vertical spread of HIV is low in Estonia (0% in 2015 and 2016) [11].

⁴ ART consilium data.

In the context of ART, it is also important to monitor the prevalence of HIV drug resistance. The spread of drug resistance is often associated with the failure of ART. HIV drug resistance is evaluated in patients who receive ART and who are suspected to be resistant to a HIV drug and, in individual cases, in patients who do not receive ART, but are suspected to have received the infection from a person with drug resistant HIV. In 2016, 3% of PLHIV registered with a doctor were confirmed to be resistant to the HIV drug used to treat them (ART council, unpublished data). In order to plan the arrangement of ART and the scope of the HIV drug resistance monitoring more effectively, it is also important to monitor the prevalence of transmitted drug resistance. The prevalence of transmitted drug resistance has been monitored in Estonia in 2006, 2008, 2010 and 2013 when the prevalence was 0% [30], 5,5% [31], 4,5% [32] and 6,7% (University of Tartu, unpublished data).

Although the outpatient health care services provided by the infectious disease specialist are free of charge for all PLHIV (only standard visit fee is applied), the use of these services often leads to a socio-economic problem for many of the PLHIV. Very often the standard visit fee is left unpaid, which is most probably linked to the fact that many of the PLHIV belong to the key affected populations (see chapter 3.1) and their economic situation is often problematic [34]. As major hospitals use dept collection services to deal with the liabilities associated with unpaid visit fees, this is increasing the already substantial dept burden these people often have.

High priority measures

- Ensuring ART medication and treatment services for PLHIV (including people in detention facilities and people lacking health insurance) on the basis of commonly agreed clinical guidelines;
- Preventing the transmission of HIV from mother to child, including:
 - ✓ ART for pregnant women during pregnancy;
 - ✓ Prophylactic treatment of new-borns of mothers living with HIV;
 - ✓ Providing free breast milk substitute in order to prevent vertical transmission.
- Providing integrated ART and opioid substitution treatment;
- Case management service for PLHIV (including psychological, social and peer counselling services);
- Providing counselling services that support the mental health and social coping mechanisms of PLHIV and the people close to them;
- Identification, testing and counselling of people who have been exposed to HIV;
- Sexual health counselling for PLHIV;
- HIV drug resistance monitoring (including monitoring transmitted drug resistance).

Indicators

Table 3. Indicators for the treatment and counselling of PLHIV

Indicator	Baseline (2016)	2020	2025
The proportion of PLHIV who have started ART within 6 months after receiving the diagnosis from all HIV cases identified during the last 12 months	85% ⁵	90%	>90%
Vertical transmission of HIV	<0,01% ⁶	<0,01%	<0,01%
The proportion of transmitted resistance from all new HIV cases identified during the last 12 months	6,7% ⁷	<5%	<5%

⁵ E-HIV database data.

⁶ Health Board data.

⁷ Data from 2013. University of Tartu, unpublished data.

2.2. Prevention and treatment of HIV-associated infections

Current situation

An important part of HIV treatment is the diagnostics and treatment of HIV-associated infections such as tuberculosis, sexually transmitted infections (STIs) and viral hepatitis [14]. Based on the study carried out in 2013, it was found that the prevalence of STIs in PLHIV and registered with the infectious disease specialists was low (e.g, 1% prevalence of chlamydia). In addition, only 4% of the patients had suffered from tuberculosis during their lifetime. However, it emerged that the spread of viral hepatitis was high among PLHIV (about 20% had hepatitis B and about 71% had hepatitis C) [34].

In Estonia, outpatient infectious disease services are available free of charge to all PLHIV, regardless of health insurance coverage. This includes the diagnostics and treatment of tuberculosis, diagnostics of hepatitis B and C, and diagnostics of STIs. Diagnostics of hepatitis B and C and STIs is also available in anonymous HIV testing centres. Nevertheless, the prevalence of hepatitis B and C is high among PLHIV, and medicines to treat these conditions are only reimbursed to persons with health insurance (only in cases of chronic progressive hepatitis C, in which case, the drugs are reimbursed 100%). The exception are people in detention facilities who receive hepatitis C treatment according to necessity. Vaccination for Hepatitis B is available free of charge to newborns and, if necessary, to people in detention facilities.

HPV infections and pneumonia caused by *Streptococcus pneumonia* may also be considered as HIV-associated infections. There are vaccines against both pathogens, but these are not included in the national immunisation program and are not available free of charge. From 2018, the exception is HPV vaccine, which is included in the national immunisation program and will be free for schoolchildren at the age of 12 years.

