The Global Fund to Fight AIDS, Tuberculosis and Malaria

Geneva, July 2002

For the use of the Global Fund Secretariat: *Date Received:* *ID No:*

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully. When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

This form is divided into 4 main parts:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed.*

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seek details on the content of the proposal by different components.

How to use this form:

1. **Please read ALL questions carefully**. Specific instructions for answering the questions are provided.

2. Where appropriate, indications are given as to the approximate **length of the answer** to be provided. Please try, as much as possible, to respect these indications.

3. **All answers, unless specified otherwise, should be provided in the form**. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.

4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).

5. When **using tables**, all cells are automatically expanded as you write in them. Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.

   To copy tables, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.

   Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund.
TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information: *Table I.a*

<table>
<tr><td>Proposal title (Title should reflect scope of proposal):</td><td colspan="4">A National Partnership to Increase the Scale of Estonia's Response to a Concentrated and Rapidly Developing HIV/AIDS Epidemic.</td></tr>
<tr><td>Country or region covered:</td><td colspan="4">Estonia</td></tr>
<tr><td>Name of applicant:</td><td colspan="4">CCM Estonia</td></tr>
<tr><td rowspan="5">Constituencies represented in CCM (write the number of members from each Category):</td><td>6</td><td>Government – Health ministry</td><td>2</td><td>UN/Multilateral agency</td></tr>
<tr><td>4</td><td>Government – Other ministries</td><td>0</td><td>Bilateral agency</td></tr>
<tr><td>4</td><td>NGO/Community-based organizations</td><td>0</td><td>Academic/Educational Organizations</td></tr>
<tr><td>1</td><td>Private Sector</td><td>0</td><td>Religious/Faith groups</td></tr>
<tr><td>1</td><td>People living with HIV/TB/Malaria*</td><td>2</td><td>Other (please specify):
Local Govt/Municipality (1)
County Government (1)</td></tr>
<tr><td>If the proposal is NOT submitted through a CCM, briefly state why:</td><td colspan="4">N/A</td></tr>
</table>

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund****:** *Table I.b*

<table>
<tr><td colspan="3"></td><td colspan="6">Amount requested from the GF (USD thousands)</td></tr>
<tr><td colspan="3"></td><td>Year 1</td><td>Year 2</td><td>Year 3</td><td>Year 4</td><td>Year 5</td><td>Total</td></tr>
<tr><td rowspan="4">Component(s)

(mark with X):</td><td>x</td><td>HIV/AIDS</td><td>2 237</td><td>1 674</td><td>1 952</td><td>4 391</td><td>N/A</td><td>10 254</td></tr>
<tr><td></td><td>Tuberculosis</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Malaria</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>HIV/TB</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2"></td><td>Total</td><td>2 237</td><td>1 674</td><td>1 952</td><td>4 391</td><td>N/A</td><td>10 254</td></tr>
<tr><td colspan="3">Total funds from other sources for activities related to proposal</td><td>1 818</td><td>2 250</td><td>2 356</td><td>2 399</td><td>N/A</td><td>8 823</td></tr>
</table>

Please specify how you would like your proposal to be evaluated*** (mark with X):

The Proposal should be evaluated as a whole	**X**
The Proposal should be evaluated as separate components	

* According to national epidemiological profile/characteristics
** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.
*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief proposal summary (1 page)(please include quantitative information where possible)**:**

- **Describe the overall goals, objectives and broad activities per component, including expected results and timeframe for achieving these results:**

Estonia has the most rapidly spreading HIV epidemic in Europe. The country is responding vigorously but needs significant and immediate external investment if it is to respond as rapidly and effectively as possible. Estonia faces an HIV epidemic spreading at 10 times the rate in most Western European countries, yet has less than a third of the resources available to respond. The Estonian government, civil society and other players have joined together to plan an ambitious and results-focused program to respond to this epidemic. This program outlines practical steps by which the country can reach its goal of stopping the progressive spread of HIV/AIDS by 2007. This goal will be reached by focusing on eight objectives within four main areas. Highlights of these include:

- 9 broad activities aimed at reducing the risk behavior of young people and increasing their knowledge about HIV/AIDS
- introduction of ambitious harm reduction and substitution treatment programs reaching over 2000 new IDUs per year in the first two years
- activities focused on minimizing the harm faced by sex workers and reducing MTCT to under 2% within four years
- eliminating cases of HIV transmission in Estonia's prison system within four years
- increasing the availability of condoms specifically for MSM thirty-fold through 5 gay clubs and saunas in Estonia within the first year of the program starting
- increasing by fourfold the number of uninsured PLWHAs with access to essential health care within two years; at least fivefold increase in number of non-pregnant adults receiving ARVs within four years
- boosting significantly the capacity of the National AIDS program by recruiting five additional staff within the first year
- promoting a co-operative approach amongst all key players by establishing a 20 person broadly representative CCM in the first year

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

Estonia's HIV epidemic has spread most rapidly amongst IDUs and those aged 15-24. This program strategically targets services to reach them and other vulnerable groups, including sex workers, MSM and prisoners. The main benefit expected is a reduction in the rate in which HIV is spreading amongst IDUs and other vulnerable groups. Estonia's prison population is approximately 4 000. No accurate figures exist for numbers in some of the other groups although some estimate that Estonia has around 15 000 IDUs and approximately 5 000 active gay men. The program will seek to establish more accurate figures for these in the first year. Estonia already has over 2 500 known PLWHAs. This program targets improving medical and social services for them with the intended outcome of improving their quality of life. All of these planned benefits are contingent on the program successfully boosting national capacity and stimulating a truly co-operative response to Europe's most severe HIV/AIDS epidemic. The program will also benefit Estonia's general population and those in surrounding countries by effectively halting the spread of this epidemic.

- **If there are several components, describe the synergies, if any, expected from the combination of different components** (By *synergies*, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken individually):

This program only has one disease component. However, it will be implemented in close co-operation with the national TB control program. Elements of the program focused on improving health services to PLWHAs, both in and out of prison, will include early detection and treatment of TB, bringing tangible and real benefits to efforts to control the spread of TB in Estonia.

SECTION II: Information about the applicant

Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines para. II.8–33

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal *(Guidelines para. 14–15)*	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines para. 24–25)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines para. 24 and 26)*	
Sub-national CCM	Sub-national proposal *(Guidelines para. 27)*	1–9 and 11
Non-CCM	In-country proposal *(Guidelines para. 28–30)*	12 – 16
Regional Non-CCM	Regional proposal *(Guidelines para. 31)*	12 – 15 and 17

Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines para. 32)

Country Coordinating Mechanism (CCM), (Refer to *Guidelines paragraph 72–78)*

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	Yes
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:** Steps have been taken to change the composition of the CCM in two main ways. First, efforts have been made to draw in more senior political figures. For example, following a consultation with the Prime Minister, it has been agreed that the CCM will be chaired by the Minister of Social Affairs, who is responsible for health, social services and labor issues in Estonia. She will act as liaison between the CCM and the country's Cabinet, who have pledged to discuss HIV/AIDS four times per year. This process started in Spring 2002. Secondly, the CCM has been broadened out by including representatives from important NGOs and international agencies. This broadening of representation is conceived as an ongoing process. A first concrete step was taken by forming six 'writing groups' which each took responsibility for writing the relevant parts of this proposal relating to the first six objectives. Organizations represented in these writing groups have been asked to be part of the CCM and will be key implementers of the program.	

1. **Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

   CCM Estonia

2. **Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3)**:**
   Estonia's CCM is constructed on the basis of the existing HIV/AIDS Program Board. It has been extended along the lines outlined in table IIb c). The current Program Board was formed in March 2002 when Estonia started a new HIV/AIDS Program. Prior to that, the program had been overseen by a committee consisting mainly of people from within

the Ministry of Social Affairs.

3. **Describe the background and the process of forming the CCM** (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

   Estonia's CCM is built on the foundation of the National HIV/AIDS Prevention Program Board which is a well-established co-coordinating mechanism for Estonia's existing HIV/AIDS program. However, this body is being expanded to increase the seniority and representativeness of committee members. The Minister of Social Affairs has been invited to chair the CCM, after consultations with the Prime Minister. She is felt to be a suitable person for this role because she has a strong and active interest in Estonia's HIV epidemic, she has direct responsibility for the key areas of health, social affairs and labor and is an influential member of the country's cabinet. In addition, the representativeness of the committee has been increased by inclusion of representatives from NGOs and international agencies. These organizations were selected for their acknowledged roles in working on HIV/AIDS in the country and their recognized technical expertise in key areas covered by the proposal.

   3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programs implemented and results achieved (1 paragraph):

   The nine member board of the National HIV/AIDS Prevention Program for 2002-2006 consists of representatives from five ministries involved in program implementation, namely the Ministries of Social Affairs, Justice, Education, Defense and Internal Affairs. In addition there are representatives from county government[1], the medical profession, civil society organizations and people living with HIV/AIDS. The current program board was formed in March 2002 to coincide with the launching of the new prevention program (see Annex 1). Prior to that, the board was mainly composed of people from the health and social sectors. The board is responsible for supervising and giving technical advice to the program's lead organization, for developing the program's objectives, for improving planning processes and for dealing with development and management issues. For example, board members have played a key role in involving ministries other than Social Affairs in the response to HIV/AIDS. The functioning of the Board is governed by a set of operating rules (see Annex 2).

4. **Describe the organizational processes** (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

   This program will be organized at three levels (see Annex 3). The first level will be a committee representing all key sectors involved in responding to the HIV epidemic and closely linked to the Estonian Cabinet. This committee has been termed the CCM. A set of draft terms of reference is attached (Annex 4). These will be refined and developed into operating guidelines during the first few months of the program's operation. The CCM will have at least six 'task forces'. These will be responsible for each of the technical (first six) objectives within this program. They will be based on the six writing groups who put together the bulk of this proposal and will liaise with the three 'thematic' co-coordinators who will be based within an expanded and strengthened national program secretariat. The second level will be the national AIDS program secretariat, which will be the central management and co-ordination body of the program. Responsibility for this secretariat rests with the Ministry of Social Affairs. Currently, this secretariat is located within the Centre for Health Education and Promotion. More details of plans for this secretariat are contained in section VI of this proposal. The third level is the operational/implementation level which will be delegated to a range of different organizations from various sectors. These will be managed through the issuing of sub-

[1] In Estonia, there are 15 county governments which are part of the overall state government. This is distinct from the more than 200 local governments throughout Estonia. Municipalities are a form of local government.

contracts by the national AIDS program secretariat.

5. **Describe the mode of operation of the CCM (**e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

   It is proposed that the CCM would meet with approximately the same frequency as the current program board, that is 4-6 times per year. This board has met twice since its formation six months ago. Minutes of those two meetings are attached (Annex 5). The proposed role and responsibilities of the CCM are highlighted in the draft terms of reference (Annex 4). However, these have not yet been formally adopted by the CCM and may need to be revised and adapted during the first year of the program's operation.

6. **Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required** (1 paragraph):

   Enormous progress has been made in raising the profile of the CCM and increasing the representation and involvement of non-governmental organizations in its working. For example, a wide range of NGOs and governmental agencies were involved in the development of this proposal through the formation of six, objective-specific writing groups.
   This builds on the existing foundation of the AIDS Prevention Program Board. It is planned to continue these processes over the next year with particular focus on the private sector and academic institutions. Faith organizations have not been particularly active on health and HIV/AIDS and consequently their involvement is not prioritized at this stage. However, constructive engagement with faith organizations will be pursued by the CCM as opportunities arise. In addition to these plans at CCM level, the program will seek to draw in other organizations and local community structures. This is specifically provided for under objective 8 of this program (section 27.1).

7. **Members of the CCM** (*Guidelines para. II.16 – 22)*:

Please note: All representatives of organizations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.

