–

European Monitoring Centre
for Drugs and Drug Addiction

Focal

2005 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

"ESTONIA"
New Development, Trends and lin-depth linformation on Sselected lissues

REITOX

REPORT ON THE DRUG SITUATION IN ESTONIA 2005

KATRI ABEL[1]
AVE TALU[1]
ANU NEUMAN[2]
ANDRI AHVEN[3]
GLEB DENISSOV[4]
LIINA LAASTIK[1]

[1]National Institute for Health Development/Research Centre, Estonian Drug Monitoring Centre/Estonian National Focal Point
[2]Estonian Forensic Service Centre
[3]Ministry of Internal Affairs
[4]Statistical Office of Estonia

National Institute for Health Development 2005
Research Centre, Estonian Drug Monitoring Centre/Estonian NFP

Hiiu 42
Tallinn 11619
ESTONIA
Phone +3726593997
Fax +372 6593998
e-mail:ave.talu@tai.ee
e-mail:Kati.Abel@tai.ee
website: http://eusk.tai.ee
http://www.tai.ee

This report was co-financed by the European Monitoring Centre for Drugs and Drug Addiction (Grant Agreement No CT.05.RTX.008.1.0)

Table of Contents

Figures and Tables

Acknowledgements and introductory note

A national report on the drug situation in Estonia is drawn up annually for the European Drug Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) and the Ministry of Social Affairs. This report gives an overview of the political and legal framework, demand and supply reduction interventions in the field of drugs in Estonia in 2004. The structure of report has been provided by the EMCDDA.

We are very grateful to our collaborators Ms Ene Katkosilt (Ministry of Justice), Mr Andres Lehtmets (Opiate Addicts` Substitution and Detoxification Treatment Unit of the Psychiatric Centre of West Tallinn Central Hospital), Ms Merike Kull (University of Tartu), Mr Kuulo Kutsar and Jevgenia Epštein (Health Protection Inspectorate), Ms Liilia Lõhmus, Ms Kristi Rüütel and Ms Aire Trummal (National Institute for Health Development), Ms. Urmel Reinoal (Health Care and Social Work Department of Tallinn City Government) and Mr Gleb Denissov (Statistical Office of Estonia) who have provided us with background information and useful comments.

We are very grateful to Ms Maarike Harro, MD, Ph.D, director of the National Institute for Health Development, member of the EMCDDA's Scientific Committee, and professor Toomas Veidebaum, MD, Ph.D, director of the Research Centre of the National Institute for Health Development) for continuous support.

Special thanks to our proofreader Ms Anneli Saluste.

The website of the Estonian Drug Monitoring Centre is available at http://eusk.tai.ee or on the website of the National Institute for Health Development at http://www.tai.ee (see Research Centre).

Summary

In terms of national policies and institutional framework there were no major changes in the reporting period. Major public debates on drug issues were not initiated on higher level in 2004.

Most significant change was observed in the drug market where the price of illegal substances decreased while the purity increased. For example, the price of heroin decreased drastically, however, despite the trend, Methylfentanyl was more popular than heroin in drug markets. Amphetamine type stimulants (ATS) were most often seized illicit drugs in 2004. Increase in the number of drug-related crime, both criminal offences and misdemeanours were observed. Available data on overdoses show that the number of calls to emergency aid increased three times in 2004. However, recent data on drug-related deaths show significant decrease (36 cases in 2003).

Establishment of a new treatment centre for minors in Jõhvi Hospital in Ida-Viru county in May 2004 was a positive initiative aiming at the provision of (drug-free) treatment for 30 children and young people aged 19 and under (see chapter 5). The idea of improving treatment opportunities is related to the discussion on the alternatives to prison raised by the Ministry of Justice of Estonia in 2004. According to the Penal Code (RT[1] I 2001, 61, 364; consolidated text RT I 2002, 86, 504) probation and subjection of convicted offender to supervision of conduct (incl. treatment and participation in social assistance programmes) can be alternatives to the prison sentence, however, it is necessary to provide more drug treatment possibilities and develop a social support network for drug users to implement the named provision of the Penal Code.

In 2004 the Health Protection Inspectorate registered a total of 743 new HIV cases which is a decrease of 97 cases compared to the previous year (HPI, 2004). Despite the falling trend in newly registered cases of HIV infection the HIV incidence remained very high in 2004 – 54.9 cases per 100,000 people (Health Protection Inspectorate, 2004). The majority of HIV infected was young people, predominately male, but the proportion of females among the HIV-infected showed a slight increase.

With respect to harm reduction measures it can be pointed out that he number of SEPs increased from 19 to 21. HIV/AIDS and drug prevention were not integrated into the curricula of primary and secondary schools and prevention work was carried out on project bases in 2004.

Drug-related data was not available on all drug-related areas (e.g TDI, PDU) or was of poor quality or was not provided on time, therefore, it was not possible for the NFP to give a comprehensive overview of the drug problem. For example, in this report data on drug-related mortality is provided on the basis of the year 2003, data on 2004 will be available in our next report. Also, a nation-wide database for registering drug-related overdoses was not set up in 2004. Monitoring and evaluation of HIV/AIDS interventions improved as a result of initiating the Global Fund Programme. The monitoring system of GF gave an overview of the number and profile of clients visiting SEPs or admitted for treatment, however, data on the quality of services were not provided. Data on responses to the HIV/AIDS issues improved considerably, however, evaluation of the implementation of specific interventions and projects in the field of drugs has to be developed further.

Data was also limited or missing on the quality of treatment, treatment demand and other major services provided for drug users. Drug Treatment Registry will be set up in January 2005 and data on treatment demand will be available in the nearest future.

In 2004 data on drug use in the population and problem drug use was not reported because of lack of studies during the reporting period. The population survey and ESPAD was carried out in 2003 and the data were provided in our previous report. Data on problem drug use will be available in 2005.

Despite the problems with drug-related data we have provided an overview of the drug situation on the bases of available data. However, it is difficult to see the consistency between indicators.

(Viimasena teha lühike ülevaade kogu pullist)

1)PART A: National Policies and context

1)1. National policies and context

During the reporting period no major changes in the national policies in the field of drugs were observed. The Ministry of Social Affairs was responsible for the overall administration of the Alcoholism and Drug Prevention Programme 1997-2007 (ADAPP) and the National Institute for Health Development was the main institution responsible for the implementation of the ADAPP. In 2004 more funds for carrying out the tasks of the ADAPP were available when compared to the year 2003, however, funding did not reach the level of 1999. With regard to the budget for HIV/AIDS prevention the Global Fund continued to provide financing in 2004 in addition to the funds allocated from the National HIV/AIDS Prevention Programme 2002-2006.