High priority measures

- Diagnostics and treatment of people in detention facilities for tuberculosis, hepatitis B and C, and vaccination against hepatitis B, if necessary.
- Free diagnostics and treatment of STIs for PLHIV.
- Ensuring hepatitis B and C diagnostics for all people;
- Free vaccination for hepatitis B among PWID receiving substitution treatment for opioid dependence.

3. HIV prevention

3.1. Prevention of HIV among key affected populations

WHO recommendations for HIV prevention among all key affected populations include free condoms and lubricants, targeted interventions for harm reduction and behaviour change, HIV testing and treatment, treatment of HIV-associated infections and sexual and reproductive health services [14].

People who inject drugs

Current situation

It is estimated that there are 9,000 PWID in Estonia [12], residing mainly in Ida-Viru and Harju Counties. The use of previously used syringes has decreased, but this figure differs substantially by region (for example, in Tallinn 23% PWID had used previously used syringes during the last four weeks in 2013, but in Kohtla-Järve the figure was 1% in 2016) [16, 18].

The primary goal of harm reduction services is to reduce the risks related to drug abuse (including transmission of HIV and viral hepatitis) among PWID and in the general population. As of the end of 2016, harm reduction services were provided by nine organisations in Estonia. In total, there are 34 sites in different regions of Estonia, of which 15 were stationary centres and 20 were fieldwork. Most services are located in Harju and Ida-Viru Counties, but services are also provided in Tapa, Pärnu and Paide. In Estonia, there are nearly 6,000 visitors and more than 130,000 visits of harm reduction services per year. Every year over two million syringes (approximately 230 syringes per visitor) are distributed through harm reduction services to PWID (National Institute for Health Development, unpublished data).

In Estonia, the following services are provided at harm reduction centres:

- counselling (peer counselling, psychological, social, and legal counselling);
- health care advice: safer use and overdose prevention;
- distribution of clean syringes, needles and condoms free of charge;
- the collection and disposal of used syringes and needles;
- the provision of a life-saving drug (naloxone) to opioid using PWID and their close ones with an appropriate training to prevent overdose deaths;
- provision of hygiene, laundry services and clothing;
- early detection of infections (e.g HIV testing) and referral to health care services;
- motivating and referral to addiction treatment and rehabilitation services;
- prevention of unwanted pregnancies among women who use drugs.

High priority measures

The seven key interventions recommended by the European Centre for Disease Prevention and Control (ECDC) for the prevention of HIV and HIV-associated infections among PWID include provision of injection equipment, vaccination, addiction treatment, testing, treatment of communicable diseases, health promotion and targeted services [35].

Measures aimed at PWID in order to prevent the spread of HIV and HIV-associated infections are:

- Offering harm reduction services that meet the needs of the target group, i.e. syringe-exchange programmes, counselling services and injecting equipment (e.g. disinfecting supplies) and condoms (which includes training on safer injecting, mobile services and introducing pharmacy-based services);
- Offering opioid substitution treatment including with other medicines in addition to methadone (at least buprenorphine or buprenorphine in combination with naloxone) and introducing a pharmacy-based opioid substitution treatment service;
- Offering counselling on overdose prevention and implementing a community-based naloxone programme.
- Ensuring diagnostics and treatment of HIV and HIV-associated infections (see chapters 1 and 2).

Indicators

Table 4. HIV prevention indicators for PWID.

Indicator	Baseline (2016)	2020	2025
HIV prevalence among PWID [12]	48–55%	<55%	<55%
Proportion of HIV-infected PWID, who are aware of their HIV status [12]	88–93%	>90%	>95%

People involved in prostitution

Current situation

It is estimated that there are 700–1,000 PIP in Estonia, especially in Tallinn. The use of condoms by PIP during sex with clients is at a very high level (97% used condom the last time they had sex with a client and 94% used condom during every vaginal intercourse with clients over the last month). Sexual behaviour is more risky with sex partners who do not pay for sex than with clients [20].

Sexual health counselling is offered to PIP in Tallinn, Jõhvi and Tartu, free diagnostics and treatment of STIs is only available in Tallinn. Approximately 1,000 consultations are provided in a year, about 50 persons receive the services of diagnostics and treatment for STIs and approximately 40,000 condoms are distributed to PIP in a year (National Institute for Health Development, unpublished data).

High priority measures

- Sexual health counselling (including during outreach work) and distribution of condoms free of charge;
- Provision of STI diagnostics and treatment services (see chapter 2.2);
- HIV testing and treatment (see chapters 1 and 2.1).

Indicators

Table 5. HIV prevention indicators for PIP.