Please print additional pages if necessary, including the following statement:

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Table II.7

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Social Affairs Government	Siiri Oviir	Minister of Social Affairs		
Main role in CCM				
Chair of CCM and contact person between CCM and senior political structures				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Health Protection Inspectorate Government	Kuulo Kutsar	Chief Epidemiologis t		
Main role in CCM				
Deputy Chair of CCM and current Chair of AIDS Program Board				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Social Affairs Government	Tiia Pertel	Chief Specialist of Public Health Department		
Main role in CCM				
Co-coordinator of AIDS Program within Ministry of Social Affairs				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
West-Tallinnn Central Hospital Local Government	Kai Zilmer	Chief Doctor		
Main role in CCM				
Chief doctor at West-Tallinn Central Hospital and has key role within CCM in giving advice on medical services for PLWHAs				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Justice Government	Elo Liebert	Adviser of Prisons Department		
Main role in CCM				
Representing Ministry of Justice with responsibility for HIV prevention and care within the prison system				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Internal Affairs Government	Tuuli Tang	Chief Specialist of Internal Security Analysis Department		
Main role in CCM				
Representing Ministry of Internal Affairs and responsible for reporting to the inter-ministerial Crime Prevention Board which has a particular interest in drug-related crime				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ida-Virumaa County Government County Government	Merike Peri	Head of Social Care and Health Care Department		
Main role in CCM				
Representative of East-Viru county government. East-Viru is the poorest county in Estonia, has a predominance of Russian-speaking population and was the place where the HIV epidemic was first recognized.				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
ESPO Society PLWHA Group	Vjatšeslav Vassiljev	President		
Main role in CCM				
Representative of PLWHA group/NGO. Key involvement in activities relating to provision of services focused on improving the quality of life of PLWHAs				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Defense Government	Teet Lainevee	Head of Health Care Department		
Main role in CCM				
Representing Ministry of Defense with responsibility for public health and health care issues within the military.				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Ministry of Education Government	Mart Kõrre	Specialist		
Main role in CCM				
Representing Ministry of Education with responsibility for HIV/AIDS within the Ministry of Education				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Estonian Centre for Health Education and Promotion Government	Aili Laasner	Director		
Main role in CCM				
Head of Estonian Centre for Health Education and Promotion which is proposed as the Principal Recipient of the grant and the host for the program’s secretariat				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
AIDS Prevention Centre Health Protection Inspectorate Government	Nelli Kalikova	Head of AIDS Prevention Centre		
Main role in CCM				
Representing AIDS Prevention Centre who are a key player in a number of elements of the prevention program including co-coordinating services to IDUs.				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

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Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
WHO International Intergovernmental Agency	Piret Laur	Representative		
Main role in CCM				
Representing WHO				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Council of Baltic Sea States Intergovernmental donor agency	Zaza Tseretelli	Representative		
Main role in CCM				
Representing Council of Baltic Sea States who are a funder of HIV/AIDS activities in the region				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Estonian Ministry of Social Affairs Government	Mari Järvelaid	Chief Specialist of Public Health Department		
Main role in CCM				
Co-coordinator of alcoholism and drug abuse prevention program within Ministry of Social Affairs				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
EGLA Arendus OÜ Private Sector	Silvar Laanemäe	Board member		
Main role in CCM				
Owner and general manager of Club 69 in Tallinn, aimed at gay men. Also active in Estonian Gay League. Key advisor to program on issues relating to MSM.				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Estonian Family Planning Association NGO	Mare Ainsaar	Board Member		
Main role in CCM				
Representing Estonian Family Planning Association who are one of the key implementers in the element of the program focused on children and young people				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Living For Tomorrow NGO	Sirle Blumberg	Head of the NGO		
Main role in CCM				
Representing Living for Tomorrow who are one of the key implementers in the element of the program focused on children and young people				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
Anti-AIDS Association NGO	Ljudmilla Priimägi	Chairperson of the Board		
Main role in CCM				
Representing Anti-AIDS Association who are a key implementer in the element of the program focused on children and young people				

Agency/Organization (including type*)	**Name of representative**	**Title**	**Date**	**Signature**
AIDS Information and Support Centre NGO	Jüri Kalikov	Head of the Centre		
Main role in CCM				
Representing AIDS Information and Support Centre who are a key implementer in the element of the program focused on sex workers				

* E.g. People living with HIV/ TB/ malaria, NGOs/ Community-based organisation, Private Sector, Religious/ Faith groups, Academic/ Educational Sector, Government Sector.

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history,scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	Alternate Chair/Vice-Chair
Name	Siiri Oviir	Kuulo Kutsar
Title	Minister of Social Affairs	Chief Epidemiologist Health Protection Inspectorate
Address	Goniori 29 Tallinn 15027 Estonia	Paldiski mnt. 81 Tallinn 10617 Estonia
Telephone	372-626-9701	372-694-3506
Fax	372-699-2209	372-694-3501
E-mail	Siiri.oviir@sm.ee	Kuulo.kutsar@terviskaitse.ee
Signature		

9. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.9

	Primary contact	Second contact
Name	Tiia Pertel	Aire Trummal
Title	Chief Specialist of the Public Health Department (Ministry of Social Affairs)	Manager of the National HIV/AIDS Prevention Program (Estonian Centre for Health Education and Promotion)
Address	Gonsiori 29 Tallinn, 15027 Estonia	Rüütli 24 Tallinn 10130 Estonia
Telephone	372-62-69-730	372 627 92 80
Fax	372-62-69-795	372-627-9281
E-mail	Tiia.Pertel@sm.ee	aire@tervis.ee

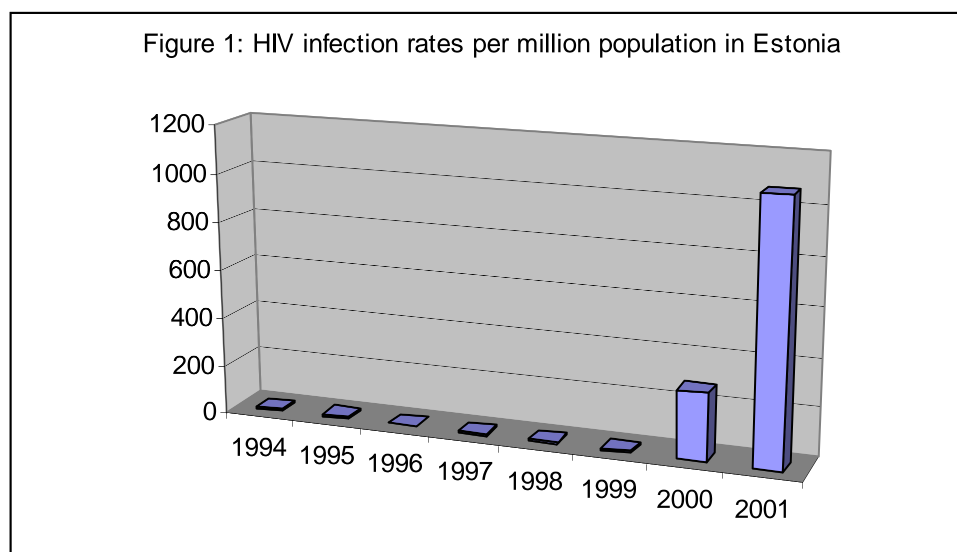
SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*
*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria: (Describe current epidemiological data on prevalence, incidence or magnitude of the epidemics; its current status or stage of the epidemics; major trends of the epidemics disaggregated by geographical locations and population groups, where this data is available and/or relevant; *Guidelines para. III.37 – 38),* (1 – 2 paragraphs per disease covered in proposal):

Since the second half of the year 2000, Estonia has experienced the fastest spreading HIV/AIDS epidemic in Europe. This has particularly affected young IDUs. From 1988, when registering of numbers of HIV infections started, to 1999, the HIV infection rate stayed low in Estonia (see figure 1). By 1999, there were only 8.5 people with HIV infection per one million inhabitants. However, the situation changed dramatically in the second half of 2000 with a marked increase in the number of injecting drug users attending for HIV testing. From September to December 2000, nearly 100 new people with HIV were identified each month amongst IDUs mostly in the border town of Narva. This town is in East-Viru County where the majority of the population are Russian speakers and there is widespread social deprivation. All together, 390 new people with HIV were registered during the year 2000. This raised the number of known people with HIV in Estonia to 279.4 cases per one million inhabitants. Of these, almost all (c90%) were known to be IDUs. The majority of these people were aged 15-24.

Figure 1: HIV infection rates per million population in Estonia

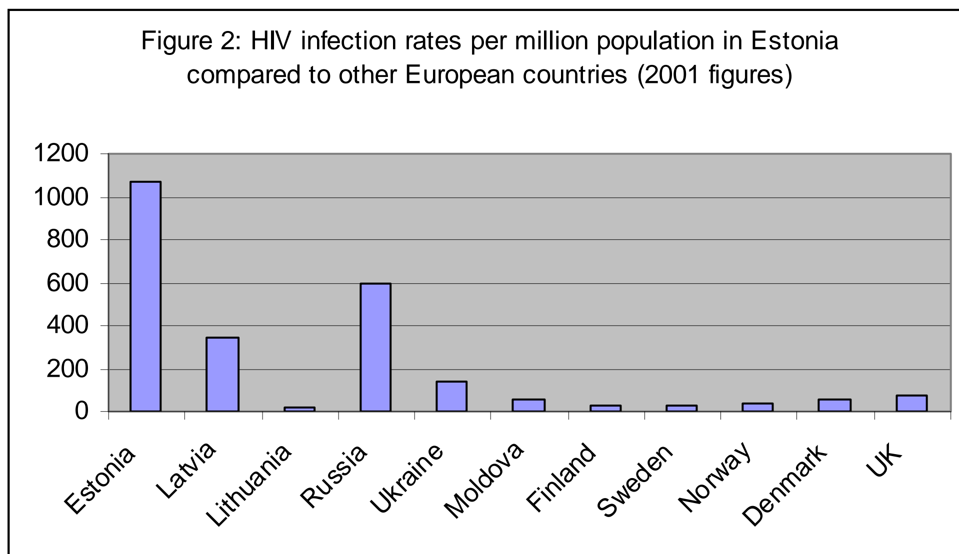


In 2001 the epidemic continued to spread amongst young IDUs. During 2001, 1474 new people with HIV were identified. This meant that by the end of 2001 there were 1960 known PLWHA in Estonia. According to the EuroHIV *HIV/AIDS Surveillance in Europe* end of year report (see Annex 6), Estonia had 1067.3 newly diagnosed HIV infections per million population by the end of 2001. This means that Estonia now has the highest HIV prevalence rate in Europe (Figure 2). This is almost twice the rate found in Russia, the country with the second highest rate and is more than ten times the rate in most countries in Western Europe. By the end of 2001, 77% of identified PLWHAs were 15-24

years old and three quarters were male. In February 2001, the Government of Estonia announced that the country had a concentrated HIV/AIDS epidemic as classified by UNAIDS/WHO. During the first half of 2002, 60-100 new people living with HIV/AIDS have been registered each month. The most vulnerable age group are young people from 15 to 24. This group constitutes 15% of the Estonian population. The epidemic that started in Narva has now spread to other towns in East-Viru County and to the capital city, Tallinn. The epidemic is particularly severe in Estonia's prisons where over 15% of prisoners were HIV positive at the end of 2001 (see table IV.26.1).

According to expert opinions, infection has slowly started to expand outside the population of IDUs through their sexual partners (who may not be injecting drug users themselves) and through sex work carried out by IDUs. Consequently, an increasing number of women are being found to be HIV positive making Mother To Child Transmission [MTCT] a real issue. In Estonia, all pregnant women are screened for HIV. During 2001, 49 women were found to be HIV positive. Of these, 16 delivered and 3 of these delivered HIV positive babies.

Figure 2: HIV infection rates per million population in Estonia compared to other European countries (2001 figures)



Estonia has decided to focus on HIV in this application because although TB has been a major problem in Estonia, significant progress has been made in this area through national and international initiatives. For example, DOTS programs now cover all the country. This expanded HIV program will link with these already expanded TB initiatives to effectively control both diseases.

19. Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases; *Guidelines para. III.39),* (1–2 paragraphs):

In global terms, Estonia has achieved high levels of human development. For example, in 1999, the country was ranked 44th in terms of human development, with an HDI of 0.812. Examples of these achievements would include life expectancy at birth of 70.8, adult literacy rates of 98% and total school enrolment figures of 81% (for more details see annex 12 or http://www.undp.ee/nhdr00/en/indicators.html). However, Estonia is still behind many Eastern European countries including Slovenia, Poland, Hungary, Slovakia and the Czech Republic. In addition, these benefits are not experienced by all parts of the Estonian population equally. The recent publication ***Social Inequalities in Health in Estonia*** (Annex 7) reveals, for example, marked inequalities between Russian and Estonian-speaking parts of the population. However, there is some evidence of improvement in these inequalities. For example, in 1995, the ratio of income of highest 20% to lowest 20% of households was 768 whereas in 1999, it was 566. Similarly, the

percentage share of income of the lowest 40% of households rose from 17 to 24% for the same period.

Although the national economic situation has improved, for example GDP per capita rose from US$5240 in 1997 to US$8355 in 1999, this remains at approximately one third of levels in most of Western Europe[2]. This is a key issue when considering the ability of Estonia to respond to its HIV epidemic. It has HIV infection rates which are ten times as great as most countries in Western Europe yet only one third of the resources available to it.

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.; *Guidelines para. III.40),* (1–2 paragraphs):

Estonia has responded to its HIV/AIDS epidemic with openness and commitment. The country has sought to make available HIV testing to those who want it, meaning that it has been possible to identify and track the epidemic as it has occurred. The country has been open about sharing these figures and in recognizing that much of the transmission is currently occurring through injecting drug use. The government has also demonstrated openness to work with emerging civil society and non-governmental organizations which themselves can be seen as evidence of community commitment to responding to the epidemic. In particular, the AIDS Prevention Centre (a government structure within the Health Protection Inspectorate) has engaged actively with such groups. The government has taken serious steps towards adopting progressive legislation and policies for responding to HIV/AIDS. For example, the government has taken on the responsibility of providing ARVs to all HIV positive pregnant women to prevent MTCT. In addition, the prison system has recently reduced punishments for injecting drug use and has permitted the distribution of condoms within prisons.

In addition, the government has established an expanded national program on HIV/AIDS for 2002-6. This program is overseen by the Ministry of Social Affairs but has sought to include and involve other ministries. The Minister of Social Affairs is enthusiastically committed to this program and is seen as a key figure within Cabinet on this issue. She has accepted the invitation to chair Estonia's CCM. In addition, the Prime Minister has demonstrated a keen personal interest in this issue. This is demonstrated by a number of recent press statements he has made (Annex 8). At a recent meeting between the Prime Minister and officials working with the National AIDS Prevention Program, he recognized the gravity of the situation and reported that the issue of HIV/AIDS would be discussed by Cabinet on a quarterly basis. The CCM will be expected to feed into these discussions through the chairperson, who will act as liaison between the CCM, on the one hand, and the Cabinet, on the other.

Local government, such as municipalities, in locations where the epidemic has been at its worst, e.g. Tallinn and Ida-Virumaa, have also reacted vigorously with finances and concrete action. For example, in 2001 Tallinn municipality contributed funds specifically for drug prevention programs.

21. Financial context

21.1. Indicate the percentage of the total government budget allocated to health*:

In 1998, 14.3% of total public expenditure was spent on health. In the same year, health expenditure comprised 6.0% of GDP. In 2001, health expenditure comprised 6.1% of GDP.