Legal framework
Legal framework

In 2004 the Ministry of Justice of Estonia initiated a discussion on alternatives to prison as provided in the Penal Code, passed 6 June 2001(RT[1] I 2001, 61, 364; consolidated text RT I 2002, 86, 504), entered into force 1 September 2002, it is possible to release a person in certain cases from punishment and arrange probation and subjection of convicted offender to supervision of conduct. Thus, if a court, taking into consideration the circumstances relating to the commission of a criminal offence and the personality of the offender, finds that the service of the imposed imprisonment for a specified term by the convicted offender is unreasonable, the court may order suspension of the sentence on probation (§ 74 section 1 of the Penal Code). According to the Penal Code in such case, the court shall order that the imprisonment imposed shall not be enforced in full or in part if the convicted offender does not commit a new intentional criminal offence within the period of probation determined by the court and complies with the supervisory requirements and obligations imposed on him or her for the term of supervision of conduct provided for

in § 75 of the Penal Code (Penal Code, RT[1] I 2001, 61, 364; consolidated text RT I 2002, 86, 504). According to section 2 of § 75 of the Penal Code regulating supervision of conduct and taking into consideration the circumstances relating to the commission of a criminal offence and the personality of the convicted offender, a court may impose certain obligations on the convicted offender for the period of supervision of conduct such as not to consume alcohol or narcotics, to seek employment, acquire general education or a profession within the term determined by the court, to undergo the prescribed treatment if the offender has previously consented to such treatment and to participate in social assistance programmes. However, alternatives to prison for drug users are not common practice in Estonia because of the very limited access to drug treatment and lack of funding.

In order to improve the coverage of vaccination for infections diseases among children, the Minister of Social Affairs approved a new immunization programme of infection diseases for children in 2005 (Decree no 94 of the Minister of Social Affairs, RT 25.08.2005, 92, 1392 , 2005) (see also chapter 7)

Institutional framework, strategies, policies

In 2004 the Ministry of Social Affairs was still responsible for the overall administration and co-ordination of Alcoholism and Drug Prevention programme 1997-2007 (ADAPP). The priorities of ADAPP in 2004 were the sStrengthening of the treatment/rehabilitation system, improvement of the quality and availability of improvement of services were defined as the priorities of the ADAPP in 2004. The Iimplementation of the ADAPP was the responsibility of the National Institute for Health Development (NIHD) which is a research and development institution in the area of government of the Ministry of Social Affairs (see National Rreport 2004). In Due to the fact that since 2005 became to forcethe National Strategy on the Prevention of Drug Dependency 2004-2012 took effect, thus, the year 2004 was the last year thewhen ADAPP remained in forcewas valid. The new strategy includes six fields of activity -– prevention, treatment/rehabilitation, harm reduction, supply reduction, drugs in prison and monitoring and evaluation of drug situation (see National Rreport 2004). Implementation of the activities in the fieled of treatment/rehabilitation, harm reduction and monitoring/evaluation is the responsibility of the Ministry of Social Affairs (MosoSA)/NIHD. Prevention is the responsibility of the Ministry of Social Affairs/NIHD and the Ministry of Education and

[1] RT = *Riigi Teataja = the State Gazette*

Science;, monitoring and evaluation belong to the competence of the Estonian Drug Monitoring Centre under the governing of what situates inthe NIHD;, supply reduction the Ministry of Internal Affairs is responsible for supply reduction and drug in prison and the Ministry of Justice for drug use in prison.

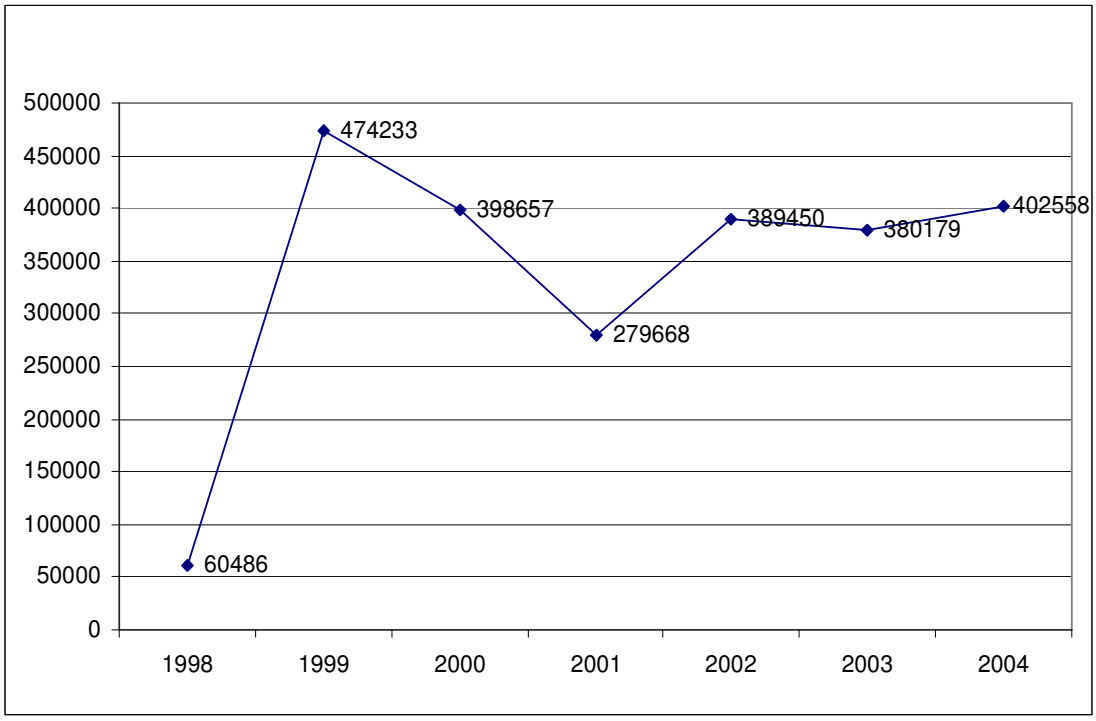
Budget and public expenditure

TStill the level of state expenditurespending on drug related activities is difficult to estimate as data onf some areas of activities are not readily available.

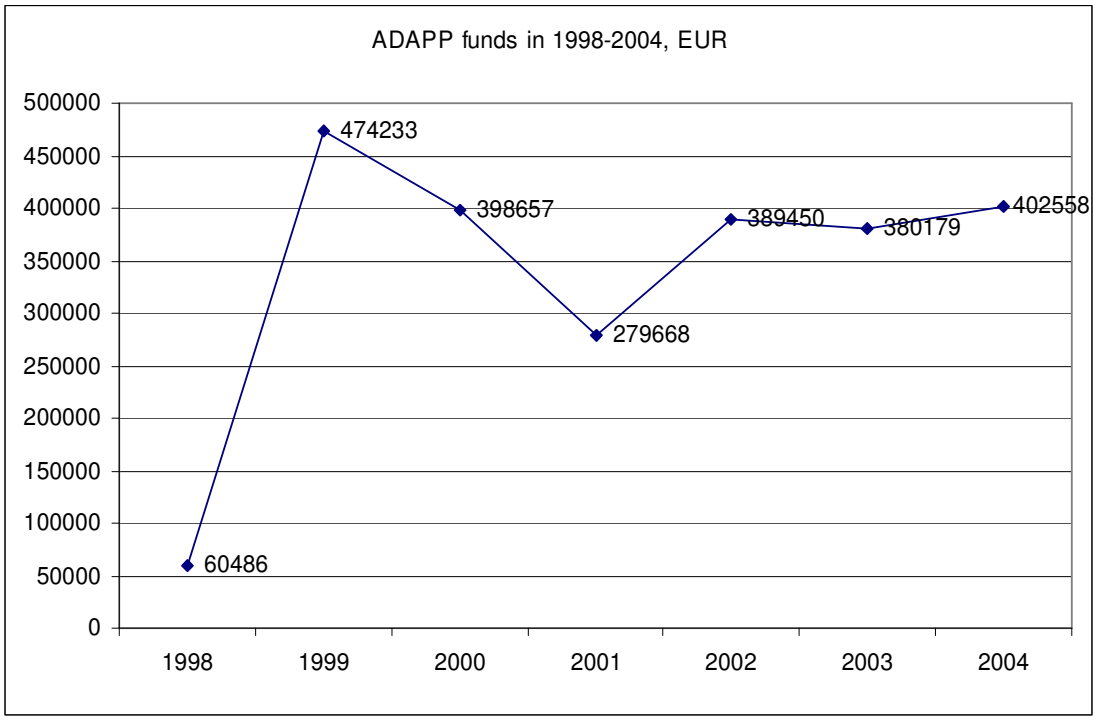
An overview of expenditures is available in terms of the activities of the ADAPPStill the best overview we have on resources of ADAPP. CComparison withed to the year 1999 shows that the financing of the ADAPP has substantially decreased (see figure 1 …)).