Indicator	Baseline (2016)	2020	2025
HIV prevalence among PIP [19, 20]	8–13%	<10%	<10%
Proportion of HIV-infected PIP, who are aware of their HIV status [20]	80%	85%	90%
STI prevalence among PIP [20]	1–5%	<5%	<5%

Men who have sex with men

Current situation

It is estimated that there are 9,000 MSM in Estonia. The level of risk behaviour is high and has not significantly decreased over the past three years [21]. Since 2009, the main activities targeted at MSM have been HIV testing (incl. rapid testing) in bars and clubs and sharing information materials, condoms and lubricants.

High priority measures

- Increasing the knowledge of MSM of HIV and its transmission pathways and distributing condoms and lubricants free of charge;
- HIV testing and treatment (see chapters 1 and 2.1).

Indicators

Table 6. HIV prevention indicators for MSM

Indicator	Baseline (2016)	2020	2025
HIV prevalence among MSM [12, 21]	2–4%	<5%	<5%
Proportion of HIV-infected MSM, who know their HIV status, from all the MSM [12]	80%	85%	90%

People in detention facilities

Current situation

In 2016, there were 2,658 prisoners in Estonia, from whom 370 were infected with HIV (14% of all the prisoners) and 325 persons received ART (88%). The proportion of HIV-infected prisoners on ART has increased over the years being 58% in 2013, 62% in 2014 and 79% in 2015 (Ministry of Justice, unpublished data).

HIV-testing and counselling is provided in all three Estonian prisons. People are tested upon imprisonment, one year after the last HIV-test and when there are medical indications that call for HIV testing. Testing is voluntary and therefore there are some, who have refused from the testing, but the proportion of these people is small (less than 1% of all prisoners). Upon refusal, these people are offered testing again after a while. All the necessary health care services (incl. ART) and counselling are provided for PLHIV in prisons. There are also support groups and psychological counselling available for PLHIV in prisons. HIV-testing, treatment and counselling are provided and monitored by the health care departments of the prisons.

In case of HIV-associated infections, hepatitis C testing and, when possible, treatment are provided to prisoners. People at risk of getting infected are tested for hepatitis B, and if needed, are provided with treatment and vaccination. Vaccinations are also provided to prison personnel. In order to prevent the spread of TB in prisons, all imprisoned people are screened with X-ray within five working days after imprisonment and the procedure is repeated once a year.

Methadone substitution treatment is provided for imprisoned PWID. From 2015, also naloxone program has been implemented with naloxone being provided to PWID upon release from the prison.

High priority measures

In addition to WHO's general measures outlined above, it is recommended that prisons also address the risks associated with tattooing and piercing [14].

- Raising awareness among prisoners of HIV, its transmission modes through counselling and improving the knowledge, life skills and attitudes that promote safe sexual behaviour;
- Distribution of condoms free of charge at long-term meetings;
- Ensuring diagnostics and treatment of HIV and HIV-associated infections (see chapter 2.2);
- HIV testing and treatment (see chapters 1 and 2.1);
- Free distribution of injecting equipment, condoms, etc. upon release from the prison.

Indicators

Table 7. HIV prevention indicators for people in detention facilities.

Indicator	Baseline (2016)	2020	2025
Proportion of PLHIV in prisons, who receive ART	88% ⁸	90%	>90%

3.2. Prevention and reduction of HIV-related stigma and discrimination in society

Current situation

At the beginning of the epidemic (2000–2001), 78% of new cases were diagnosed among the 15–24-year-olds, but in 2016, only 6% of new cases were registered in this age group. One of the reason why people who get infected with HIV are older than before may be the increase of the average age of PWID (and probably their sexual partners) and also a slight increase in the average age of new injectors. Another reason is the increase in the proportion of people infected heterosexually and their higher average age. In 2010, the average age for new HIV-infected person was 31.6 years, but in 2016, it was already 37.6 years [12].

Although young people have rather good knowledge of HIV and other STIs and increasing age correlates with better knowledge, condom use practices have not changed in casual relationships over the last ten years, and the proportion of young people who do not use a condom in casual relationships is still high [24, 36, 37]. There are no comprehensive data available on this subject for those older than 29 years of age.

Addressing sexual education, including HIV issues in schools occurs primarily within the framework of personal, social and health education, which is taught in schools in all grades according to the 2011 national curriculum. The national curriculum for primary and secondary education includes HIV as a separate topic in the second and third stage of education. The HIV topic in the same stages also involves issues related to drugs and sexual maturity. At the same time, the quality of the content being taught and the adequacy of the amount of studies have not been evaluated so far.

HIV prevention includes the implementation of the concept of sexual and reproductive health and rights of both men and women in order to reduce the stigma and discrimination by ensuring access to sex education and related information and services when implementing HIV prevention.