21.2. Indicate national health spending for 2001, or latest year available, in the Table III.21.2*:

Table III.21.2

[2] Figures for GNP per capita are much lower – US$3471 in 1999

	Total national health spending Specify year: **2000** (USD)	**Spending per capita** (USD)
Public	$252.4m	$183.79
Private	$74.5m	$54.49
Total	$326.9m	$239.00
From total, how much is from external donors?	$0.98m	$0.72

21.3. Specify in Table III.21.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)****:**

Table III.21.3

Total earmarked expenditures from government, external donors, etc. Specify Year: 2003	**In US dollars:**
HIV/AIDS	1.49m
Tuberculosis	
Malaria	
Total	

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives*, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)**:

No

22. National programmatic context

22.1. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.), (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

Although Estonia has a reasonably well-developed health system, it is not currently able to respond fully to the severe HIV epidemic it is facing without significant external investment. This requires some expansion of human resources and significant development of existing staff. For example, areas requiring staff development are both technical, such as medical treatment of IDUs and use of ARVs, and programmatic, such as financial and programmatic management and monitoring and evaluation.

Estonia's health system relies strongly on several central and local government structures. Consequently, at times, the response to HIV/AIDS has been hampered by a lack of clarity over who is responsible for what. The Ministry of Social Affairs has overall responsibility for the response to the HIV epidemic and employs a Co-coordinator of the National AIDS Prevention Program. This program is implemented by two groups based at different sites, at the Centre for Health Education and Promotion and the AIDS Prevention Centre. These bodies have not always been co-coordinated smoothly. In addition, although NGOs and other civil society organizations are developing to join the response to HIV, they are starting from a relatively low base.

Estonia already has a wide range of responses to the HIV epidemic it faces. Four areas of weakness have been identified. These are lack of sufficient prevention programs

* HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank
** Optional for NGOs

focused on the most vulnerable age group (age 15-24), prevention programs focused on other vulnerable groups, support and treatment programs for PLWHAs and the need for greater capacity and co-ordination amongst the organizations responding to the epidemic, including the need to increase the capacity to collect and analyze monitoring and evaluation data. This program has been designed to meet these needs. Two particular issues are of pressing priority for an effective response to the epidemic. These are the need for harm reduction and substitution treatment programs for IDUs and for initiatives increasing the access of PLWHAs to treatment.

Finally, Estonia has good and well-established systems for channeling domestic and external funds in a transparent and efficient manner. The availability of social funds within the country is limited. Particular concern has been expressed about the number of HIV positive people who do not have medical insurance. Extending services to include these people is a key feature of this program.

22.2. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes[**]:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period) 2002
Ministry of Social Affairs	Government	National HIV/AIDS Prevention Program Drug Abuse and Alcoholism Prevention Program	709,375 390,438
AIDS Prevention Centre[3]	Government	Key player in HIV prevention programs directly and through links with NGOs	Funded through national program
Centre for Health Education and Promotion[4]	Government	Responsible to Ministry of Social Affairs for delivery of national HIV prevention program	Funded through national program
Ministry of Justice	Government	HIV prevention in prisons	NK
West-Tallinn Central Hospital	Municipality	Provision of medical services to PLWHAs	Funded through national program
Estonian Health Insurance Fund	Government	Youth friendly services	247,000
ESPO Society	PLWHA Group	Self-help group for people living with HIV/AIDS	NK
AIDS Information and Support Centre	NGO	Prevention projects for sex workers and IDUs	NK
Anti-AIDS Association	NGO	Prevention projects for youth	NK
Estonian Gay League	NGO	Provides information services for MSM	NK
Living for Tomorrow	NGO	Working on exploring gendered approaches to HIV/AIDS amongst young people	NK

[**] For NGOs, specify here your own partner organizations

[3] The AIDS Prevention Centre functions as part of the Health Promotion Inspectorate a semi-autonomous organization which is under the Ministry of Social Affairs

[4] The Centre for Health Education and Promotion functions as a semi-autonomous organization. It is under the Ministry of Social Affairs

Estonian Family Planning Union	NGO	Prevention work with youth, 16 youth-friendly counseling rooms	c129 000
RAAAM	NGO	Forum Theatre	c100,000
Tallinn Municipality	Municipality	Needle exchange, health services and teacher training, helpline	65,675
Gambling Foundation	Foundation	Needle exchange	47,000
Family Health International	NGO	Work with youth	37,000 (over 2 years)
American Embassy	Bilateral	IDUs	36,000
Council of Baltic Sea States	Multilateral	IDUs	10,000 (these funds came from the Finnish government)
World Health Organization/UNAIDS	Multilateral	Provider of technical support on HIV/AIDS issues	NK

22.3. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

The underlying principle guiding the development of the proposal is that everything within it should strengthen and develop the current national program on HIV/AIDS. In particular, every effort has been made to ensure that this program does not duplicate existing efforts and that it does not result in establishment of parallel structures. Key foci of efforts to develop this capacity are the national program secretariat and implementation agencies, including NGOs.

The major gaps which this program will be responding to have been highlighted in section 22.1. These are the need for:

- prevention programs focused on those within and those approaching the most vulnerable age group, i.e. aged 15-24 and 10-14
- prevention programs focused on other vulnerable groups, including IDUs, sex workers, MSM and prisoners
- support and treatment programs for PLWHAs
- greater capacity and co-ordination amongst the organizations responding to the epidemic, with a particular focus on strengthening M&E capacity

This program has been designed to meet these needs. Within these, two particular issues are of pressing priority for an effective response to the epidemic, namely the need for harm reduction and substitution treatment programs for IDUs and for initiatives increasing the access of PLWHAs to treatment.

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X):		
	x	**HIV/AIDS**
		Tuberculosis
		Malaria
		HIV/TB

24. Provide a brief summary of the component (Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved) (2–3 paragraphs):

Estonia has the most rapidly spreading HIV epidemic in Europe (see section 18) and it has been recognized that a significantly scaled up approach is needed to respond to this effectively. This approach needs to include and involve all sectors within Estonia, including government, NGOs and the private sector. This program is designed to do this by having the goal of stopping the progressive spread of HIV/AIDS by 2007.

The program has four main areas of emphasis with a total of eight specified objectives. The four areas are:

- Prevention work with young people
- Prevention work with vulnerable groups including injecting drug users, sex workers, prisoners and men who have sex with men
- Services for people living with HIV/AIDS
- Building institutional capacity of and co-operation between participating organizations

The program will be overseen by the Estonian Country Coordinating Mechanism which is built on the foundation of the current HIV/AIDS Program Board. This Board has been extended to increase the seniority of members and to make it more representative, e.g. of civil society organizations. The program will be managed through the Ministry of Social Affairs, which will be the principal recipient for funds from the Global Fund to Fight AIDS, TB and Malaria. Objectives will be reached through a range of activities which will be

clustered into specific projects. These projects will be delivered and managed by a range of organizations, including NGOs and government with a strong track record of work in this field.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year)**:**	January 2003	**To** (month/year)**:**	December 2006

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programs within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national program and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

The overall goal of the program is to stop the progressive spread of HIV in Estonia by 2007. This goal ties in with the agreed goal towards which the current national HIV/AIDS program is working (see annex 1). However, it has been recognized that if this target is to be met, significant and immediate investment is needed to scale up efforts and to extend them into new areas, such as harm reduction programs for injecting drug users. This is the purpose of this proposed program. The program will link to other initiatives, such as the promotion of youth-friendly health services. These services are intended to have a major impact on sexually-transmitted infections through increasing health-seeking behavior relating to STIs and increasing the coverage of accessible and appropriate STI service delivery. A focus on STIs will also permeate activities with all vulnerable groups, for example in the proposed personalized case management system for IDUs.

Table IV.26.1

Goal:	*To stop the progressive spread of HIV in Estonia by 2007*		
Impact indicators		***Baseline***	***Target** (last year of proposal)*

(Refer to Annex II)	***Year: 2001***	***Year: 2006***
Percent of pregnant women aged 15-24 who are HIV infected	*49/16 533 i.e. 0.3%*	*0.3% or less*
Percent of infants born to HIV infected mother who are HIV infected	*3 babies out of 16 delivered to HIV positive mothers, i.e. 19%*	*Percentage – less than 2%*
Percent of IDUs who are HIV infected	*No baseline data as yet. This will be collected in the first six months of the program and targets set on this basis.*	
Percent of MSM who are HIV infected		
Percent of sex workers who are HIV infected		
Percent of prisoners who are HIV infected	*504 HIV positive prisoners out of a prison population of 3270, i.e. 15.4%*	*Total number – 600 or less Percentage – less than 11%*[5]
Percent of each target population (e.g. IDUs, MSM, sex workers, prisoners) with specific STIs	*No baseline data as yet. This will be collected in the first six months of the program and targets set on this basis.*	

27. Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programs within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national program and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

This program is focused on achieving eight specific objectives. These have been selected based on the need to focus efforts on vulnerable groups identified as most affected by/at risk of HIV/AIDS in Estonia. This has been done by means of a broad consultative process which has included not only all key players within Estonia, but has also drawn on external technical inputs, e.g. from UNAIDS and WHO. In addition, the program has incorporated feedback from GFATM that was received based on Estonia's submission to the first round of the Fund, in particular the inclusion of a large harm reduction component focused on IDUs.

The program's eight objectives are:

1. **To reduce risk behavior of adolescents and young people and to increase knowledge on HIV related issues among children and young people aged 10-24**. The expected outcomes within this objective are increased knowledge about HIV/AIDS amongst children and young people and increased condom use. Although a number of small studies have been done to collect baseline data, a larger baseline survey is planned for the start of this program.

Table IV.27

Objective 1:	*To reduce risk behavior of adolescents and young people and to increase knowledge on HIV related issues among children and young people aged 10-24*

[5] The prison population is one over which government, through the judicial system, has control. Consequently any changes in sentencing/release policy could affect this statistic markedly. The main foci within the prison system are on preventing spread within prisons and in providing care and support for PLWHAs

Outcome/coverage indicators	*Baseline*	*Targets*			
(Refer to Annex II)	*Year: '00*	*Year 2:*	*Year 3:*	*Year 4:*	*Year 5:*
Increased knowledge about HIV/AIDS amongst children aged 10-24	*No baseline data as yet. This will be collected in the first six months of the program and targets set on this basis.*				
Increased condom use	*47% - M 48% - F*[6]	*50%*	*55%*	*60%*	*65%*

2. **To reduce the risk of harm faced by injecting drug users aged under 25**. The expected outcomes within this objective are a reduction in the annual percentage of IDUs sharing injecting equipment and solutions from 50 to 20% and an increase in the percentage of IDUs reporting that they always used condoms over a period of one year from 15 to 50%.

Table IV.27

Objective 2:	*To reduce the risk of harm faced by injecting drug users aged under 25*				
Outcome/coverage indicators	*Baseline*	*Targets*			
(Refer to Annex II)	*Year: '01*	*Year 2:*	*Year 3:*	*Year 4:*	*Year 5:*
Reduction in the percentage of IDUs reporting sharing injecting equipment and solutions in the past twelve months	*50%*	*45%*	*40%*	*30%*	*20%*
An increase in the percentage of IDUs reporting that they always used condoms over a period of one year	*15%*[7]	*25%*	*35%*	*45%*	*50%*

3. **To reduce the risk of harm faced by female sex workers and to reduce the risk of vertical transmission of HIV**. The expected outcomes within this objective are to increase the number of sex workers/IDUs who report consistent condom use and no incidence of sharing injecting equipment or injecting solutions over the past six months. Baseline data needs to be established for these. In addition, it is expected to increase the percentage of female sex workers reporting consistent condom use with clients over the past six months.

Table IV.27

Objective 3:	*To reduce the risk of harm faced by female sex workers*				
Outcome/coverage indicators	*Baseline*	*Targets*			
(Refer to Annex II)	*Year: '99*	*Year 2:*	*Year 3:*	*Year 4:*	*Year 5:*
An increase in the number of sex workers/IDUs who report consistent condom use over the past six months	*400*[8]	*500*	*600*	*800*	*900*
An increase in the number of sex workers/IDUs who report no incidence of sharing injecting equipment or injecting solutions over the past six months.	*80%*	*80%*	*85%*	*90%*	*90%*
An increase in the percentage of female sex workers reporting consistent condom use with clients over the past six months.	*56%*	*50%*	*60%*	*70%*	*80%*

4. **To prevent HIV transmission in prison**. The specific outcome within this objective is to reduce the known number of people contracting HIV within prison per annum from two to zero. This outcome measure has been selected because of the difficulties of accurately ascertaining information on other possible

[6] This is based on data collected by the Estonian Centre for Health Education and Promotion in their biannual study conducted in Spring 2000 entitled *Health Behavior among Estonian Adult Population.* Figures reflect those young people aged 16-24 who answered 'almost always' or 'always' to a question about using condom 'if having more than one sexual partner'

[7] Data collected from survey conducted by needle exchange programs

[8] Data supplied by AIDS Information and Support Center

outcome measures, such as condom use and behavior relating to injecting drugs in the prison setting.

Table IV.27

Objective 4:	*To prevent HIV transmission in prison*				
Outcome/coverage indicators	***Baseline***	***Targets***			
(Refer to Annex II)	***Year: '01***	***Year 2:***	***Year 3:***	***Year 4:***	***Year 5:***
A reduction in the number of prisoners known to have contracted HIV whilst in prison	*2*[9]	*0*	*0*	*0*	*0*

5. **To reduce the risk behavior of men who have sex with men and to increase their knowledge on HIV related issues**. Specific outcomes within this objective include increasing the number of MSM who report always using condoms during penetrative sex during the last six months, increasing the percentage of MSM with correct beliefs about HIV/AIDS. Baseline data needs to be collected on these outcome indicators. Data will also be sought as to the extent of injecting drug use amongst MSM. This data will be reviewed by the task force on MSM and appropriate actions planned.