In 2004 total of NIHD received EUR 402,558 was allocated to the NIHD forto carry out meeting the goals of the ADAPP[2] as well as some of the and partly the goals of the NSPDD (approved 22 of April 2004).

Figure 1. : ADAPP funds in 1998-2004, EUR.



[2] ADAPP remained in forcewas valid until to the end of 2004.

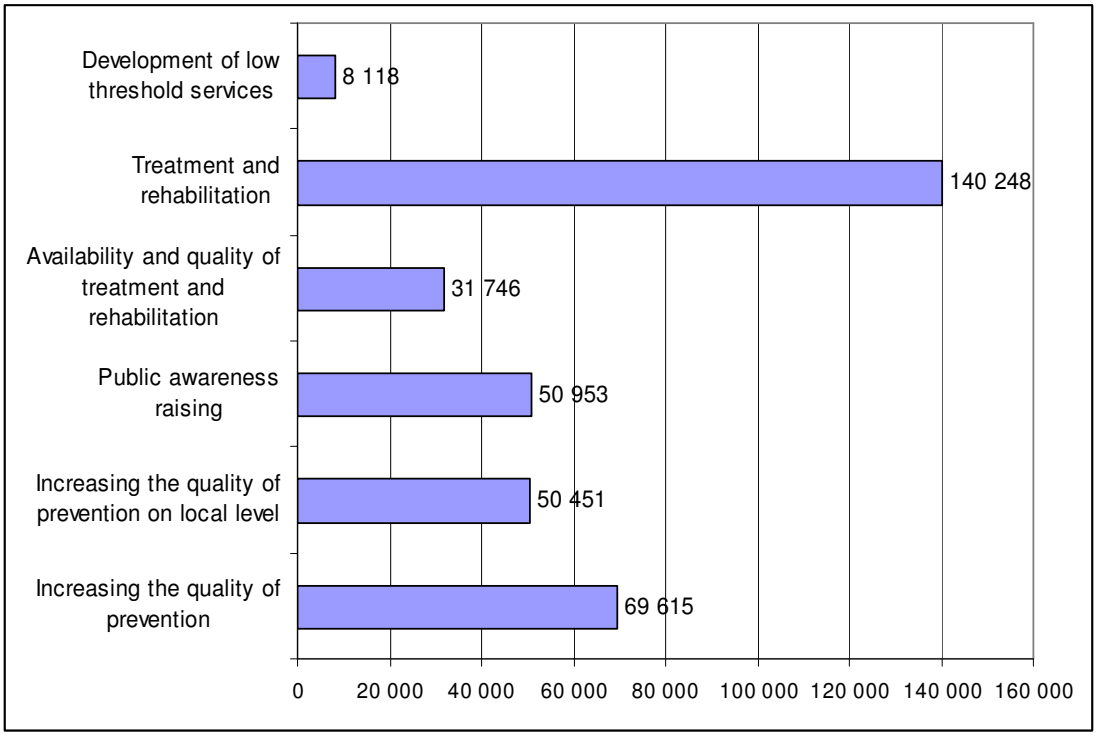


Source: Estonian Alcohol and Drug Abuse pPrevention Programme, 2005.

The ADAPP broken down by activities in 2004 is shown in the figure 2….. We can see that priorities for 2004 were the treatment and rehabilitation and improving the quality of prevention were the priorities in 2004.

The ADAPP allocated EUR 24, 943 for the prevention work in special schools and trainings of teachers. TheAlso Ministry of Education and Science (MEC) allocated EUR 10,486 from its budget to three special schools and 3,231 EUR to supported activities at three schools. with the amount of 10 486 EUR and schools within their budget with 3231 EUR.

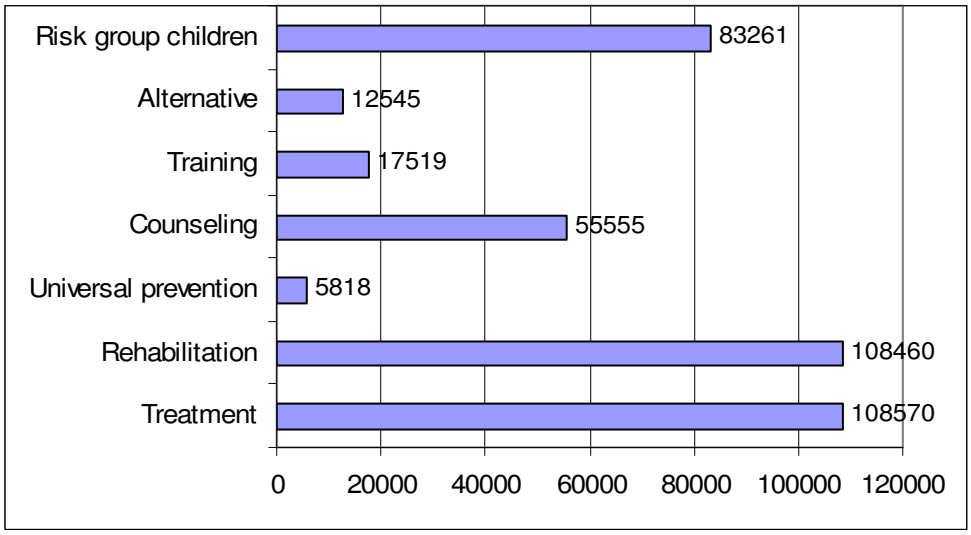
Figure 2…. ADAPP funds of the financial year 2004 (EUR) broken down by activities.



Source: Estonian Alcohol and Drug Abuse Pprevention Programme, 2005.

The Health Care and Social Work Department of Tallinn City Government funded totally with 391 728 EUR the HIV/AIDS and drug prevention projects with total of EUR 391,728 in on Tallinn level. Projects involved treatment, rehabilitation, prevention, counselling, training and information exchange activities in the field of HIV/AIDS and drug prevention (see Ffigure 3)). For the comparison in 2003 Rresources for HIV/drug prevention allocated by Tallinn City Government given by Tallinn were comparable with the year 2003 totalling to EUR 429, 580 EUR from whichere drug prevention accounted for wasEUR 363, 295 EUR (see National Rreport 2004).