⁸ Ministry of Justice data

High priority measures

- Raising awareness about HIV and its transmission modes among the population and improving people's knowledge, life skills and attitudes that promote safe sexual behaviour, including:
 - ✓ implementation of WHO-approved health education quality standards and European sexual health standards in the education system;
 - ✓ communication activities for the entire population, with the emphasis on people aged 35 and above;
 - ✓ youth communication activities (including counselling on sexual health);
- Increasing the knowledge and skills of HIV-related professionals, including:
 - ✓ increasing the knowledge about HIV, its prevention, diagnostics and treatment options and harm reduction measures of the education, health and social workforce;
- STI diagnostics and treatment (free of charge, including for people who do not have health insurance) for the following target groups:
 - ✓ young people up to 26 years of age (in youth counselling centres);
 - ✓ key affected populations (see chapter 3.1).

3.3. Prophylactic (biomedical) interventions

Current situation

In addition to treating HIV infection, ART medicines can also be used to prevent HIV infection [38]. Based on the WHO recommendations, both pre-exposure (PrEP) and post-exposure (PEP) prophylactic treatment should be available for key affected populations (on voluntary basis) [14]. In Estonia, PEP is guaranteed to all those at occupational risk of getting HIV infection (treatment is paid for the employer). In case of non-occupational exposure to HIV, people need to pay for PEP by themselves (excluding victims of sexual abuse for whom the State provides the treatment). So far, PrEP has not been implemented in Estonia and there are no guidelines on how this treatment should be offered.

High priority measures

- Ensuring the availability of PEP;
- Ensuring the availability of PrEP and develop guidelines for PrEP;
- ART as prevention (ART to prevent the spread of infection among serodiscordant partners).

4. Surveillance, monitoring and evaluation

Current situation

HIV case monitoring (passive surveillance) is organised by the Health Board. Behavioural surveillance is organised mostly by the National Institute for Health Development who conducts prevalence studies among the main key affected populations together with the various research institutions and non-governmental organisations. The Estonian Infectious Diseases Society manages the HIV-positive patient database. All methods of data collection included in the aforementioned monitoring and surveillance activities are in need of improvement. In particular, registration of HIV transmission routes and identification of sexual partners of people who have acquired HIV hetero- or homosexually, biological surveillance among PIP and MSM, and the continuation of the HIV-positive patient database with the collection of data of all patients who seek treatment (currently, data is collected based on informed consent). In addition, data about the overall HIV prevalence among pregnant women is missing (only the

cases detected during the pregnancy are registered, but the number of HIV-infected pregnant women aware of their HIV status prior to pregnancy, is unknown).

High priority measures

- Surveillance of new HIV cases and HIV-associated infections;
- Biological and behavioural surveillance of HIV and HIV-associated infections among the key affected populations and general population;
- Processing of HIV-positive patients' data in the national information system;
- Monitoring and evaluation of interventions (e.g prevention, treatment and care).

Indicators

Table 8. Indicators of HIV surveillance and monitoring.

Indicator	Baseline (2016)	2020	2025
Proportion of new HIV cases with known transmission route from all the new cases registered during passive surveillance	72% ⁹	80%	85%
Proportion of new HIV cases with sexual transmission route, where the key affected population status of the sexual partner of the new HIV patient is known from all new HIV cases with sexual transmission route	12% ¹⁰	25%	40%

⁹ Health Board data.

¹⁰ Health Board data.

V. Definitions and Abbreviations

AIDS – acquired immune deficiency syndrome

ART – antiretroviral treatment, which purpose is to stop the replication of the virus and the resulting progress of HIV infection. As a rule, the therapy combines three or more different drugs that affect different stages of virus replication.

Drug resistance – the mutation of HIV in the organism of an HIV-infected person who is receiving ART; the consequence is resistance to the specific ART medicine taken by the person.

HIV – human immunodeficiency virus

HIV indicator disease – a disease or condition that indicates the need for HIV testing (as it may be caused by immunodeficiency resulting from HIV or it is often observed in PLHIV).

MSM – men who have sex with men.

New HIV case – means a person who has been diagnosed with HIV for the first time (after the diagnosis has been verified in the reference laboratory).

PEP – post-exposure prophylaxis. Taking ART medicines at the latest within 72 hours after possible exposure to HIV (e.g. sexual intercourse with a HIV-positive person, exposure to the infected person's blood, etc.) to prevent the spread of the virus in the body.

PIP – a person involved in prostitution who is paid money or traded goods for sexual favours on a regular basis or from time to time, regardless of whether the person consciously considers this activity a source of income.

PLHIV – people living with HIV.

PrEP – pre-exposure prophylaxis or using ART medicines on people who do not have HIV but are in high-risk of acquiring the disease to prevent them from being infected (e.g. sexual partners of PLHIV).

PWID – people who inject drugs, i.e. a person who injects illegal drugs or psychotropic substances intravenously, into muscle and/or skin.