Table IV.27

Objective 5:	*To reduce the risk behavior of men who have sex with men and to increase their knowledge on HIV related issues*				
Outcome/coverage indicators	***Baseline***	***Targets***			
(Refer to Annex II)	***Year:***	***Year 2:***	***Year 3:***	***Year 4:***	***Year 5:***
Increasing the number of MSM who report always using condoms during penetrative sex during the last six months	*No baseline data as yet. This will be collected in the first six months of the program and targets set on this basis.*				
Increasing the percentage of MSM with correct beliefs about HIV/AIDS					

6. **To improve the quality of life of people living with HIV/AIDS by improving access to social support and health care**. The importance of this objective is recognized in the program's overall goal. Specific outcomes in this area include increasing the number of PLWHAs receiving regular health services from 400 to 2500, increasing the percentage of known PLWHAs receiving regular health services from 15-50% and increasing the number of PLWHAs receiving ARVs from 44 to between 250-500[10]. However, this element will not only focus on medical services for PLWHAs but on reduction of stigma and access to other services (e.g. social, legal) etc.

Table IV.27

Objective 6:	*To improve the quality of life of people living with HIV/AIDS by improving access to social support and health care*				
Outcome/coverage indicators	***Baseline***	***Targets***			
(Refer to Annex II)	***Year: '01***[11]	***Year 2:***	***Year 3:***	***Year 4:***	***Year 5:***

[9] Data supplied by Ministry of Justice – targets may need revising in light of baseline survey data

[10] Please note: One of the most contentious issues in developing this proposal has been trying to estimate the number of adult, non-pregnant PLWHAs who might need ARVs over the lifetime of the project. Currently, the Estonian government provides treatment for 50 and is committed to increasing this to 105 by 2007. However, given Estonia's current HIV infection rates, this is likely to be inadequate. Estimates vary hugely from as view as 250 to as many as 1000. For the purposes of this program it is intended to provide ARVs to at least 250 PLWHAs by 2007, but the budget contains provision for increasing this up to 500 if needed.

[11] Data supplied by West-Tallinn Central Hospital

An increase in: • the number of PLWHAs receiving regular health services • the percentage of known PLWHAs receiving regular health services • the number of PLWHAs receiving ARVs	*400* *15%* *44*	*900* *30%* *60*	*1400* *40%* *90*	*1900* *48%* *120*	*2500* *50%* *250-500*
Percentage of PLWHAs reporting an improvement in self-assessed quality of life scores	*No baseline date. This will be collected in first six months of program.*				

7. **To increase the institutional capacity of organizations taking part in the program, now and in the future, to effectively meet the objectives and goal of this program**. Specific outcomes within this objective are that all organizations who are part of the program are able to carry out their responsibilities with respect to financial and narrative reporting and monitoring and evaluation of activity level on time and to the required standards. However, the focus of this element goes well beyond this specific outcome and seeks to contribute to increased capacity in all key sectors, e.g. health, education, NGOs etc. Within Estonia, a key emphasis is on building capacity in the non-health sector which has been the focus of most response to date. This builds on the current direction of the national HIV prevention program.

Table IV.27

Objective 7:	*To increase the institutional capacity of organizations taking part in the program, now and in the future, to effectively meet the objectives and goal of this program*				
Outcome/coverage indicators (Refer to Annex II)	***Baseline*** ***Year:***	***Targets*** ***Year 2:***	***Year 3:***	***Year 4:***	***Year 5:***
Coverage of vulnerable sub-groups with programs specifically targeted towards their needs	*No baseline data as yet. This will be collected in the first six months of the program and targets set on this basis.*				
Number of organizations who are part of the program who are able to carry out their responsibilities with respect to financial and narrative reporting and monitoring and evaluation of activity level on time and to the required standards					

8. **To build consensus and cooperation amongst participating organizations so that the program can be effectively co-coordinated and delivered**. The specific outcomes in this area are that the percentage of participating organizations within CCM express satisfaction with the functioning of this body remains over 90%. There is currently no baseline data for this.

Table IV.27

Objective 8:	*To build consensus and cooperation amongst organizations taking part in the program, now and in the future, so that the program can be effectively co-coordinated and delivered*				
Outcome/coverage indicators (Refer to Annex II)	***Baseline*** ***Year:***	***Targets*** ***Year 2:***	***Year 3:***	***Year 4:***	***Year 5:***
The percentage of organizations identified as key stakeholders in the program who are satisfied with the activities of the program and their involvement in it	*No baseline data as yet. This will be collected in the first*				

The percentage of members of CCM and other key stakeholders expressing satisfaction with the functioning of this body	*six months of the program and targets set on this basis.*

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

> *Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.*
>
> *Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.*
>
> *For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.*

It is proposed to reach objective 1 through a wide range of activities carried out mainly by a number of NGOs who work directly with children and young people using a range of methods which are innovative and creative in nature and include young people as active participants in the activities and associated processes.

Living for Tomorrow is an NGO which works with young people through an intensive eight week training course which takes a group of 30 (15 male and 15 female) through a process which explores how gender relations affect sexual health. This process is followed up with support after the training course as the main focus is not on the training alone but on the group of trained young people being involved in challenging social norms after the training has been concluded. During the period of the program, it is proposed to conduct seven courses in different towns/cities of Estonia (Tallinn, Viljandi, East Virumaa, Pärnu, Tartu, Võru and Paide). The process is based on the experience of the Living for Tomorrow action research project which was implemented between 1998 to 2000 with support from the Nordic Institute for Women's Studies and Gender Research. This experience is documented in the book *Challenging Gender Issues: Report on findings from the Living for Tomorrow Project about young people's attitudes to men, women and sex* (Annex 11).

Activities 2-4 focus on training and educating three groups of people who have been identified as key in controlling the spread of HIV/AIDS, namely young people themselves in two settings (schools and on recruitment to the military) and an influential group of school teachers. This training not only focuses on provision of information but also on seeking to assist young people to set personal health goals and to gain skills which help them to reach these goals. Based on experience of these courses, it has been decided to scale up the delivery of courses to young people in both schools and the military whilst focusing in more depth on smaller groups of teachers.

The fifth activity will seek to mainstream HIV/AIDS prevention and support activities into the work of the 15 existing family planning counseling centers throughout Estonia. This activity incorporates a spectrum of different activities which will be delivered at and from these bases, including training, information provision, condom provision etc. The program will also improve and strengthen the collection and sharing of data by providing a shared database linking the 15 centers together.

The sixth activity will seek to actively involve young people in efforts to prevent HIV/AIDS in Estonia by training and supporting them to work as peer educators with other young people, for example in schools and in summer camps.

The seventh activity will include a wide range of activities focused on raising public awareness of HIV/AIDS amongst the population, in general, and amongst young people,

in particular. This activity encompasses activities such as provision of information materials, social advertising, media campaigns, posters, lectures etc.

The eighth activity seeks to provide counseling services to young people through the Internet. This service has been operating in a small way and demand for this service is rapidly increasing because young people have increasing access to these services and appear to value the anonymity that seeking support in this way provides.

The ninth activity is focused on the Russian-speaking minority within Estonia. It has been planned on the basis of findings from the 'KISS' study conducted in 1999 (KISS is an acronym for the Estonian words for growing up, human relations, friends and sexuality) which demonstrated the need for young Russian-speaking people to be empowered to behave in ways which promote sexual health by increasing their knowledge and social skills (see Annex 10). Forum Theatre has been selected as an appropriate tool to allow young people to explore important and sensitive topics relating to sexual behavior such as communication, self-esteem, peer pressure, substance abuse, condom use etc.

Table IV.27.1

Objective 1:	*To reduce risk behavior of adolescents and young people and to increase knowledge on HIV related issues among children and young people aged 10-24*				
Broad activities	**Process/Output indicators** *(indicate one per activity)* (Refer to Annex II)	**Baseline** ***(Specify year '02)***	**Targets**		**Responsible/Implementing agency or agencies**
			Year 1	***Year 2***	
To mobilize young people as volunteers and peer educators through the Living for Tomorrow *program*	*No. of centers* *No. of YP trained* *No. of YP as volunteers* *No. of YP as peer educators*	*2* *60* *30* *8*	*3* *90* *40* *12*	*5* *150* *60* *20*	*Living for Tomorrow*
To educate school children concerning HIV prevention	*No. of workshops* *No. of participants*	*136* *2060*	*200* *3000*	*200* *3000*	*Anti-AIDS Association, Ministry of Education*
To educate teachers concerning HIV prevention	*No. of sessions* *No. of participants*	*16* *237*	*8* *120*	*8* *120*	*Anti-AIDS Association, Ministry of Education*
To educate recruits to the military about HIV prevention	*No. of workshops* *No. of participants*	*30* *596*	*90* *1500*	*90* *1500*	*Anti-AIDS Association, Ministry of Defence*
To incorporate HIV prevention and support activities into the 15 family planning youth counseling centers throughout the country	*No. of young people receiving individual HIV-related counseling*	*6050 in first six months of 2002*	*15000*	*20000*	*Estonian Family Planning Association*
Training and supporting youth peer education programs	*No. of trained peer educators*	*13*	*28*	*28*	*Estonian Family Planning Association*
To conduct public awareness campaigns/social advertising	*No. of promotional activities and campaigns*	*4*	*12*	*12*	*Estonian Family Planning Association/AIDS Prevention Center/Futura/AIDS Information and Support Center/Living for Tomorrow/Ministry of Social Affairs*
To provide counseling services to young people through the Internet	*No. of young people accessing these services*	*369 (2001)*	*1000*	*1000*	*Estonian Family Planning Association*

To use Forum Theatre to communicate about HIV/AIDS in Russian-speaking schools in Estonia	*No. of performances*	*40*	*56*	*56*	*NGO RAAAM*

Objective 2 is particularly important because of the nature of the epidemic in Estonia which has particularly spread amongst people who use drugs. It is also responsive to feedback received from the Fund during the first round of applications where it was pointed out that consideration should be given to inclusion of a harm reduction program focused on the needs of IDUs. This has now been done. This objective will be reached by implementing six broad activities. Implementation will be a range of organizations working co-operatively, including governmental and non-governmental agencies.

One of the key activities within this objective is the scaling up of needle exchange programs throughout the country. These will focus on providing IDUs with sterile needles and associated consumables reducing the need for them to share injecting equipment and injecting solutions. In addition to the indicators specified programs will establish systems for monitoring 'retention rates', i.e. the number of IDUs who attend regularly over time.

The needle exchange activities will be supported by an expansion of drop-in centers and outreach services for IDUs. These services will seek to provide IDUs with a broad and responsive range of services which will support the provision of sterile needles and related commodities.

All activities will be implemented with the active involvement of IDUs themselves. In particular, it is proposed to expand the number of projects working with IDUs as peer educators. These peer educators will seek to work with other IDUs to discuss issues relating to reducing the harm of injecting drug use more broadly with a specific focus on HIV prevention.

Another key activity is the dramatic expansion of services offering substitution treatment with methadone for IDUs. Again this is responsive to the feedback given from the submission to the first round of GFATM. This activity along with the expansion of needle exchange programs are seen as the two central pillars on which achievement of this objective rests.

Fifthly, it is proposed to underpin the delivery of services for IDUs by establishing a system of individualized case management through which each IDU would deal with an individual case manager who would liaise with all the different institutions providing services and would ensure that the individual user was aware of all the various services available. Particular emphasis would be placed on a client-centered approach aimed at maximizing uptake of available services. This would involve the case manager liaising with a wide range of organizations, including for example the police and the prison system.

The final activity focuses on training providers of health services to work supportively and constructively with IDUs. Many IDUs have faced considerable stigma and discrimination. The training will focus on ways of working with the IDU in a way which affirms and respects their human dignity.

Table IV.27.1

Objective 2: *To reduce the risk of harm faced by injecting drug users aged under 25*					
Broad activities	***Process/Output indicators*** *(indicate one per activity)* (Refer to Annex II)	***Baseline (Specify year '01)***	***Targets***		***Responsible/Implementing Agency or agencies***
			Year 1	***Year 2***	
Establishment of needle exchange programs for IDUs in Estonia	*No. of centers* *No. of new clients*	*8* *3000*	*10* *2000*	*12* *2000*	AIDS Information and Support Centre (NGO), Rehabilitation Centre for Alcoholics and Drug Addicts of Narva (NGO), municipalities

Provision of drop-in centers and outreach services for IDUs	*No. of drop-in centers* *No. of IDUs visiting centers* *No. of outreach programs* *No. of IDUs using outreach programs*	*2* *250* *4* *500*	*3* *300* *6* *700*	*5* *400* *8* *800*	AIDS Information and Support Centre (NGO), Rehabilitation Centre for Alcoholics and Drug Addicts of Narva (NGO), municipalities, local NGOs
Establishment and implementation of peer education projects for IDUs	*No. of projects* *No. of IDUs as peer educators*	*2* *10*	*4* *20*	*6* *30*	*AIDS Information and Support Centre (NGO), Rehabilitation Centre for Alcoholics and Drug Addicts of Narva (NGO), municipalities, local NGOs*
Provision of methadone maintenance/ substitution treatment to IDUs	*No. of IDUs in methadone programs*	*10*	*50*	*100*	National Prevention Program for Alcohol and Drug Addiction, West-Tallinn Hospital, municipalities, local NGOs, General Practitioners
Establishment of a continuum of care for rehabilitation of IDUs based on the principles of case management, including the establishment of rehabilitation centers and day centers	*No. of case-managed clients* *No. of rehabilitation centers* *No. of clients* *No. of day centers* *No. of clients*	*0* *3* *15* *2* *80*	*75* *3* *25* *2* *150*	*150* *4* *40* *3* *250*	AIDS Information and Support Centre (NGO), National Prevention Program for Alcohol and Drug Addiction, ESPO Society, hospitals, HIV prevention and drug treatment centers, prisons, MOJ, police departments, MIA, municipalities, local NGOs
Provision of training for health professionals in how to approach and manage IDUs	*No. of health professionals trained on methadone treatment*	*N/A*	*5*	*10*	AIDS Information and Support Centre (NGO), National Prevention Program for Alcohol and Drug Addiction, Merimetsa Hospital, ESPO Society, HIV prevention and drug treatment centers

Objective 3 will be achieved with a combination of seven broad activities focused on the needs of women working as sex workers in Estonia.