Figure 3….. Budget of Tallinn City Government`s funds of the financial year 2004 (EUR) broken down by activities.



Source: Health Care and Social Work Department of Tallinn City Government, 2005.

In 2004 alstheo GCambling Tax Committee (GCTC) and Estonian Health Insurance Fund (EHIF) financed several projects in the area of from the health and social affairsfield.. In general broader contextthe drug problem is related towith many other social problems, therefore so it is difficult to make distinction between divide projects specifically targeting at on drug issues and projects focusing on drug-related issues among othersnot.. EURFrom CTC 3,389 EUR where allocated from GTC for specific directly to drug projects concentrating on what where related with rehabilitation and counselling of risk group children. There were counselling Some of the projects where covering counselingfocusing on , dealing with problems of atic youth unemployed young people ment and other crucial issues of great importance in our societycommunity.. From EHIF financed projects there There whwere no specific drug projects among the EHIF financed projects,, however,but most major part of projects were wherfocusing one about the promotion of healthy lifestyles, prevention

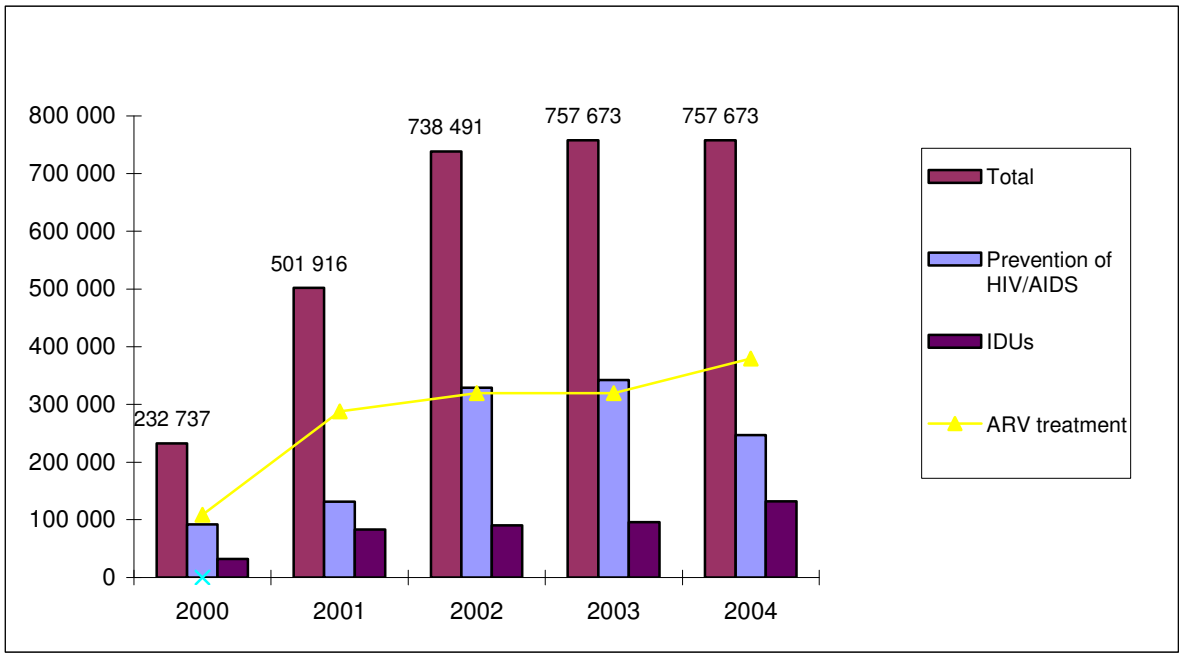
of infectious diseases prevention and provision of young people with counselling to the youth in the about framework of mental health issues.

HIV/AIDS prevention budget

In 2004 the Government allocated total of EUR 757, 673 for the implementation of the HIV/AIDS Prevention Programme 2002 – 2006, of which EUR 247, 050 was allocated for the prevention of HIV/AIDS, EUR 131, 660 for the interventions targeted atto IDUs and EUR 378, 962 was allocated for ARV treatment (sSee fFigure 4)[3].

However, in ccomparison withng 2003 the total sum allocated by the Government for the HIV/AIDS prevention by the government in 2004 remaineds on at the same level.

Figure 4:. Breakdown of expenditures for HIV/AIDS pPrevention 200-2004.



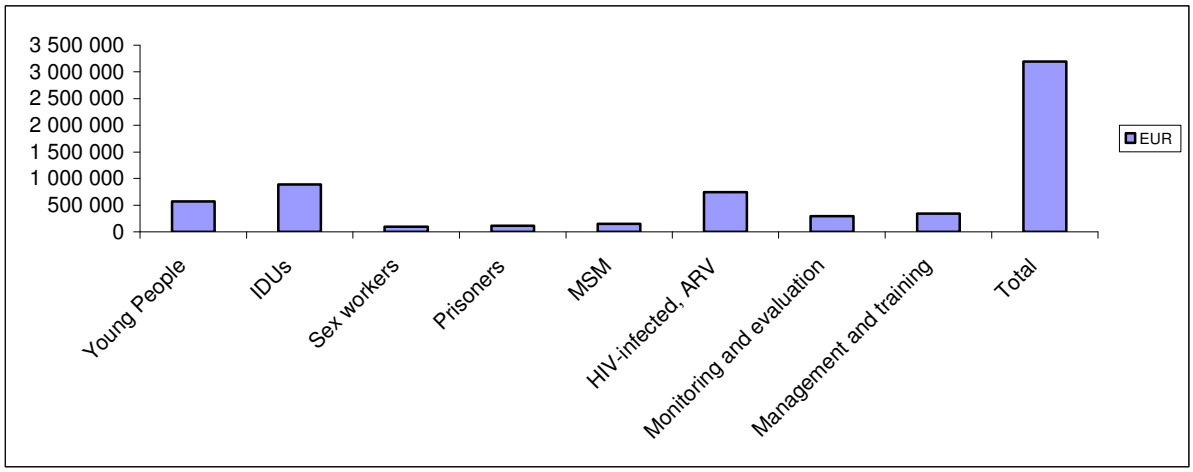
Source: Annual Reports of HIV/AIDS Programme, 2000 – 2005.

As it was stated in our previous report submitted toprovided by the EMCDDA, in 20043, the NIHD as the Estonian contractual partner to the Global Fund to Fight AIDS, Malaria and Tuberculoses (GFFAMT) entered into a contract on the

[3] In 2004 funds for ARV treatment were allocated directly from the budget of the Ministry of Social Affairs

implementation of thea programme “National pPartnership to lincrease the Sscale of Estonia’s rResponse to a cConcentrated and Rrapidly developing HIV/AIDS eEpidemic” in Estonia (sSee also sSub-Cchapter on pPrevention of dDrug-related iInfectious Ddiseases)[4]. In order to stop progressive spread of HIV/AIDS by the year 2007 the GFFAMT has allocated a total ofaltogether EUR 3, 191, 815.9 for the period September 2003 to September 2005 to the NIHD, as thea pPrimary rRecipient[5]. The funds have been are divided betweeninto 7 main targets of the programme such us yYoung Ppeople, IDUs, Ssex workers, pPrisoners, mMen who have sex with men (MSM), HIV-infected and people in who need of ARV treatment, Mmonitoring and eEvaluation, Management of pProgramme management and tTrainings (sSee National Report 2003 and sSub- cChapter on pPrevention of HIV/AIDS pPrevention) asnd are shown in fFigure 5.