Reproductive health – a state of complete physical, mental and social well-being, related to the reproductive system, its properties and functioning. Reproductive health thus means that the person can live a satisfying and safe sex life and is able to have children, as well as freely decide whether or not, when and how often they would like to have children. Consequently, the concept of reproductive health is wider than mere illness or poor health.

Serodiscordant partners – partners with different HIV status (i.e. one is infected with HIV and the other is not).

Sexual health – means sexuality-related state of physical, emotional, mental and social well-being. Sexual health presupposes a positive and respectful attitude towards sexuality and sexual relationships and the opportunity of enjoyable and safe sexual experiences, which lack coercion, discrimination and violence. It is necessary to respect, protect and implement everyone's sexual rights in order to achieve and maintain sexual health. Consequently, the concept of sexual health is wider than just a lack of disease, disability or disorder.

STI– sexually transmitted infection, which in this action plan includes, in particular, trichomoniasis, chlamydia, gonorrhoea and syphilis.

Transmitted drug resistance – infection with HIV that is already resistant to ART medicine(s); the outcome is the spread of drug resistance among treatment naïve patients.

Vertical HIV transmission – means transmission of HIV from the mother to the child during pregnancy, at the time of giving birth or during breastfeeding.

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Annex 1. Activities and Measures to Achieve a Steadily Decreasing Trend in HIV Transmission for 2017–2020 by Areas of Responsibility

Ministry of Social Affairs

	Measure/Activity	Outcome by 2020	Financial resources (EUR)					
			2017	2018	2019	2019 (supplementary budget) ¹¹	2020	2020 (supplementary budget) ¹²
1. HIV testing and diagnostics								
1.1.	The funding of HIV testing carried out by primary health care specialists is organised outside of their usual therapeutic fund	Primary health care specialists are guaranteed a budget for HIV testing separate from their usual therapeutic fund to allow testing to be carried out according to the guidelines for HIV-testing and referring PLHIV to care.	28,197 ¹³	100,000	150,000	-	200,000	-
1.2.	Providing HIV testing as a health care service (excluding primary health care centres) for all people (with and without health insurance)	HIV testing is guaranteed for all those in need.	277,301 ¹⁴	299,485	323,444	-	349,319	-
1.3.	Providing anonymous and voluntary HIV testing and counselling services, including central procurement of HIV rapid tests	HIV rapid tests are available for anonymous and voluntary HIV testing.	300,000	301,000	301,000	39,000	301,000	39,000
1.4.	Confirmatory diagnostics for HIV	All preliminary positive or un-conclusive HIV tests are confirmed.	Covered by the Health Board's general budget for the infectious diseases laboratory.					
1.5.	Evaluation of HIV antibody avidity	After the period of three years, the HIV antibody avidity has been analysed for new HIV cases with the aim of distinguishing the actual new HIV cases from previously infected people, but who have been unaware of their infection.	8,500 ¹⁵	-	-	-	-	12,500
2. Activities targeted at PLHIV								
2.1. HIV treatment and counselling								
2.1.1.	Elaboration of HIV treatment guidelines	HIV treatment guidelines are published and implemented.	35,000	-	-	-	-	-
2.1.2.	Ensuring ART medicines to PLHIV	ART medicines are available to all those in need.	10,427,000	15,427,000	15,427,000	-	15,427,000	-

¹¹ There is no financial cover for supplementary budget.

¹² There is no financial cover for supplementary budget.

¹³ The expenditure budget for the first eight months.

¹⁴ The expenditure budget for the first eight months.

¹⁵ Covered by scientific funds of University of Tartu and the National Institute for Health Development.