The first activity is to provide voluntary counseling and testing services to sex workers. It is proposed that this service would not only focus on HIV/AIDS but also on other STIs. Through referral systems, sex workers found to be HIV positive or to have another STI would have access to appropriate treatment through governmental and non-governmental service providers, including antiretrovirals where appropriate. The Estonian government already has a well-established system for the provision of antiretrovirals for pregnant women for the prevention of MTCT. However, this program would seek to extend this provision to non-pregnant women who require such treatment.

The second activity would support the first in providing a range of professional consultative services for sex workers. These would include a range of medical specialities, including venereology, gynecology etc. and non-medical services such as legal consultations.

The third activity is the promotion of safer sexual practices amongst sex workers. A key part of this activity is the provision of condoms and lubricants to sex workers. This will be supported by distribution of appropriate literature on safer sexual practices.

The fourth activity will be focused on providing a 'safe space' for sex workers over which they feel a sense of ownership through the provision of drop-in facilities. Such drop-in centers will include practical facilities, such as opportunity to wash clothes, shower, food etc. and opportunity to meet informally with others,

A key problem faced by sex workers is the negative perceptions of them within society and the resultant stigma and discrimination that they face. The fifth activity will seek to address this by attempting to promote more positive and supportive messages in the national media and actively engaging with incidents of discriminatory and hostile reporting. This activity will focus on the basic human rights of sex workers and their views and perspectives.

Although the AIDS Information and Prevention Centre will play a lead role in the delivery of activities within this objective, it will network with other organizations within Estonia and externally. The focus of such interactions will be promoting approaches amongst other agencies which treat sex workers with dignity and respect. There will be a specific focus on providers of social/health services and other elements of this program, e.g. services for IDUs. In addition, the Centre will network with international agencies for the purpose of receiving and sharing learning through the hosting and making of visits from/to appropriate projects in other countries.

Although activities will be mainly focused on Tallinn because this is where most sex workers are based, outreach activities will take place to two other cities, Narva and Pärnu. These cities have been selected because Narva is home to an estimated 35% of the sex workers in Estonia and Pärnu is a tourist resort and a focus for sex work during the summer months.

Table IV.27.1

Objective 3:	*To reduce the risk of harm faced by female sex workers and to reduce the risk of vertical transmission of HIV*				
Broad activities	***Process/Output indicators*** *(indicate one per activity)* (Refer to Annex II)	***Baseline (Specify year '99)***	***Targets***		***Responsible/Implementing agency or agencies***
			Year 1	***Year 2***	
Voluntary counseling and testing services	*No. of sex workers receiving counseling and testing*	*700*	*800*	*900*	AIDS Information and Support Centre (NGO)
Provision of medical and psychological consultations	*No. of sex workers attending such consultations*	*500*	*500*	*700*	AIDS Information and Support Centre (NGO)
Promotion of safer sex through distribution of condoms, lubricants and appropriate literature	*No. of condoms distributed* *No. of leaflets distributed*	*7000* *2400*	*9000* *2400*	*12000* *3200*	*AIDS Information and Support Centre (NGO)*
Provision of drop-in centers	*No. of sex workers using these services*	*700*	*700*	*900*	AIDS Information and Support Centre (NGO)
Advocacy work with mass media promoting the rights and perspectives of sex workers	*No. of media articles*	*20*	*20*	*30*	AIDS Information and Support Centre (NGO)/ Institute of Human Rights
Peer Education Programs	*No. of sex workers acting as peer educators*	*14*	*10*	*20*	AIDS Information and Support Centre (NGO)
Networking with other organizations nationally and internationally	*No. of meetings attended*	*10*	*10*	*20*	AIDS Information and Support Centre (NGO)
Outreach activities to cities of Narva and Pärnu	*No. of sex workers reached by these services*	*50*	*100*	*150*	AIDS Information and Support Centre (NGO)

Objective 4 focuses on prisoners and is particularly important because of the high number of HIV positive prisoners in Estonian jails. Currently, there are 544 known HIV positive prisoners within the Estonian prison system, which represents over 10% of all prisoners. Because of this high number, prevention of HIV transmission within prisons has been recognized as a priority. Eight broad activities are proposed within this objective.

The first activity is promotion of voluntary counseling and testing for prisoners. The purpose for this is to allow those prisoners who are HIV positive to be identified so that they can receive appropriate treatment under this program, including where appropriate access to ARVs.

The second activity supports the first and is focused on provision of training on HIV prevention delivered to both staff and prisoners. Although the focus of this training is on HIV prevention it also highlights the need for positive and supportive attitudes towards people with HIV.

Activities 3-6 are described more fully in other parts of this proposal, e.g. in the section relating to IDUs. These consist of providing methadone substitution treatment for prisoners who inject drugs, providing condoms to those prisoners who are unable to buy them through prison shops, providing disinfectant for the cleaning/disinfection of needles and providing HIV/AIDS prevention materials, e.g. leaflets. At the moment, Estonian law prevents needle exchange programs operating inside the prison system. Consequently, this activity has been adopted to try to minimize some of the risk of sharing needles.

Activity 7 seeks to create a more supportive policy environment by promoting discussion amongst key players, such as staff within the Ministry of Justice, prison directors and politicians. There has been recent evidence of adoption of more supportive policies such as marked reductions in penalties imposed for using drugs in prison and the acceptance of condom distribution within prisons. However, not all prison directors allow condom distribution and needle exchange is specifically prohibited by law. It is proposed that meetings be held (one to one and in groups) to discuss these difficult and controversial issues with the aim of adoption of more supportive policies within the Estonian prison system.

Activity 8 is linked particularly to the first activity in that the provision of treatment is essential if there are to be perceived benefits of being tested. Medical services under this program will include provision of ARVs where appropriate.

Table IV.27.1

Objective 4:	*To prevent HIV transmission in prison*				
Broad activities	***Process/Output indicators*** *(indicate one per activity)* (Refer to Annex II)	***Baseline***	***Targets***		***Responsible/Implementing agency or agencies***
		(Specify year '01)	***Year 1***	***Year 2***	
Voluntary counseling and testing services	*No. of prisoners receiving counseling and testing*	*2087*	*3500*	*3500*	Ministry of Justice/medical workers in prisons
Training of prison staff and prisoners in HIV prevention	*No. of staff trained* *No. of prisoners trained*	*750* *400*	*1200* *800*	*1400* *1000*	*Ministry of Justice/AIDS prevention centre/medical workers in prisons*
Provision of methadone substitution treatment for IDUs	*No. of prisoners receiving methadone*	*12*	*15*	*20*	*Ministry of Justice/medical workers in prisons*
Provision of condoms to those prisoners unable to buy them	*No. of condoms distributed*	*800*	*7000*	*10000*	Ministry of Justice/medical workers in prisons
Provision of disinfectant to prisoners for disinfection of needles used for injecting drugs (provision of sterile needles in Estonian prisons is currently prohibited by law)	*Amount of disinfectant distributed*	*120kg*	*130kg*	*140kg*	Ministry of Justice/medical workers in prisons
Provision of printed materials for HIV/STI prevention	*No. of materials distributed*	*4500*	*6000*	*6000*	Ministry of Justice/AIDS prevention centre/medical workers in prisons

Discussions of key policy issues to create a more supportive policy environment	*No. of meetings attended/held*	*No data*	*10*	*15*	Ministry of Justice/medical workers in prisons
Appropriate medical treatment of HIV+ prisoners including provision of ARVs where appropriate	*No. of HIV+ prisoners receiving ARVs*	*2 (2002)*	*6*	*6*	Ministry of Justice/medical workers in prisons

Objective 5 focuses particularly on men who have sex with men. Although this group has not yet been affected to the same extent as men who have sex with men in other countries or IDUs in Estonia, it has been identified as a potentially vulnerable group. Efforts will be focused on seeking to prevent the spread of HIV into this group. Four broad activities are proposed in this area.

The first activity will focus on the production of appropriate literature for gay men in the Estonian and Russian languages. To date, there has only been one booklet on this issue in these languages. Under this program, it is proposed to produce a range of relevant printed materials including research and monitoring information, analyses of the current situation as it affects gay men and additional HIV prevention materials.

The second activity is similar to the first in that it promotes the availability of relevant information, this time in electronic format. The current website (http://www.gay.ee) will be upgraded and extended to attract more visitors through the provision of relevant and up to date information.

Stronger condoms for anal sex are not readily available in Estonia. At least one gay sauna within Tallinn is purchasing these and making them available for its users. However, the number is limited. The program will seek to make this kind of condom more available through five identified gay saunas/clubs in Estonia. Initially, these condoms will be made available free of charge to promote their use. However, this provision will be phased out over the life of the program and replaced with more sustainable approaches such as social marketing, automated machines etc.

Finally, there used to be a gay and lesbian information centre in Tallinn but this closed when donor funding was withdrawn. It is proposed to re-establish this under private ownership so that it continues at the end of the project. Links with gay saunas and clubs will be developed to assist this sustainability process.

Table IV.27.1

Objective 5:	*To reduce the risk behavior of men who have sex with men and to increase their knowledge on HIV related issues*				
Broad activities	***Process/Output indicators** (indicate one per activity)* (Refer to Annex II)	***Baseline (Specify year)***	***Targets***		***Responsible/Implementing agency or agencies***
			Year 1	***Year 2***	
Production and distribution of HIV prevention literature aimed at MSM in Estonia	*No. of booklets/leaflets distributed*	*1300*	*2000*	*3000*	Estonian Gay League
Production and distribution of HIV-related information through the Gay League's website	*No. of page downloads by new users*	*1500*	*3000*	*6000*	*Estonian Gay League*
Free distribution of strong condoms through gay saunas and clubs	*No. of condoms distributed*	*10000*	*300000*	*200000*	*Estonian Gay League, EGLArendus OÜ and other gay clubs/saunas*

Re-establishment of a national gay and lesbian information centre	*Centre established*	*0*	*1*	*1*	Estonian Gay League

Objective 6 focuses on provision of services to PLWHAs with the aim of improving their quality of life. There are currently 2558 known PLWHAs in Estonia. This number is rapidly growing and is likely to be a significant underestimate. There are ten broad activities which will contribute to reaching this objective.

The first focuses on the provision of essential health services to PLWHAs without health insurance. This is currently a key barrier to treatment as the Estonian government has provided adequate resources for ARVs at current levels of need but patients without health insurance are unable to access them because there are no funds for essential laboratory tests. These essential services would include a consultation with a doctor and some basic laboratory tests, including a CD4 count, a hepatitis screen and a Chest X-Ray (see Annex 13). Viral load testing would also be available to those where it was clinically indicated.

Where there are clinical indications or the CD4 count is below 200, it is proposed to start treatment with ARVs. Support for this is requested from GFATM because Estonia is currently able to provide such treatment for pregnant women but is currently only able to provide ARVs to a few other adults (approx 50). It is difficult to estimate the number of people who will need ARVs during the lifetime of this program as it will depend on factors such as the rate of progress of the epidemic and the speed with which individual PLWHAs deteriorate. This activity will include introducing measures to monitor the development of resistance to ARVs in Estonia. This will be done as part of viral load testing for patients who start on treatment and for those where therapy appears to be failing.

Thirdly, a major expansion in the treatment of PLWHAs with ARVs will require investment in the training of doctors and other personnel in how to manage and treat such people. This will involve bringing foreign experts to Estonia for training purposes and taking Estonian staff to other countries to see how they approach this issue there.

The fourth and fifth activity are linked in that they are focused on providing different types of support services to PLWHAs. The former is focused on psychological and social support whilst the latter is focused on legal and human rights services. It is also proposed that the services outlined under the fifth activity deal with any complaints from PLWHAs which arise from any organization within or associated with the program. This will include establishing a grievance procedure for PLWHAs to follow if they feel they have just cause.

The sixth activity is broadly similar to the activity providing case management services for IDUs described in another part of this proposal. The difference is that these case management activities focus on PLWHAs who are not IDUs.

The seventh activity focuses on extending the use of the current drop-in centre focused on PLWHAs. This centre will co-ordinate with other centers covered by this program focused on IDUs but has a different focus.

The eighth activity focuses on raising awareness amongst the general public of issues of concern to PLWHAs. This activity will seek to counter much of the stigma and discrimination still faced by PLWHAs.

The ninth activity focuses on learning from and sharing learning with other organizations inside Estonia and beyond through attending national and international meetings.

Finally, there is an existing group of people who provide services within the home setting to people who are sick. However, these people have not yet been trained to provide services to people with HIV/AIDS. It is felt that these could be an invaluable resource for the provision of such services. This activity focuses on training them relating to HIV/AIDS.