Figure 5. e……Distribution of funds between the main areas of the GFFAMT p Programme s main objectives in the period of September 2003 to September 2005 (EUR).



[4] Target groups of the programme are young people aged 10-24, IDUs, female sex workers, prisoners, men who have sex with men (MSM) and PLWHA.

[5] The NIHD as a Pprimary rRecipient of the GFFAMT pProgramme will fund the foallowing activities: counselling, methadone detoxification and substitution treatment, syringe exchange, rehabilitation for drug addicts, media campaigns, establishment of drop-in centre for sex workers, counselling of sex workers, pre-and post-testing counselling in prison, prevention of the spread of HIV among MSM, establishment of gay’s´ and lesbian’s` information centre, creation of support groups for HIV positives, raising the awarenessknowledge of schoolchildren of HIV, training of 18-24- year- old students of vocational schools students, and schoolchildren of special school students, as well as and conscripts, training of youth organizations, ARV treatment)

Source: NIHD, GFFAMT reports, 2005.

During the period of September 2003 to September 2005 the NIHD as the a P primary Rrecipient of the GFFAMTi pProgramme "National Partnership to Increase the Scale of Estonia's Response to a Concentrated and Rapidly developing HIV/AIDS EpidemicNational partnership to increase the scale of Estonia's response to a concentrated and rapidly developing HIV/AIDS epidemic" allocated funds for the 7 above named areas as follows: EUR 571,036 to reduce risk behaviour among yYoung Ppeople aged 10 – 24 and to increase the awareness of the public ofknowledge's related with HIV/AIDS related issues, EUR 884,335 to reduce risk behaviour of IDUs, EUR 95,588 to reduce risk behaviour ofamong sex workers, EUR 111,765 to prevent the spread of HIV in pPrison, EUR 151,790 to reduce risk behaviour ofamong MSM and to increase their awareness of knowledge's on HIV/AIDS related issuesthemes,, EUR 745,013 to improve the quality of life of PLWHAs increasing their access to health care and support services. The rest of the funds were divided into 2 areas aiminged to at increase ccapacity-buildingbility of organizations participating in the GFFAMT pProgramme and to developing co-operation between organizations in order to meet the objectives of achieve goals of the programme – monitoring and evaluation, management and training of the programme (sSee also Ssub-cChapter 7.1 on pPrevention of dDrug-related Iinfectious dDiseases).

Social and cultural context

Attitude to drug addicts and drug addiction

The attitude to drug addicts reflected in media is still negative. Drug addicts are mostly described as criminals. In 2004 a few articles gave a review of provision of drug addicts with support and treatment, overviews were given about different centres and services set up for drug addicts. However, media presented the drug addict as a criminal rather than a sick person in need of help. A heroine injecting drug addict was the stereotype of the drug addict in writing press.

Media considered the issue of drug addiction to be of great importance, however, it was seen as a personal problem of the drug addict rather than a problem of general concern. Only a few articles tackled drug issues from another point of view. According to media drug addiction was a huge problem in connection with HIV/AIDS. Articles described the provision of HIV positives with treatment as a huge economic burden imposed on the state. HIV infection was a good reason for supporting drug addicts and ensuring establishment of facilities for substitution treatment and treatment. According to media drug addiction as well as HIV/AIDS were problems of the Russian-speaking population and provision of support to and treatment of drug addicts was not about improving the quality of life of drug addicts but finding possibilities for harm reduction (Laastik 2005).

Initiatives in parliament and civil society

In 2004 discussions about drug issues were not carried out on the level of government. M. Pomerants, minister of social affairs made a presentation on HIV/AIDS-related issues and the scope of the problem in Estonia at a cabinet meeting of the government. The minister acknowledged in his presentation that if systematic implementation of harm reduction measures had been initiated in the second half of the 90-ies, it would have been possible to hinder the spread of the HIV epidemic and prevent transcending of the epidemic from the risk groups. The minister also stated that provision of drug addicts with services was not yet sufficiently funded and it was necessary to develop syringe exchange and substitution treatment (http://www.riik.ee/brf/index.php?id=24604&tpl=1006).

Media representations

Media reported on drug-related issues mostly in connection with crimes. The topic of criminal offences included articles on crimes committed by drug addicts: thefts, robberies etc. Also, the issues of drug business caught the attention of media: business carried out by criminal drug leaders and big groups of drug offenders, drug couriers, drug transit, drug dealers and street traders, confiscations of drugs and production of drugs.

Estonian newspapers wrote most often about heroin as it is used by injecting drug users. Synthetic drugs such as ecstasy and amphetamine were also written about quite often, mostly in the context of confiscations and young people.

In 2004 the number of newspaper articles covering drug issues in relation with HIV/AIDS increased considerably. In 2004 media focused on HIV/AIDS more often than in previous years and a number of articles on HIV/AIDS covered the issues of drug addiction.

Overall the number of articles reporting on drug issues decreased to a certain extent, however, the content of such articles improved as experts on drugs were asked to participate in writing articles on drug-related issues. News on drugs were most numerous, however, the proportion of opinion pieces increased (Laastik 2005).

(tõlgilt 1 lk)

2.2. Drug use in the population

- Drug use in the general population
  No new information available. See the ESTONIA ESTONIA Drug Situation Drug Situation 2004.
- Drug use in the the school and youth population
  No new information available. See the ESTONIA Drug Situation 2004.
- Drug use inamong specific groups.
  No new information available.

3.3. Prevention

No significant changes have were observedoccurred i in the prevention system during the reporting period. Prevention work was still mainly based on projects financed by the ADAPP or local governments and carried out by the local governments. With respect toRegarding school based prevention no obligatory national school based programmes on drug prevention did not existed in Estonia in 2004. Within the framework of Under targeted selective prevention Tallinn City Government financed several it is possible to mention projects focusing on directed to risk group children what .were financed by Tallinn City Government. Also, targeted prevention included projects carried out in three E Estonian three special schools drug prevention programs fit under the category selective prevention.

Universal prevention

<u>School- based prevention</u>

The situation ofwith universal prevention at schools in 2004 was is similar to that of the year 2003. No oCompulsory bligatory national school basedd p programmes on the prevention of drug use were not developedis made regarding prevention of drug use, although meetings and negotiations werehave been held between relevant partiesners to integrate such programmesit into the health education curriculum. In 2004 there were 3 study books on social skills available covering the first, second and third level. The books were used on vVoluntary bases. They include are available three study books on social skills covering the first, second and third level. Three books consists theory, notes for teachers and worksheets for students. The books were used according to The mthe methodology ofethod is based on the UNDCP methodology (see previous reports).