2.1.3.	Provision of outpatient health care services of infectious disease specialist for PLHIV	Outpatient health care services of infectious disease specialist are provided for all PLHIV in need of these services.	Covered by the Estonian Health Insurance Fund and the Ministry of Social Affairs.					
2.1.4.	Management of ART commission	All ART treatment centres are advised by the ART commission, consistent compliance with ART regimens is ensured and all drug resistance cases have been resolved.	11,000	13,579	13,579	-	13,579	-
2.1.5.	Transmitted drug resistance monitoring	Transferred ART medicines resistance is monitored after every three years.	8,600 ¹⁶	-	-	-	-	13,000
2.1.6.	The provision of integrated ART and opioid substitution treatment, including provision of the this service in every infectious diseases treatment centre based on the example of West Tallinn Central Hospital Infection Centre	Integrated services is available at least in Tallinn, Kohtla-Järve, Narva, Tartu and Pärnu.	100,000	150,000	150,000	50,000	150,000	50,000
2.1.7.	Ensuring case management services for PLHIV, including: - Nurse's appointments, psychological, social and peer counselling; - Finding patients who are lost for follow-up and encouraging them to continue the treatment by case management teams; - Contact tracing, partner notification and partner testing	Case management services are available at all infectious diseases treatment centres in a sufficient volume. The number of case managers has increased and there are no more than 250 patients per one case manager.	300,000	335,000	337,000	13,000	337,000	13,000
2.1.8.	Offering counselling services that support the mental health and social coping mechanisms of PLHIV and their close ones, including: - Offering psychological and social counselling to PLHIV and their close ones outside health care system; - Providing peer counselling services	The services are available at least in Tallinn / Harju County and Ida-Viru County.	30,000	30,000	30,000	45,000	30,000	45,000
2.1.9.	Offering free infant milk formula to mothers who are living with HIV	All mothers living with HIV receive infant feeding formula until the baby is 1 year old.	61,000	61,000	61,000	11,500	61,000	11,500
2.1.10.	Training and education of health care workers for identification of HIV infection (e.g diagnosis of indicator conditions) and referral of PLHIV to specialist care	Health care professionals (incl. primary health care specialists) have knowledge and experience to identify HIV infection and refer them to specialist care. Specialists are implementing their knowledge.	Covered under the activity no. 3.2.5.					
2.2. Prevention and treatment of HIV-associated infections								
2.2.1.	Hepatitis B and C and STI testing as part of health care services	Hepatitis B and C and STI testing is available free of charge for all PLHIV.	Covered under the activity no. 2.1.3.					

¹⁶ Covered by scientific funds of University of Tartu and the National Institute for Health Development.

2.2.2.	Hepatitis B and C testing in anonymous testing and counselling centres	Hepatitis B and C testing is available free of charge to everyone in need.	Covered under the activity no. 1.3.					
2.2.3	Ensuring diagnostics and treatment of STIs for people involved in prostitution	STI diagnostics and treatment are provided free of charge to people involved in prostitution at least in Tallinn and Ida-Viru County, as well as in other regions, if necessary.	Covered under the activity no. 3.1.1.					
2.2.4.	Organising STI testing for men who have sex with men	Offering regular HIV testing opportunities during the events with target audience of men who have sex with men.	5,000	5,000	5,000	5,000	5,000	5,000
2.2.5.	Offering Hepatitis B vaccination free of charge to people in opioid dependence substitution treatment	All patients in opioid substitution treatment are offered hepatitis B vaccination free of charge.	-	-	-	10,500	-	10,500
3. HIV prevention								
3.1. Prevention of HIV among key affected populations								
3.1.1.	HIV testing for people involved in prostitution, including: - HIV rapid testing outside the health care setting; - providing self- tests for key affected populations, who do not actively access the services	HIV testing is ensured as part of the services for people involved in prostitution, including rapid testing carried out by health care specialist and self-tests.	50,000	55,000	55,000	10,000	55,000	10,000
3.1.2.	Raising awareness among men who have sex with men about HIV, its transmission, and promoting life skills and attitudes that support safe sexual behaviour	The awareness among men having sex with men has increased.	Covered under the activity no. 2.2.4.					
3.1.3.	Providing harm reduction services and supplies (e.g. syringes, needles, disinfectants, condoms, etc.) that meet the needs of people who inject drugs, including: - expanding the service to Pärnu, Tartu and all the districts of Tallinn; - establishing mobile services and acquiring vehicles for this purpose; - procuring other disposable supplies (at least filters and distilled water) in addition to syringes, needles and condoms that are already procured; - involving pharmacies in providing the services	The following outcomes have been achieved: - at least 60% of the target group is covered with the services; - injecting equipment is provided according to the WHO, UNODC and UNAIDS recommendations – persistently at least 200 syringes (400 needles) per client per year, and providing other injecting supplies (filters, distilled water, heating vessel, disinfectant); - about 10 pharmacies have been included in providing the services with clean injecting equipment distributed through them; - in addition to existing locations, the services are available in at least Pärnu and Tartu and have been expanded to all the districts of Tallinn; - mobile harm reduction service has been implemented.	1,450,000	1,684,000	1,684,000	76,000	1,684,000	76,000