Table IV.27.1

Objective 6:	*To improve the quality of life of people living with HIV/AIDS by increasing access to social support and health care*				
Broad activities	***Process/Output indicators** (indicate one per activity)* (Refer to Annex II)	***Baseline** (Specify year '02)*	***Targets** Year 1*	***Year 2***	***Responsible/Implementing agency or agencies***
Provision of essential health cares services to PLWHAs with no health insurance, including basic laboratory tests including CD4 counts	*No. of uninsured PLWHAs receiving services*	*150*	*450*	*650*	West-Tallinn Central Hospital
Provision of ARVs to PLWHAs with CD4 counts below 200 or clinical indications	*No. of PLWHAs receiving ARVs*	*45*	*70*	*80*	*West-Tallinn Central Hospital*
Provision of training to health professionals on the clinical management of PLWHAs, with a particular focus on use of ARVs	*No. of health professionals trained*	*0*	*10*	*20*	*West-Tallinn Central Hospital*
Provision of social and psychological support services to PLWHAs	*No. of PLWHAs receiving those services*	*10*	*20-30*	*50-100*	NGO ESPO, social departments of local city governments
Provision of support to PLWHAs on legal and human rights issues. This will include establishing grievance procedures and dealing with complaints relating to any services delivered through this program	*No. of PLWHAs receiving those services*	*5*	*15*	*30*	NGO ESPO, Estonian Institute of Human Rights (NGO), Estonian Patients Advocacy Association, Bureau of Legal Services
Establishment of case management system for PLWHAs who are not IDUs	*No. of PLWHAs (non-IDU) receiving case management*	*0*	*50*	*100*	Aids service organizations
Establishment of drop-in centre for PLWHAs	*No. of PLWHAs visiting drop-in centre per month*	*25*	*75*	*100*	NGO ESPO
Raising awareness of issues affecting PLWHAs	*No. of volunteers participating on street work* *Public events* *Information distributed*	*10* *7* *2000*	*15* *12* *3500*	*15* *12* *4000*	NGO ESPO
Networking with other organizations nationally and internationally	*No. of international conferences participated in per year* *No. of international conferences organized in Estonia per year.*	*2* *0*	*4* *1*	*6* *1*	NGO ESPO in co-operation with ILGA, EuroCaso, GNP+ and PG (Sweden Positive Gruppen).
Provision of training for homecare/social assistants in providing training for PLWHAs, including the provision of written training materials	*No. of homecare assistants trained in HIV per year* *No. of copies of handbook distributed*	*0* *0*	*5* *2000*	*6* *4000*	Aids Prevention Centre, West-Tallinn Central Hospital, Tallinn Social and Health Care Office, NGO ESPO, NGO

Although objectives 7 & 8 are seemingly less technical than the preceding six and appear to relate less directly to HIV control, experience has shown that developing institutional capacity to respond to the epidemic and developing a cross-sectoral co-operative approach to tackling the epidemic are equally as important as the technical interventions which they effectively underpin. Objective 7 will be achieved through a focus on six broad activities.

The first activity focuses on development of institutional capacity amongst those organizations and groups participating in the program. This includes those organizations that are involved from the start and those who may join at a later stage. In the first year, there will be two main foci to this activity, namely strengthening financial and programmatic mechanisms and strengthening M&E capacity at all levels of the program. A key focus of this activity will be on developing the capacity of the national HIV/AIDS program.

The second activity recognizes that Estonia is a relatively small country with well-established historical and cultural links to other countries. Some historical HIV/AIDS programs delivered to date have recognized those links, e.g. support from the Council of Baltic Sea States and the support provided by USAID to the Network of Excellence initiative. It is proposed to continue to share and receive learning through such regional and international networking.

The third activity recognizes the importance of effective M&E for the delivery of results through any program and the importance placed on this area by GFATM. More details of the program's approach to M&E are found in section vii of this proposal.

The fourth activity develops the third by not only seeing M&E as a mechanism for ascertaining progress towards pre-set objectives but uses it as an opportunity to consider and review progress with a view of documenting and sharing lessons learned. Such lessons may be shared both informally and formally, within and outside the program. This activity would include all these elements.

The fifth activity would seek to use experience of lessons learned, the broad co-operative approach facilitated by the CCM and the links to senior political structures (also through the CCM) to influence the development of national policies which are supportive of efforts to prevent the further spread of HIV and ensure that PLWHAs are treated with respect and dignity.

In addition, the CCM will convene a round table meeting and establish a task force to look into the issue of MTCT. In the last year, 16 HIV positive women delivered. Of the babies born, three were HIV positive. Although there is a well-established system within Estonia of antenatal screening for HIV, availability of TOP, treatment for mother and child with ARVs, delivery by Caesarean Section and alternative approaches to feeding the infant, these women (all of whom were IDUs) did not access all of these services. In one case, testing was not done until the time of delivery and in the other two treatment with ARVs was discontinued. The conference and task force established by the CCM will critically review the provisions of this program to see if they adequately provide for prevention of MTCT, e.g. through the proposed services to IDUs or whether they need to be supplemented with further activities focused specifically on this element.

Table IV.27.1

Objective 7:	*To increase the institutional capacity of organizations taking part in the program, now and in the future, to effectively meet the objectives and goal of this program*				
Broad activities	***Process/Output indicators*** *(indicate one per activity)* (Refer to Annex II)	***Baseline (Specify year '01)***	***Targets Year 1***	***Targets Year 2***	***Responsible/Implementing agency or agencies***
Development of institutional capacity amongst participating organizations, including national AIDS program	*% of quarterly narrative/ finance reports received on time and to the required standard*	*N/A*	*80*	*90*	CCM/Ministry of Social Affairs/All participating organizations

Development of linkages with organizations in other countries, internationally and within the region	*No. of visits made/hosted*	*NK*	*20*	*20*	*CCM/Ministry of Social Affairs/ All participating organizations/Program Manager*
Program is effectively monitored at impact, outcome and output level	*Baseline and end of project impact assessments* *Annual review of progress against outcome indicators* *Quarterly review of process indicators*	*N/A* *N/A* *N/A*	*1* *8* *4*	*0* *8* *4*	*Program Manager/CCM* *M&E Co-coordinator/Other program staff/ CCM task forces* *Implementing agencies/M&E Co-coordinator*
Program documents its lessons learned and shares them broadly	*No. of lessons learned documents produced*	*0*	*0*	*1*	*M&E Co-coordinator*
Program facilitates development of supportive national policies and program standards[12]	*No. of new policies/standards developed*	*NK*	*1*	*2*	Estonia CCM/Ministry of Social Affairs
Program identifies and actively promotes methods to prevent MTCT	*Percentage of pregnant HIV+ women proceeding to delivery who receive appropriate treatment with ARVs*	*13 of 16 i.e. 81%*[13]	*90%*	*95%*	CCM Task Force on MTCT

This objective is linked to the previous one and reflects the high priority placed on building consensus and cooperation amongst all organizations involved in responding to HIV/AIDS in Estonia. It is acknowledged that cooperative efforts between all sectors is crucial if an effective response to HIV/AIDS is to be generated. It is also recognized that it is not always easy to achieve this, particularly where previous efforts have been fragmented or strongly centralized within one organization, e.g. government. It is for these reasons that this issue has been explicitly recognized in this objective. This objective will be achieved through six broad activities.

The first two activities focus on the establishment and functioning of a country co-coordinating mechanism for Estonia which is broadly representative of all sectors involved in responding to the epidemic. This has been presented in more detail in section 2 of this proposal. The second underpins the need for this program and its CCM to be linked closely to senior political structures within Estonia.

The third activity acknowledges that although considerable progress has been made in putting together a program which is inclusive of all major players regarding HIV/AIDS, more can still be done. Steps will be taken in to draw in other organizations including other civil society organizations, including NGOs, local community structures and municipalities, academic institutions, private sector companies and faith-based institutions where appropriate. The fourth activity is linked to the third and explicitly expresses the desire to involve local communities and their political structures in this process.

The fifth activity acknowledges the need to create spaces to build consensus and common approaches within such a broad coalition and also to allow space for frank and open discussion of disagreements and misunderstanding which inevitably arise in such a process. In particular, this program proposes a national AIDS conference as part of the program. This would focus on topical issues of the day with particular emphasis on finding practical ways of responding to these issues to produce tangible results. It was noted during the preparation of

[12] In the first year, it is proposed that the program focus on the establishment of minimal standards for needle exchange programs
[13] Although the Estonian health system provides for all HIV +ve pregnant women to receive ARVs to prevent MTCT, in the last year, two started treatment but did not complete the course. A third was found to be HIV+ve only at the time of delivery.

this proposal that there had been no such national forum until the Canadian Embassy called all players together to discuss the situation in February 2002. The value of such meetings is recognized in this activity.

The final activity simply focuses on the importance of effective program-wide management in order to deliver all the results outlined in the sections preceding this.

Table IV.27.1

Objective 8:	*To build consensus and cooperation amongst organizations taking part in the program, now and in the future, so that the program can be effectively co-coordinated and delivered*				
Broad activities	***Process/Output indicators*** *(indicate one per activity)* (Refer to Annex II)	***Baseline (Specify year '02)***	***Targets***		***Responsible/Implementing agency or agencies***
			Year 1	***Year 2***	
Establishment of a functional country co-coordinating mechanism which is broadly representative of all sectors working on HIV/AIDS in Estonia	*No. of meetings* *Average no. of members at each meeting*	*0* *N/A*	*4* *15 (75%)*	*4* *15 (75%)*	Estonia CCM and all participating organizations
Development of linkages between Estonia's CCM and senior political structures	*No. of times Estonia's cabinet discusses HIV/AIDS with input from CCM*	*NK*	*4*	*4*	*Minister of Social Affairs/Estonia CCM and all participating organizations*
Inclusion of additional organizations into the program	*Additional organizations involved in the program*	*N/A*	*2*	*2*	*Estonia CCM/Program Manager/Ministry of Social Affairs*
Promotion of involvement of local communities, municipalities and local government	*No. of meetings held with local government/ municipalities*	*0*	*4*	*4*	Estonia CCM, Program Manager/Ministry of Social Affairs
Meetings held to build consensus/common approaches and topical issues and to troubleshoot problems that may arise	*National AIDS Conference*	*0*	*1*	*1*	Estonia CCM/Program Manager
Program effectively and efficiently managed, including all GFATM reporting requirements met	*% of narrative and financial reports submitted to GFATM on time and to required standard*	*N/A*	*100*	*100*	Program Manager

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programs such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

This program has been devised within the framework of the existing national HIV/AIDS prevention program within Estonia. The leading players in the development of this program are government officials tasked with the responsibility for overseeing Estonia's national HIV prevention program. This proposal uses the same timeframe and goal as the national program. The government's commitment to this initiative is demonstrated in

a number of ways including the willingness of the Minister of Social Affairs to serve as Chair of the CCM.

This proposal has been developed to both scale up existing services, for example testing for HIV and provision of appropriate treatment and to filling gaps in the existing program, for example the provision of harm reduction activities for IDUs. Both national program and activities described in this proposal have a strong focus on inclusion of vulnerable groups in services intended to prevent the spread of HIV/AIDS and to improve the quality of life of people living with HIV/AIDS.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. The involvement of beneficiaries such as people living with HIV/AIDS:

Every effort has been made to involve beneficiaries, particularly PLWHAs in all stages of the component including design, management, implementation and monitoring. A person with HIV/AIDS was part of the 'writing group' for objective 6, is an existing member of the AIDS program board and will be part of the CCM. The proposal is particularly strong at the implementation level with beneficiaries from a range of groups actively involved in various activities, most notably as peer educators. In addition, it is proposed to include beneficiaries in M&E activities in partnership with objective-specific task groups which will be established as part of the CCM.

29.2. Community participation:

The involvement of members of vulnerable communities has been addressed in the previous section. Because of the specific nature of Estonia's HIV epidemic, it has proved more difficult to engage the community in general with the response to AIDS, in general, and this proposal in particular. Efforts will be made in the first two years of the program to engage local communities more through local municipalities as outlined in the provisions for activity four within objective 8.

29.3. Gender equality issues (*Guidelines paragraph IV.53*):

The program will strive in general to promote gender equality in all its activities. This is in keeping with the Estonian setting where gender equality is receiving an increasingly high profile. A gender equality law is currently passing through parliament. The Ministry of Social Affairs has a three person team in a Gender Equality Bureau and there is a newly-established inter-ministerial working group on gender which is seeking to mainstream gender issues throughout all ministries. However, there are still significant differences in perceptions of appropriate roles for men and women which have important implications for the way HIV spreads. These are most fully explored in the publication ***Challenging Gender Issues*** (see annex 11) which looks at the experiences of the Living for Tomorrow project in Estonia. The continuation and expansion of this project is a key part of this program. It is hoped that lessons learned from this project will be used to shape and inform other parts of this program. All program M&E activities will seek to use a gender perspective. Training in this will be provided as part of initiatives to improve in-country M&E capacity (section 38). In addition, a number of the program's activities focus specifically on men's role in preventing the spread of HIV, for example in prisons and amongst gay men.

29.4. Social equality issues (*Guidelines paragraph IV.53*):

A key publication on this issue is the report of a study conducted by the World Bank and Estonian Ministry of Social Affairs and published in early 2002. It is entitles ***Social inequalities in health in Estonia*** (see annex 7). This report concludes that there are large variations in health outcome indicators between different population groups and that these differences have worsened in the 1990s. Specifically, the report notes that these differences are observable between men and women, between Russian and

Estonian-speaking people and between different places of residence. Issues relating to gender have been highlighted in the previous section. The program is particularly conscious of the problems facing Russian-speaking people in Estonia and the need to provide people with materials in their own language. A number of projects within this program specifically focus on these issues, e.g. the Forum Theatre and Living for Tomorrow projects.

29.5. Human Resources development:

The development of existing human resources is a key element of this proposal. It focuses on three main areas. First, human resources will be developed in technical areas to gain additional competencies and skills, e.g. for health professionals to learn about how to deliver ARVs. In addition, human resource development is a key element of the initiatives focused on increasing institutional capacity. For example, efforts focused on improving program management and M&E will involve delivering training to key staff. The final element of human resource development focuses on developing positive and supportive attitudes towards a range of people considered beneficiaries of this program. Many of them are in groups which have been stigmatized and discriminated against for long period. A key focus of the program will be for all its staff to treat all beneficiaries with respect.