Provision Publishing of theose study books and training of teachers was funded bybased on the finances of N the National Institute for Health Development in 2004 (EUR 15,033 EUR). Totally of 380 health education teachers were trained in 20 trainings sessions.

Efficiency of the Some efforts to evaluate the use of the namedose social skills study books on social skills inat schools was studied are also made in a the framework of Master's thesismaster diploma. The study was carried out on the basis of data collected made based on data from two counties – Tartumaa and Põlvamaa. TheAnd the result showed was that 70,4% of the teachers who had participated in the training on the use of the had the study books training had actually used the material at school and 94,4% of the teachers having used the books where satisfied with the quality of theose social skills study material books (Mark 2005).

Publicity Informative events

OIn the framework ofne of the major publicity events was production of communication and information exchange the documentary “Sergei and Boriss” was made (80 copies). A Also cCinema bus tour was organized to show the documentary. The cCinema bus visited 20 schools in Estonia. and in wWorkshops were organized to communicate information about drug use and give schoolchildren a possibility to organize had a chance to create anti anti-drug campaignsadverts.. A nNational dDrug cConference in 2004 November focused on *the question-Ddrug addicts – - victims or the criminals*? was held in November 2004.

Also, several publicity some informative events were organized by the Health Care and Social Work Department of Tallinn City Government within the framework of HIV/AIDS and drug prevention projects. An interestingOne bigger project causing attention was about organizing school visits tour “With Cookies against Drugs” including were distribution of ed information materials/ condoms and carrying out organized role-plays and situation games. Also, funding was allocated for a Also youth music festival “The Mmillennium without Ddrugs” and a club event under the drug free guide received financing. Also Tallinn City Government continued to support the radio programme show concerning drug-related issues “Islands in the Ocean” about drug-related issues.

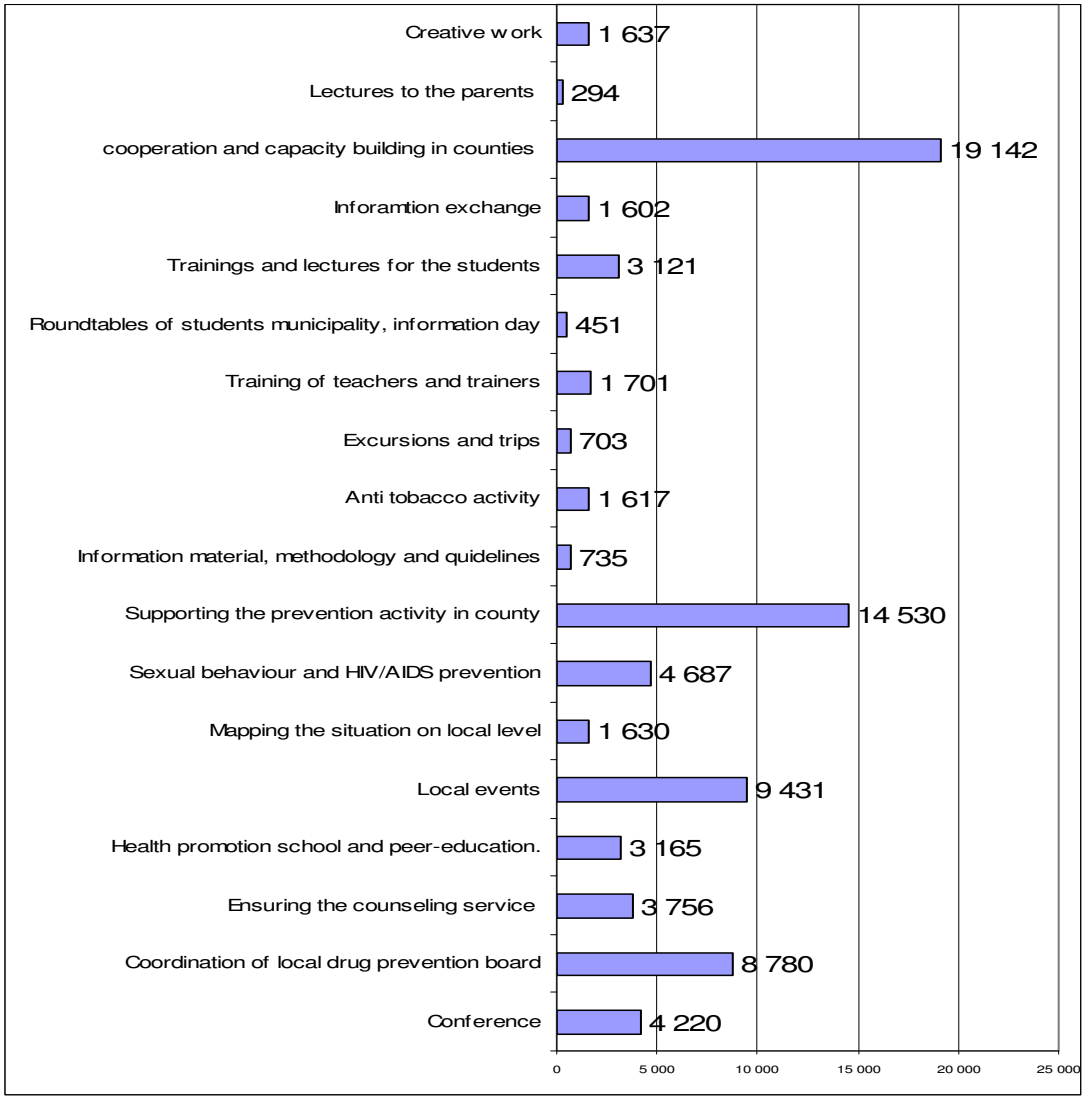
Project- based prevention on local level

It wasis very difficult to get a comprehensivegood overview of prevention activitiesy in Estonia because the fundsresources for prevention work were allocatedare coming from different sources. Considering the circumstancesIn that framework we do not have a clear idea of complete picture the funding broken down byhow much local governments, privateet companies, external partners or embassies for carrying outsupport drug prevention activitiesy.. From the year 2005 onward it would be easier to monitor it would be easier to the monitor recourses allocations of funds for drug prevention by local governments but in 2004 such data was not the data is not reported. To In summarizey , we can say that in addition to the allocated financial resourcesthat local governments supported prevention work with free media outputs, transport, rooms and other non- monetary contributions. ways including monetary recourses given.

It wasis possible to make an overview of the use of resources allocated by the National Institute for Health Development for the prevention work and activities carried out on local level. given and activities taken on local level by National Institute for Health Development under prevention work. Altogether 15 counties where allocated total of financed totallyEUR 81,202; EUR where the minimum amount per county waswas EUR 4,795 EUR and maximum EUR 6,714 EUR. Funding was allocated according to the action plans of the counties. Local drug prevention boards (established in 2001 in every county) are acting as coordination units of prevention activities. As a rule, each Counties received money based on local action plans and coordinating unit was local drug prevention board (since 2001 in each county). In was common that countyies has developed and action plan foron drugs and HIV

prevention together only with the exception of was Harju and maa ja Viljandi countyy which havewho focused only on drug prevention activities. In fiFigure 6…. is showsn all the the summarized activities undertaken according underto the county ose aaction plans, as well as and resource distribution between activities on local level in 2004.