3.1.4.	Implementing a community-based naloxone programme in order to reduce deaths related to drug overdose, including: - naloxone training/counselling in all health care and social facilities that work with people who inject drugs; - involving pharmacies in providing the services	The following outcomes have been achieved: - at least 40% of people who inject opioid drugs have received instruction/counselling on naloxone use; - number of deaths due to drug overdose per year is consistently below 80.	30,000	30,000	30,000	40,000	30,000	40,000
3.1.5.	Ensuring opioid substitution treatment, including: - updating the clinical protocol for opioid substitution treatment; - improving the geographical availability of the service (including establishing treatment options in Pärnu and Maardu). - offering government-funded opioid substitution treatment with other medicines in addition to methadone (e.g. buprenorphine and buprenorphine in combination with naloxone) according to the updated clinical protocol of opioid addiction updated in 2017; - involving primary health care specialists in providing the service; - involving pharmacies in providing the service	The following outcomes have been achieved: - at least 30% of the target group is covered with the service; - about 10 pharmacies have been included in providing the service with substitution treatment being offered through them; - in addition to existing locations, the government-funded service is available in at least Pärnu and Tartu; - it is possible to prescribe buprenorphine and buprenorphine combined with naloxone in government-funded substitution treatment.	1,287,500	1,287,500	1,287,500	212,500	1,287,500	212,500
3.1.6.	Continuing opioid substitution treatment in detention houses	Opioid substitution treatment is available to persons in need in detention houses.	7,500	7,500	7,500	10,500	7,500	10,500
3.2. Prevention and reduction of HIV-related stigmatisation and discrimination in society								
3.2.1.	Raising awareness among population aged 30 and older about HIV and its transmission and shaping life skills and attitudes that support safe sexual behaviour	Awareness among 30-year-olds and older has increased.	110,000	110,000	110,000	-	110,000	-
3.2.2.	Raising awareness among population aged up to 30 years about HIV and its transmission, and shaping life skills and attitudes that support safe sexual behaviour	Awareness of young people has not declined.						

3.2.3.	Counselling young people (especially young men) on reproductive health, and diagnostics and treatment of STIs, including: - ensuring the service for young people aged 19–26 with and without health insurance; - online counselling on reproductive health for young people	STI testing and treatment, and counselling on reproductive health is provided to all young people in need of the services free of charge.	95,000	100,000	100,000	-	100,000	-
3.2.4.	Activities aimed at reducing HIV-related stigma and discrimination in the general population, including distributing the information through web-based channels and continuously updating information in www.hiv.ee	The general public has been informed about HIV related problems and issues (including through www.hiv.ee)	3,500	9,000	9,000	6,000	9,000	6,000
3.2.5.	Increasing knowledge among health care professionals about HIV, its transmission and treatment in order to reduce stigma and discrimination, including: - carrying out courses and informative events for different target groups; - distributing informative materials for different target groups	The knowledge of relevant healthcare professionals and social workers about HIV and its transmission has increased.	10,000	40,000	40,000	-	40,000	-
3.3. Prophylactic interventions								
3.3.1.	Providing post-exposure prophylaxis for the victims of sexual violence	Post-exposure prophylaxis is provided for all victims of sexual violence free of charge (if the following criteria are met: the doctor has completed the report on the victim's sexual abuse record, medicines are issued in accordance with the guidelines for medical care for victims of sexual violence and the evidence necessary for police investigation has been collected).	Covered under the activity no. 2.1.2.					
3.3.2.	Development of pre-exposure prophylaxis (PrEP) guidelines and ensuring access to PrEP	The treatment guidelines (incl. PrEP treatment) have been established and are implemented.	Covered under the activity no. 2.1.1.					
4. Surveillance, monitoring and assessment								
4.1.	Processing HIV-positive patients' data in the national information system	Clinical data of patients living with HIV are processed through the national information system.	15,000	15,000	15,000	385,000	15,000	15,000
4.2.	Biological and behavioural surveillance among key affected populations and general population	Surveillance plan is implemented, including HIV-prevalence studies among people who inject drugs (in at least three cities after minimum every four years); people involved in prostitution (at least once every 5 years); men who have sex with men (at least once every 3 years); and HIV behavioral	49,500	50,000	50,000	-	50,000	-

		study among general population at least once every 5 years.						
4.3.	Surveillance of new HIV cases	Data on HIV transmission mode is recorded for 85% of new HIV cases.	Covered by the Health Board's general budget.					
4.4.	Monitoring and assessment of interventions	Monitoring and evaluation covers all services and interventions financed and implemented by the National Institute for Health Development.	7,000	7,000	7,000	3,000	7,000	3,000