29.6. For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured (i.e. to maximize adherence and monitor resistance), *(Guidelines para. IV.55),* (1–2 paragraphs):

The main drugs covered under this programme are methadone for substitution treatment for IDUs and ARVs for the treatment of PLWHAs who either have clinical indications for treatment or CD4 counts below 200. ARVS currently used in Estonia include Zidovudine (Retrovir), Didanosine DDI (Videx), Lamivudine 3TC (Epivir), Indinavir (Crixivan), Nelfinavir (Virasept), Saquinavir (Fortovase), Efavirenz (Stocrin) and Nevirapin (Viramune). Treatment with ARVs will follow existing national guidelines for use of ARVs, which themselves are based on the International Consensus Statement. This is based on the use of combined therapy, usually with three drugs. Monotherapy has not been used in Estonia for several years, apart from the use of Zidovudine for prevention of MTCT for women who have not required treatment with ARVs. The national guidelines are currently being revised to reflect changes in international standards. Currently, there are no provisions to monitor resistance to ARVs within Estonia. Plans to establish this are included as part of this programme. This will be incorporated into provisions for viral load testing and will be carried out when treatment is commenced and in situations where therapy appears to be failing.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed (USD)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Human Resources	425 706	410 441	416 758	437 792	N/A	1 690 696
Infrastructure/ Equipment	450 440	45 052	45 902	46 768	N/A	588 162
Training/ Planning	172 550	172 077	166 647	167 614	N/A	678 888
Commodities/ Products	571 337	595 249	652 113	727 435	N/A	2 546 135
Drugs	197 871	136 308	389 774	2 564 770	N/A	3 288 723

Monitoring and Evaluation	169 828	54 274	32 956	183 805	N/A	440 863
Administrative Costs	84 010	76 742	75 900	87 369	N/A	324 022
Other (Please specify)[14]	165 125	181 942	169 323	172 705	N/A	689 094
Total	2 236 866	1 674 297	1 951 884	4 390 986	N/A	10 254 034

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries of front-line workers, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, program management, audit costs, etc*
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the FIRST YEAR ONLY:

Table V.30.1

Item/Unit	Unit Cost (USD	Volume (specify measure)	Total Cost (USD)
Educational Materials			
Living for Tomorrow - AIDS Newspaper	2.50	500	1250
Booklets for workshop participants	0.40	10000	4000
Training manuals for teachers	10.00	150	1500
Booklets about AntiAIDS Association	0.40	6000	2400
Estonian FPA Publishing leaflets for young people			
STIs	0.13	25000	3125
STIs - in Russian	0.13	10000	1250
Tips for young men	0.05	30,000	1500
About a visit to the gynaecologist	0.05	30000	1500
How to protect yourself	0.05	30000	1500
How to protect yourself - in Russian	0.05	30000	1500
About a visit to the gynaecologist - in Russian	0.05	30000	1500
Tips for young men - in Russian	0.05	30000	1500
STIs and safe sex	0.05	30000	1500
Materials for use by YCC and YtoY			
Educational game on HIV/AIDS	28.20	30	846
Manual on HIV-prevention at YCC	16.00	30	480
Update of guidelines of work	2.67	180	480
Illustrative material kit for workshops	50.00	35	1750
Educational videofilms for YCC	125.00	100	12500
Books and other materials relating to needle exchange	0.31	28000	8750
Books and other materials relating to	0.33	5000	1650

[14] Includes publicity for Family Planning Program amongst young people ($7 691), transportation within the SEX WORKER programme ($6 800), provision of food within the social services programme for PLWHAs/IDU element ($7 334) and a major media campaign focused on young people ($143 300). Figures here are for Y1 only.

IDU rehabilitation			
Other educational material relating to IDU rehabilitation	0.35	5000	1750
Educational Materials for sex workers	0.40	6000	2400
Promotional materials for national HIV prevention programme	2.50	1000	2500
Materials for work with MSM	3.20	5000	16000
Materials about HIV/AIDS Booklets of ESPO ($1.67)	1.67	1000	1670
Booklets of ESPO ($0.06)	0.06	1850	111
Handbook for home care assistants and relatives of HIV+ people ($2.50)	2.50	400	1000
Newspaper "HIV+"	1.25	500	625
Stickers (100000 pieces @0.037)	0.037	100000	3700
Printed materials – information leaflets (155000 pieces @ 0.044)	0.044	155000	6820
Posters (50000 pieces @$0.312)	0.312	50000	15600
Balloons (10000 pieces @$0.18)	0.18	10000	1800
Key-rings (25000 pieces @$1.06)	1.06	25000	26500
Key-string (5000 pieces @ $3.12)	3.12	5000	15600
T-shirts (1000 pieces @ $7.50)	7.50	1000	7500
Mouse-pad (200 pieces @ $8.00)	8.00	200	1600
Candies (50 kilos @ $4 per kg)	4.00	50	200
Reflectors (5000 pieces @ $0.94)	0.94	5000	4700
Condoms			
Condoms	0.21[15]	356500	73925
Condoms for MSM	0.42	250000	105000
Lubricants	0.30	250000	75000
Other commodities			
Syringes with needles (needle exchange)	0.07	235000	16450
Syringes with needles (sex workers)	0.07	11500	805
Needles and vaccutainers (Prisons)	0.07	20000	1400
Other sterile equipment (needle exchange)	0.02	235000	4700
Other supplies and devices (sex workers)	0.02	80000	1600
HIV and syphilis testing	2.81	5000	14050
Chest Xrays	4.94	50	247
Blood Counts	3.38	50	169
Urine tests	0.75	50	38
Opiate tests	4.38	250	1095
Hospital Admissions (per day)	21.88	100	2188
Basic laboratory tests - estimated at $173 p.p. (Aim to assist uninsured people - Y1 500, Y2 750, Y3 1000, Y4 1500)	173.00	500	86500

[15] The total budget for condoms has been calculated as the sum of all the individual budgets submitted by participating organizations. These have then been amalgamated giving an average unit cost of $0.207363

Viral load (VL) and resistance testing - unit cost $227 (Y1 200, Y2 300, Y3 500, Y4 600)	227.00	200	45400
Drugs			
Methadone for detoxification 15mgs daily (price for one year)	51.27	30	1538
Methadone for maintenance 40mgs daily (price for one year)	136.88	50	6844
Methadone for maintenance 40mgs daily (price for one year) (prisons)	150.00	20	3000
Treatment for STIs for sex workers @ $5 per person	5.00	160	800
ARVs for prisons (price per person per year)	7000.00	4	28000
Antifungal treatment (price per person)	927.00	15	13905
ARVs @ $6500 per year. Needed per year Y1 70, Y2 80, Y3 150, Y4 500. Estimated government provision Y1 50, Y2 70, Y3 100, Y4 105. Balance from this fund Y1 20, Y2 10, Y3 50, Y4 395	6300.00	20	126000
Total commodities and drugs			**769208**

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR spending will strengthen health systems capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over (1 paragraph):

Expanding and strengthening human resources is a key feature of this program. The main focus of this is to improve the delivery of services to the identified vulnerable groups, for example IDUs, prisoners, PLWHAs without health insurance etc. A key element of this will be enabling the health and social system and society in general to be more responsive to the needs and perspectives of people within these vulnerable groups and to provide services in a way which promotes the dignity of and respect for individuals within these groups. Where possible, it is envisaged that the salary requirements of new posts created within this program would be mostly absorbed locally, e.g. through government funding provided that the program has shown itself to be effective, that the posts are still considered to be needed and the economic situation within Estonia allows this to happen.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*)**:**

Table V.31.1

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	83 000	83 000	393 000	1. 35m	1.68m	2.23m	2.35m
External	28 000	5 000	14 000	138 000	136 000	10 000	0 000
Total	**111 000**	**88 000**	**407 000**	**1.49m**	**1.82m**	**2.23m**	**2.35m**

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the

last row the total of funding from other sources for 2003 for all components of the proposal.

32. *Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.*

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in percentage (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* *(%)*	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Government	15%	16%	13%	8%	N/A	**12%**
NGOs / Community-Based Org.	44%	52%	43%	19%	N/A	**35%**
Private Sector	6%	7%	5%	2%	N/A	**4%**
People living with HIV/ TB/ malaria	4%	4%	4%	2%	N/A	**3%**
Academic / Educational Organizations	6%	5%	4%	3%	N/A	**4%**
Faith-based Organizations	0.1%	0.1%	0.1%	0.1%	N/A	**0.1%**
Others *(please specify) Municipality Hospital*	25%	16%	32%	67%	N/A	**43%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	**2.19**	**1.67m**	**1.94m**	**4.34m**	**N/A**	**10.14m**

**** If there is only one partner, please explain why.***

Please note: The following three sections (VI, VII and VII) are all related to proposal/component implementation arrangements.

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

SECTION VI – Programmatic and Financial management information

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),*(1–2 paragraphs)**:**

Overall the program will be managed by the CCM which will liaise with senior political structures (Cabinet) through the Chairperson, Minister of Social Affairs (see Annex 3). The Ministry of Social Affairs will assume responsibility for the program but this may be managed through the Estonian Centre for Health Education and Promotion[16]. The CCM will have a number of task forces/working groups focused on the first six objectives of the program. In addition, a seventh task force/working group will be established during the first year of the program to develop and oversee efforts focused on the prevention of MTCT. These groups will provide technical input and will be based on the 'writing groups' who put together the various parts of this proposal.

There will not be a separate program secretariat for this program. Rather, this program will be used to strengthen and develop the Estonian National HIV/AIDS Program, which may continue to be based at the Estonian Center for Health Education and Promotion (see footnote 10). Currently this center has two staff, a manager and a person responsible for data gathering and monitoring. It is proposed that the manager take responsibility for this program and that the secretariat be strengthened by the addition of the following staff:

- Youth Co-coordinator
- Vulnerable Groups Co-coordinator
- PLWHA Services Co-coordinator
- M&E Co-coordinator
- Finance/Administrative Officer

These staff will co-ordinate activities at program level. Delivery of activities and monitoring of process indicators will be decentralized to individual organizations.

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

These management arrangements are based on three key principles. First, at overall CCM level, there is a desire to have a co-coordinating mechanism which is as representative as possible and which combines senior figures from political and other areas of life with people with key technical expertise. Secondly, the program wishes to strengthen the National AIDS Program through a unified management system. This will make liaison with GFATM smoother and will provide a coordinating overview for the

[16] The Centre for Health Education and Promotion currently manages the National HIV prevention program on behalf of the Ministry of Social Affairs. However, there are currently plans for this center to be combined with two other centers, Public Health and Social Education Center and Experimental and Clinical Medicine Institute to form a National Health Development Institute. If this happens, it is proposed that this program either be managed by this Institute or directly by the Ministry of Social Affairs.

program as a whole. Finally, the program wishes to decentralize responsibility for delivery of activities and monitoring of process indicators to a range of organizations from different sectors. All these features have been incorporated into this program.

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

Table VI.35

	First suggestion	Second suggestion
Name of PR	Ministry of Social Affairs	None
Name of contact	Ain Aaviksoo	N/A
Address	Gonsiori 29 Tallinn, 15027 Estonia	N/A
Telephone	372-62-69-730	N/A
Fax	372-62-69-765	N/A
E-mail	Ain.Aaviksoo@sm.ee	N/A

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

The Ministry of Social Affairs has overall responsibility for social services, health and labor issues within Estonia. The government of Estonia has decided that the Ministry of Social Affairs is the lead ministry on issues relating to HIV/AIDS. It is currently responsible for the National HIV/AIDS Prevention Program which is managed through the Estonian Centre for Health Education and Promotion. It also is responsible for other national public health programs, such as TB control, Alcoholism and Drug Abuse. It has a strong and proven track record of effectively running such programs, often through a decentralized, 'contracted out' management structure. It has the institutional capacity to deal with the programmatic and administrative demands of hosting the program, including arranging for funds to be disbursed to other agencies.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

The National HIV/AIDS Prevention Program Secretariat will report to the CCM through its Program Manager, who will be an ex-officio member of the committee. She will report on progress of the program at each of the CCM's meetings. In addition, the program's technical staff (Co-coordinators for youth, vulnerable groups, service to PLWHAs) will co-ordinate with the CCM's technical task forces (one for each of the first six objectives) (see annex 3). Provisions for interaction between different parts of the program on M&E are covered in section VII. The National HIV/AIDS Prevention Program Secretariat will develop sub-contracts with each implementing agency which will specify mutual expectations.

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

Efforts will be made to integrate all arrangements of this program into existing arrangements. In this regard, it would be helpful if the program could have a January to December financial year. The program will be integrated into the overall financial

management and auditing arrangements in place within the National HIV/AIDS Prevention Program. Additional auditing/reporting requirements can be accepted where these are needed by GFATM but it is hoped that these can be minimized.

In order to effectively implement this program, it is proposed to add five additional staff to the national AIDS program. Three of these would be 'thematic' co-coordinators, focused on youth, vulnerable groups and services for PLWHAs. Their main focus would include co-ordination of initiatives in these areas and overseeing monitoring and evaluation activities at outcome level, with a particular focus on analysis of and learning from M&E data. In addition, the importance of monitoring and evaluation within this program is recognized the inclusion of a post for M&E Co-coordinator. Finally, it is anticipated that an additional Finance and Administrative Officer will be needed to deal with contracts, reporting etc.

SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1 Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)***:**

Information on HIV prevalence and incidence is available from a number of sources. According to national policy, all blood donors and pregnant women are counseled and tested for HIV. In addition, results of voluntary counseling and testing in other settings are collated by the National AIDS reference laboratory at West-Tallinn Central Hospital. These figures then go through the Health Protection Inspectorate to the Ministry of Social Affairs. Similar information is available on STIs but currently the data is not integrated. In addition, every two years, the Ministry of Social Affairs conducts a survey into health behavior amongst the Estonian Adult Population (see Annex 9). Questions about HIV/AIDS were first added to this in 1994. The latest edition (2000) included questions on knowledge about HIV/AIDS and condom use. Data collection for 2002 has been completed. Data is currently being analyzed. In addition, other studies have been carried out by NGOs and other groups including the 'KISS' study (1994 and 1999 – KISS is an Estonian acronym for growing up, human relations, friends and sexuality)(Annex 10) and a report on gender issues and HIV/AIDS published by Living for Tomorrow (Annex 11). A number of other studies have been done on sex work and injecting drug use.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.)**:**

Data collection will occur at three levels. Approaches are outlined in the table below:

Level	Type of Indicator	Approaches
Goal	Impact	Where possible, use will be made of available data collection systems, e.g. on percentage of pregnant women and prisoners with HIV. In addition, steps will be taken to integrate the analysis and dissemination of HIV and STI statistics. However, there is a large amount of data (see table IV 26.1) for which there is currently no baseline data. Two major surveys will be carried out during the life of the program. The first (baseline) study will take place in the first year and the second (impact) study will take place in the final year. The main focus of these studies will be collecting data on impact indicators, particularly the percentages of the four target groups (IDUs, sex workers, MSM, prisoners) with HIV and particular STIs. In addition, these studies will collect data concerning the perceived quality of life of PLWHAs living in Estonia. A detailed methodology for the IDU element has already been developed by the National Drug Monitoring Centre, the Estonian Institute of Experimental and Clinical Medicine and the Royal College of Science, Technology and Medicine by the University of London. Further design work is needed for the other elements.
Objective	Outcome/Coverage	Where baseline data does not exist, this will be gathered during the first year as part of the baseline survey. This includes some of the four groups mentioned above, e.g. MSM and sex workers, and

Level	Type of Indicator	Approaches
		will also include collecting data from a fifth group, i.e. young people. It is then proposed to review progress against outcome indicators on an annual basis. Where possible this will be done through existing means, such as the biannual health survey and data from antenatal services. Where necessary, this will be strengthened, e.g. through the production of an annual report looking into the issue of MTCT. Where existing means are not available, new means will need to be devised. Examples of this would include measuring self-assessed quality of life scores amongst PLWHAs. One innovative way of assessing this within the MSM element has been suggested using the Internet for responses. This has the advantage of anonymity but would need to be validated/triangulated against more established means of data collection. This annual data collection process would be supported by mid-term and end of project evaluations (at end Y2 and Y4 respectively). The mid-term evaluation would focus particularly on process and outcome indicators, whereas the end of project evaluation would focus on these and the impact level (tying in to the impact study described earlier).
Activities	Output/Process	Output/process indicators will be monitored quarterly at project/implementation level.

37.3. Timeline:

The three levels of M&E will follow different timelines. Impact will be assessed at the end of the project (4yrs). Outcomes will be reviewed annually with particular focus on these at two and four years. Processes will be monitored quarterly.

37.4. Roles and responsibilities for collecting and analyzing data and information:

The following table shows responsibilities for both collection and analysis of M&E data at all three levels identified. This does not necessarily mean that the group/individual identified will do all the work involved but they will take responsibility for ensuring that the work is carried out:

Level	Collection of M&E Data	Analysis of M&E Data
Impact	Manager of National HIV/AIDS Prevention Program	CCM
Outcome/Coverage	M&E and Thematic Co-coordinators, National AIDS Program	CCM Task forces
Output/Process	Implementing Organizations	M&E Co-coordinator – also with responsibility for validating and troubleshooting

37.5. Plan for involving target population in the process:

Members of target populations will be involved in both collecting and analyzing M&E data wherever possible. Involvement in collection will be ensured through use of participatory methods, such as focus groups and through involving peer educators and others as data collectors. Involvement in analysis will be through involvement in meetings and other processes used by CCM task forces for M&E data analysis.

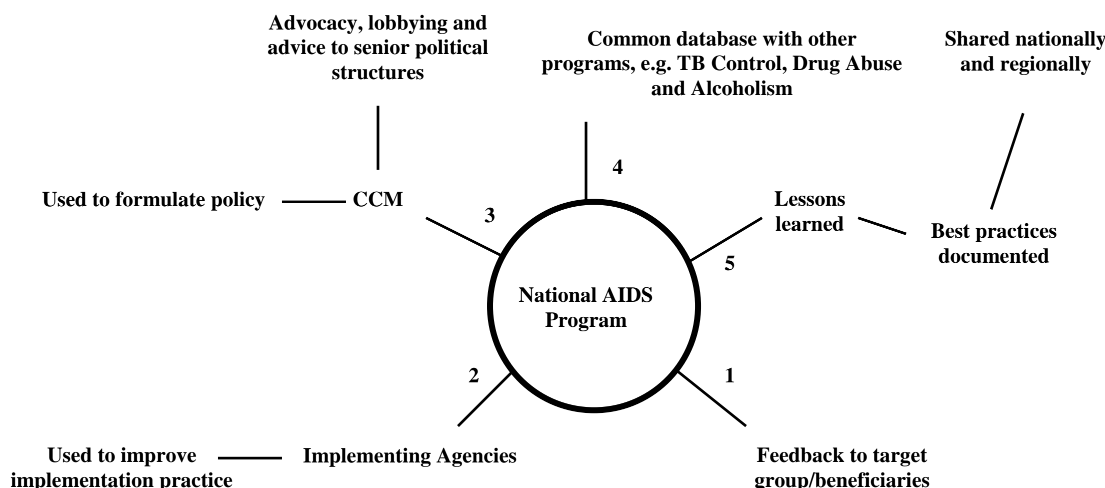
37.6. Strategy for quality control and validation of data:

Again this issue will be considered at three levels, impact, outcome and output. At the impact level, a key factor will be the rigorous design of the proposed baseline and impact studies within the five target groups (youth, IDUs, sex workers, MSM and prisoners). A key strength of the proposed study with IDUs is the technical input which has been provided by Imperial College, London. Similar external technical assistance will be sought in the other four areas for both design and implementation stages. Where possible this will be sourced locally or regionally. At the outcome level, a key quality control method will be subjecting the data produced to rigorous peer review, through discussions organized by the thematic task forces. Finally, at the output/process level, quality of data will be assured by periodic checks by the program's M&E co-coordinator, including project site visits. At all levels, a mixture of qualitative and quantitative methods will be used and data will be triangulated using a variety of collection methods.

37.7. Proposed use of M&E data:

M&E data will be used in at least five different ways by the program (see Figure 3). First and foremost (arrow 1), it will be fed back to the people from whom it was collected, i.e. the members of specific target groups. Secondly (arrow 2), it will be fed back to implementers with the aim of further improving practice. Thirdly (arrow 3), data will be fed to the CCM for them to formulate appropriate policies and to advise senior political structures, e.g. Cabinet of appropriate actions that need to be taken at that level. Fourthly (arrow 4), it is proposed to store data in a common database so that it can be used by other programs, e.g. TB control, drug abuse and alcoholism prevention and their data can benefit the AIDS program. Finally (arrow 5), it is proposed that M&E data should be used to document lessons learned and best practices for wider dissemination.

Figure 3: Use of M&E data by Estonia's National HIV/AIDS Program



38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.

Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partner(s)** (which may help in strengthening M&E capacities)	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Training staff of National AIDS Program Secretariat and Implementing Organizations in M&E including M&E from a gender perspective	UNAIDS, WHO, Council of Baltic Sea States Task Force	3800	0	0	0	N/A	**3800**
Employment of Monitoring and Evaluation Co-coordinator within National AIDS Program Secretariat	N/A	15510	9700	9894	10092	N/A	**45196**
Technical assistance for design and implementation of baseline and impact studies; ongoing technical support	UNAIDS, WHO, Institute of International and Social Studies, Tallinn	27750	11322	11548	29449	N/A	**80069**
Development of common database for M&E information, linking National AIDS Program with other programs, such as Drug Surveillance Center	Drug surveillance center and other programs	5000	0	0	0	N/A	**5000**
Total requested from Global Fund		**52060**	**21022**	**21443**	**39541**	**N/A**	**134065**
Total other resources available		0	0	0	0	N/A	0

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	Commodities to be purchased under this program include condoms, needles, syringes and pharmaceuticals. By law (Medicinal Products Act), only medicinal products registered by the Agency of Medicines and medicinal products for which the Agency of Medicines has issued a single authorization for import and use may be marketed and used in Estonia. For more details see http://www.sam.ee/index.aw?section=83 Considerations to be taken into account when pre-qualifying suppliers of products will include reputation, track record, guarantees of quality and price. Feedback from users will be taken into account in these processes.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	All pharmaceuticals used in this program will need to be registered in Estonia. Selection of drugs to be purchased will be guided by local expert advice and international treatment guidelines. Details of Estonia's guidelines on ARV are included as Annex 14. According to Estonian law (Public Procurement Act), there is an obligation to implement competitive tender procedures for all purchases that exceed US$6 250. For more details see http://www.rha.gov.ee/eng/?nav_PeaLink=Oigusaktid&id=9
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	Estonia has a set of *Rules for Putting into Service and for Use of Medical Devices*. These specify that medical devices which are put into service and used must be safe for patients, appropriately trained staff and other persons and comply with the essential requirements for medical devices and in vitro diagnostic medical devices established by the Minister of Social Affairs. For more details see http://www.sam.ee/parem.aw/section=2236 .A key focus of the program in this area is to ensure that all staff involved in any stage of product delivery are well-trained for this function. In addition, the highest standards of practice are expected at all stages of product management, including ensuring optimal and secure storage facilities. Care is also taken to ensure that products are used

	according to chronological order of expiry date and that control measures are in place to ensure that no product is used after its expiry date. Procedures for safe disposal of sharp items, like needles are well-established and will be rigorously followed and monitored.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	All institutions handling pharmaceuticals must be licensed and all health care workers must be registered by the Health Care Board under the Health Services Organization Act. For more details see http://www.sm.ee/gopro30/Web/gpweb.nsf/pages/indexeng.html Drugs will be stored in a secure pharmacy and will only be dispensed to a patient when prescribed by a doctor. Patients receiving ARVs will be given enough for one month under normal circumstances. They are currently asked to sign acknowledging receipt of their drugs. All provisions made will be consistent with Estonian law.

40. Describe the existing arrangements for procurement of <u>services</u> (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

Each participating organization will have its own arrangements for procurement of services e.g. hiring of staff. These are regulated by Republic of Estonia Employment Contracts Act. These will be examined by the National HIV/AIDS Prevention Program Secretariat on signing of any contract. Where these are not felt to be sufficient, e.g. in guaranteeing equality of opportunity regardless of sex, disability, sexual orientation, ethnicity etc., the National HIV/AIDS Prevention Program Secretariat will offer technical support to develop such procedures. Similar principles will apply to the procurement of services as for the procurement of products/commodities.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

Estonia has adequate infrastructure to deal with these requirements. In the most part, these activities will be carried out through existing channels. The Finance and Administrative Officer recruited to the National HIV Prevention Program will take overall responsibility for overseeing this area. Existing institutions within Estonia of relevance include:

- The Public Procurement Office is a semi-autonomous institution under the Ministry of Economic Affairs. The main responsibility of this institution is general management and supervision of public procurements procedures under the Public Procurement Act. For more details see http://www.rha.gov.ee/eng/?nav_PeaLink=Oigusaktid&id=9
- The Estonian State Agency of Medicines is a governmental body under the Ministry of Social Affairs which has the following obligations: marketing authorization and quality control of medicinal products, import and export authorization of medicinal products, pharmaceutical inspection and supervision over medical devices

42.Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of

support. Examples of such programs are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Details of funds for support of programs including purchase of commodities are detailed elsewhere in this proposal. There are no other major commodity donation programs relevant in this context.

Table VIII.42

Program name	**Contact person (with telephone & email information)**	**Resources requested (R) or granted (G)**	**Timeframe and duration of request or grant**

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

N/A

LIST OF ATTACHMENTS

Please note:
The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.
The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	Attachment #
1. Poverty Reduction Strategy Paper (PRSP)	________
2. Medium Term Expenditure Framework	________
3. Sector strategic plans	________
4. Any reports on performance	________
HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	
6. Baseline data for tracking progress[17]	
7. National strategic plan for HIV/AIDS, with budget estimates – **National HIV Prevention Program Plan**	1
8. Results-oriented plan, with budget and resource gap indication (where available)	
TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	________
10. Documentation of technical and operational policies for the national TB program, in the form of national manuals or similar documents	________
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	________
12. Most recent independent assessment/review of national TB control activities	________
Malaria specific documentation:	**Attachment #**
13. Situation analysis	________
14. Baseline data for the tracking of progress	________
15. Country strategic plan to Roll Back Malaria, with budget estimates	________
16. Result oriented plan, with budget and resource gap indication (where	

[17] Where baselines are not available, plans to establish baselines should be included in the proposal.

available)	
General documentation:	**Attachment #**
Social Inequalities in Health in Estonia	7
Health Behavior amongst Estonian Adult Population, Spring 2000	9
HIV/AIDS specific documentation:	**Attachment #**
Operating Rules of HIV Prevention Program Board	2
Proposed Management Structure for Estonian Proposal to GFATM	3
Proposed Terms of Reference for Estonian CCM	4
Minutes of program board meetings x 2	5
EuroHIV *HIV/AIDS Surveillance in Europe* end of year report	6
Press statements	8
KISS study	10
Living for Tomorrow study	11
HDI figures	12
Basic Laboratory Tests	13
Guidelines for use of ARVs in Estonia	14
TB specific documentation:	**Attachment #**
Malaria specific documentation:	**Attachment #**
Crosscutting documents/activities	**Attachment #**