Figure 6.... . HIV/AIDS and drug prevention according to activities in counties by type of activity in 2004.



Source: National Institute for Health Development, 2004.

** Explanations to the categories*[6]

- ✓ [6] *Creative work -- competition of HIV and drug- related art and posters contest*
- ✓ *Lectures forto the parents - on- lectures from the prevention issuesfield*
- ✓ *Cooperation and capacity building in counties - trainings and seminars for drug prevention boards (DPB), local prevention networks, staff of recreational settings, NGOs and local governments, meetings of the chairmen of DPBs, reports oning conferences and seminars, updatinggrade the database onf prevention network partners, prevention rewards, participation inon information days.*
- ✓ *Information exchange -– articles on prevention inarticles on local newspapers, specific radio programmes, information days, creation of internet output, information exchange in workplaces.*
- ✓ *Trainings and lectures for the students -– HIV and drug prevention lectures, studies of social skills learning,, lectures forof the youth police and trainings "It`s your choice"*
- ✓ *Roundtables meetings of students self-governments municipality, information days- roundtables of students municipality and information days to improve the drug prevention*

Support for drug prevention work was the The biggest budget heading with the linebiggest amount of resources for carrying out the activities of the in counties action plans was supporting the drug and HIV prevention network focusing on activity by ensuring the capacity building (trainings, seminars) of local drug prevention boards and administration.routine of work. The budget heading The next line was *supporting to the prevention activitiesy in countiesy* covered what in principal meanswork with young people within the framework of "fFrom youth to youth" projects" concurs within the county. Information about the activities was not available Iin 2004, however, we expect to get the data for the next reporting period –do not

---

- ✓ *Training of teachers and trainers -– training for teachers on social skills methodology, training for teachers, prevention trainings on prevention for teachers and to other persons working with the youth.*
- ✓ *Excursions and trips -– thematic theatre visits and study trips*
- ✓ *Anti- tobacco activitiesy -– a competition to declare a tobacco- free class at schoolcontest, celebration of international tobacco- free day, propagation ofadvertising the competition "Quit and Win", training of teachers onof health education, information days for the medical staff at schools on the harm of smoking, using alcohol and other drugs for school medical teams.*
- ✓ *Information material, methodology and guidelines -– dissemination of information on stribution of drugs and, HIV/AIDS prevention information and provision of methodological guidelines and ensuringguaranteeing the availability of informationthem on local level.*
- ✓ *Support toing the prevention activitiesy in countiesy -– a contest for enhancing to promote the prevention activitiesy, supporting and evaluatingon of the youth directed projects targeting the youth.*
- ✓ *Sexual behaviour and HIV/AIDS prevention -– lectures on sexual education, training of teachers onf health education, establishing astart the counselingcounseling cabinet and supporting the activitiesy of the counseling cabinet.*
- ✓ *Mapping the situation on local level -– questionnaires on health damaging lifestyles, questionnaires targeting the at local school population on local levels, comparative analysis ofn the use of alcohol and, narcotic substances,, and compiling creation of crises files on local level.*
- ✓ *Local events - HIV/AIDS and drug prevention events on local level (celebration of International AIDS Day, Children Protection Day, International Yyouth Day, International Anti-dDrug Day, aAnti-drug campaigns and a graffitiy festival, and drug prevention and health weeks inat countyies schools.*
- ✓ *Health promotion schools and peer-education: - seminars forof the staff teams of health promotion schools, provision of training andand support toing of peer students movement, organizing camps of health promotionng schools, support for students` teams and student self-governmentsstudents municipality.*
- ✓ *Provision ofEnsuring the counseling services - ensuringguaranteeing theaccess to anonymous counseling on HIV, drugs and condoms counseling, support foring the counselling cabinets, training of youth advisersconsultant, provision of psychological counseling forof children, group work with parents, purchasing of equipment and hard wear supply to improve the counseling.*
- ✓ *Covering of administrative expenses of cCoordination of the work of local drug prevention boards-.administrative expenses*
- ✓ *Conferences:- participation in the national HIV/AIDS conference, conferences organized on county level (Child Protection, HIV/AIDS)*

have the correct overview of the projects within this line but in 2005. Other budget headings included we can assure the information on those projects. Following lines where provision of counselling, both for service what included also children ofat risk groups and their parents.

Within the area of universal prevention the Extra for resources allocated from NIHD and the Health Care and Social Work Department of Tallinn City Government allocated special funds for financing ed from the field of universal prevention two youth summer camp projects what for school children includingvolved activities targeting sexual behaviour and drug prevention (using aactive studylearning methods (methods such as role plays, psychological training, conversations, individual work and promotion of healthy life style). The on sexual behaviour and drug prevention. The target group included of those camps was 763 school children.

SelectiveTargetedSelective prevention

The main focus of pPrevention projects financed by the Health Care and Social Work Department of Tallinn City Government were in most cases focusing on children belonging to risk groups. children Totally 16 projects targeted involved risk group children. and aApproximately 358 risk group children/parents of risk groups participated in those projects. The biggest project which got funding from Tallinn City Government was initiated to provide support to support to the problematic children in the inpatient department of the daycare stationary in Foundation Tallinn of Children Hospital. Other funded projects carried out offered alternative activities, established support groups, launched networking and focused on capacity building, as well as carried out . Also counselling work through establishing hhelp lines and youth cabinets forinvolved risk children at risk.

Estonian has three special schools: Tapa, Puiatu and Kaagvere. In the period of years 2004/2005 total oftogether 234 students aged 10-17 studied in these schoolsunder special regime.. The ADAPP allocated EUR 24, 943 for the prevention work in special schools and trainings of teachers. Also, the Ministry of Education and Science (MEC) allocated supported these three schools with the amount of EUR 10, 486 EUR and other schools within their budget with EUR 3,231 EUR. from its budget to support prevention work.

The mMain activities in these three special schools includedwere provision of trainings forof teachers, staff and students, alternative activities such aswhat included sport, cultural/social events and outdoor activitiesy, counseling both individual and group counselling, treatment and rehabilitation what includinged also provision of the supply of medicaments, vaccination and health control. The treatment was provided wasin both in-patient as well as out-patient settingambulatory and stationary..

Due to the lack of a reporting system it wasis difficult to get an overview ofon the allocation of resources allocation by activityies andaccording every source of fundingfinancial source.. Allocation of The division of fundingresources by type of activityies provided given by the HIHD is shown in the table 1…….. The NIHD was mainly responsible for the treatment/ counselcounselling and rehabilitation. Funding Resources came ffrom the MEC was were used for training purposes and alternative activities. Schools provided with their budget supported for the administration of the performance of ve functions of drug prevention and alternative activities.

Table 1….. Allocation of funds byThe division of type of resources between aactivityies in special schools in 2004.

Activity	**EUR**
Trainings for staff and teachers	3,937
Trainings for students	4,907
Alternative activities	1,438
Counselling	3,881
Treatment and rehabilitation	6,386
Administrative Administrationcosts	4,394

Source: National Institute for Health Development 2005.