Ministry of Justice

	Measure/Activity	Outcome by 2020	Financial resources (EUR)			
			2017	2018	2019	2020
1. HIV testing and diagnostics						
1.6.	Testing prisoners for HIV upon arrival to prison and afterwards regularly once a year. Counselling and advising prisoners, who have tested positive for HIV and providing necessary health care services and treatment	All prisoners who had agreed to testing have been tested for HIV and prisoners who have been tested positive for HIV have received counselling.	170,000	185,000	200,000	215,000
2.1. HIV treatment and counselling						
2.1.10.	Prisoners living with HIV or suffering from AIDS are ensured necessary health care services and treatment (including ART) and counselling	Prisoners receive necessary health care services and medications, if needed.	ART is covered under the activity no. 2.1.2 and other health care services are covered by the medical budget of the prisons.			
2.1.11.	Prisoners living with HIV have access to support groups and psychological counselling	It is possible to take part in support groups and meet with a psychologist in prisons.	30,000	32,000	34,000	36,000
2.2. Prevention and treatment of HIV-associated infections						
2.2.6.	Performing a mandatory prophylactic chest X-ray for detection of tuberculosis upon arrival to prison and afterwards regularly once a year. Prisoners with TB receive necessary health care services and treatment	All prisoners have been screened for TB and prisoners diagnosed with TB have received necessary health care services and treatment.	20,000	22,000	24,000	26,000
2.2.7.	Hepatitis C testing and counselling is offered to prisoners belonging to hepatitis C risk group (people who inject drugs, PLHIV, people involved in prostitution, people with history of imprisonment and people aged 40 years and over, who have tattoos), who are not aware of their hepatitis C status, and who have not refused from testing. Confirmatory diagnostics, necessary health services and treatment are provided in case of a positive test result	Prisoners belonging to the risk group have been tested for hepatitis C and infected persons have received necessary health care services and treatment.	463,039	1,134,000	1,134,000	1,134,000
2.2.8.	Vaccination is provided for the prisoners belonging to the risk group of hepatitis B (people who inject drugs, PLHIV, people involved in prostitution), who have not been infected with the virus and have agreed to the vaccination	Risk group prisoners have been vaccinated.	10,000	11,000	12,000	14,000
3.1. Prevention of HIV among key affected populations						

3.1.7.	Raising awareness among prisoners about HIV and its transmission, and improve the knowledge, life skills and attitudes that promote safe sexual behaviour	The awareness of prisoners has not declined.	Covered by the general budget for medical staff in the prison budget system.			
3.1.8.	Ensuring condoms for long conjugal visits and increasing awareness about the prevention of infectious diseases among prisoners and their partners/wives/husbands	Condoms are available and awareness among prisoners and their partners/wives/husbands has increased.	1,000	1,100	1,100	1,200
4. Surveillance, monitoring and assessment						
4.5.	Prisons collect data on monthly basis on prisoners living with HIV and AIDS, hepatitis B and C (including data on how many prisoners have TB-HIV co-infection), and about testing and treatment (HIV, hepatitis B and C) carried out in prison settings	The prison system has an overview of performed tests and positive results on a monthly basis; this makes it possible to monitor trends and plan actions necessary for disease prevention and harm reduction. The prison system has an overview on the share of prisoners living with HIV and/or some other HIV-associated disease, what makes it possible to monitor trends and plan treatment needs.	Covered by the general budget for medical staff in the prison budget system.			

Ministry of Defence

	Measure/Activity	Outcome by 2020	Financial resources (EUR)			
			2017	2018	2019	2020
3.2. Prevention and reduction of HIV-related stigma and discrimination in society						
3.2.7.	Conducting training on HIV prevention and risk behaviours for conscripts	Every year, at least 750 conscripts have completed the training.	Funded by the US Cooperation Program.			

Ministry of the Interior

	Measure/Activity	Outcome by 2020	Financial resources (EUR)			
			2017	2018	2019	2020
2.1. HIV treatment and counselling						
2.1.2.	Ensuring the availability of necessary medicines (including ART, TB medicines, etc.) to patients located at detention houses with the help from the hospitals	The treatment of patients housed in detention houses continues after the arrest.	Covered under the activity no. 2.1.2.			
3.2. Prevention and reduction of HIV-related stigmatisation and discrimination in society						
3.2.8.	Providing the employees of the Police and Border Guard Board (PBGB) and the Rescue Board (RB) with knowledge on HIV and its transmission, personal protective equipment, and the options for diagnostics and treatment	The officials have the opportunity to take part in training sessions that provide information on HIV and its transmission, personal protective equipment, diagnostics and treatment options.	RB: 1,000	RB: 1,000	RB: 1,000	RB: 1,000
3.2.9.	Ensuring personal protective equipment to PBGP and RB officials who may be exposed to HIV	Personal protective equipment is available for the officials in need.	RB: 1,000 PBGB: 17,740	RB: 1,000 PBGB: 17,740	RB: 1,000 PBGB: 17,740	RB: 1,000 PBGB: 17,740
3.3. Prophylactic interventions						
3.3.3.	Ensuring PEP in the case of occupational HIV exposure	PEP is provided for all occupational HIV exposure cases.	Covered from PBGB budget for healthcare services and supplies of the staff.			