4. Problem drug use

Prevalence and incidence estimates
No new information available
Profile of clients in treatment
No new information available. The drug treatment data base will be launchedstart working in January 2006.
Main characteristics and patterns of use from non-treatment sources
No new information available.

5. Drug-related treatment

Summary

In Estonia, the drug treatment is a part of the National Strategy on the Prevention on Drug Dependency 2004-2012 adopted by the Government on 22on the April, 22 2004. The main objectivetarget of the national drug strategy is development of professional and efficient treatment for drug-addicts, improvement of the quality of treatment and expansion of drug treatment services across Estonia.

However, TTallinn City Government has adopted a Drugs and HIV/AIDS Action Plan for 2003- 2007. TheAbove-mentioned Action Plan focusesplace on greater emphasis on treatment and its availability of treatment in Tallinn[7]. The Tallinn City Government opened the first specializsed substitution treatment centre in 2003 in Tallinn in 2003 and it is stillhas continued to be the biggest specializsed substitution treatment centre in Estonia. In 2004 Tallinn City Government supported provision of gender specific assistanceintervention and initiated the with implementationing of the specializsed treatment programme targetingtailored to female drug users. More in-depth aspects of the developments in the field of treatment, including greater availability of detoxification and substitution treatment will be described in this chapter hereafter.

Treatment system

In order to give a comprehensive overview of the describe treatment system, more descriptive data areis needed on the characteristics of treatment providers (e.g. type of treatment, size and type personnel, a sservices provided tooffered to drug addicts, profile of clients etc), their capacity building, funding, quality assurance systems and additional services to be provided by that a drug treatment provider would like to offer additionally in the future. In 2005 the EDMC conducted a small survey aiming ated to getting a better overview of the treatment system in Estonia. Results of this study will be published in next National Report on Drug Situation.

Due to lack of comprehensive data we have described new developments in the field of drug treatment in 2004 on the basis of the projects funded by the NIHD withinon the framework of Alcohol and Drug Prevention Programme for the years 1997 - 2007, GFPFMTA[8] and Tallinn City Government.

[7] Tallinn City Government supports treatment of those PDUs who are officially registered in the database of permanent residents of Tallinn.

[8] NIHD is a Primary Recipient of the Global Fund to Fight Malaria, Tuberculoses and AIDS Programme in Estonia

CurrentThe existing scope of treatment and rehabilitation services is far from sufficient despite some efforts made in this fieled in 2004. A notable development in the filed of treatment is in some extent the Rremoval of treatment from psychiatric hospitals, historically known as a primary treatment providers for problematic drug users can be considered as a notable development in the field of treatment.

In 2004 the number of treatment institutions providing treatment for drug addicts has increased to some extent.

A new treatment centre for minors was opened ion August 2004 atin Jõhvi Hospital in Ida -Viru County, Jõhvi Hospital aimed to provide (drug-free) treatment for 30 children and young people aged under 19 and younger. In 2004 it was planned to set up was planned to open a new treatment and rehabilitation centre for adult drug addicts atin Sillamäe, Ida-Viru County, with close co-operation of a Phare Twinning Project, however,but for various reasons it was postponed for to the next year.

To improve the quality of drug-related treatment The NIHD provided funds from the budget of NDAPP for supporting the organization of 5supported from the budget of NDAPP altogether 5 trainings to improve the quality of drug-related treatment. Funds were allocated for a sSeminar on tTreatment methods; Ttraining on Ccare mMethods and lLow tThreshold sServices; tTraining on pProject and tTeam mManagement; sSeminar and workshops on the dDevelopment ofing a N networking, tTraining on oOutreach wWork were aiming ed tto increase the knowledge 's of the staff of treatment and rehabilitation centre's staff and strengthen the cooperation between different actors in this fieled. The aAbove- – mentioned trainings and seminars were organised in partnership together with Trimboos Instituut, Netherlands.

Drug- –free treatment

As we stated earlier in this report, absence of data has not does not allowed aus to give athe comprehensive overview of in-patient and out-patient drug- free treatment in Estonia. As we noted eEarlier in this cChapter we, mentioned that the Estonian NFP conducted a surveytudy in 2005 onamong drug treatment service providers aiminged to giveprovide an overview of drug treatment institutions and delivery of services, quality assurance and other aspects related to their work. The findings of the survey , which will be published in the next National Report. As we stated noted in 2003 National Report 2003, several approaches werehave been used in the drug-

free treatment such as cognitive behavioural method, 12-steps addiction counselling, family therapy and other methods. However, the scope of the in-patient –an and out-patient drug-- free treatment remaineds unclear.

Medically – -assisted treatment

In 2004 Estonia continued to expand programmes of substitution treatment and increase the quality of drug treatment services by provision of through the training of practising medical staff with relevant training (see also sub-chapter Treatment System). On the whole, limited data dido not enable us to give a comprehensive overview of medically- – assisted treatment in Estonia. Therefore, in this cChapter we have described medically assisted treatment on the basis ofbased on the reports of Tallinn City Government, the NIHD and Global Fund Programme in Estonia. In the reporting period within the framework of the National Alcohol and Drug Prevention Programme During the periodthe NIHD allocated invested on the framework of the National Alcohol and Drug Prevention Programme EUR 140, 247.5 forto treatment and rehabilitation , of which EUR 80, 731.3 was was used for to setting up 2 new treatment centres: an in-patient treatment centre for children and an in-patient tTreatment Ccentre for adults in Sillamäe (see also Treatment System). As a result of this, the most of the funds were were spent onto the establishment of new treatment centres, thus, and due to that the resources for only limited funds were allocated for ddrug treatment were limited. However, during in the same period Tallinn City Government supported 3 treatment projects with the amount of EUR 228, 152.2 (EEK 3, 568, 300 EEK).

WithinOn the framework of the GF Programme to Fight Malaria, Tuberculoses and AIDS, Principal Recipient,the National Institute for Health Development, the primary recipient, supported detoxification and substitution treatment from January to October 2004, however, since November 2004 the NIHD has and continued to provided funds forsupport only substitution treatment only. since November 2004. InDuring the period of September 2003 to September 2005 total ofaltogether EUR 219, 318.7 (EEK 3, 430, 145 EEK) were allocated forinvested to the provision of detoxification and substitution treatment with methadone. As at September, 2005 ap5 proximately close to 350 persons had received substitution treatment withinon the framework of the GFPFMTA programme (Veimer, 2005).

As at 31 December 31, 2004 total ofaltogether 253 persons hadve been received detoxification and substitution treatment of which 66,4% (b=168) were HIV positives (NIHD, 2005).

In 2004 Tallinn City Government allocated EUR 82,864.5supported from their budget with amount offor EUR 82 864. 5 the provision of drug treatment to 95 children with drug treatment in Tallinn Children's Hospital.

Tallinn Children Hospital continued to provide detoxification and substitution treatment with buprenorfine. Ninety five children received buprenorphine treatment inDuring the reporting period, 1.01.2004 – 31.12.2004., 95 children received buprenorphine treatment.

The first substitution treatment programme with methadone was launched in 2003 in the substitution and detoxification treatment unit of the West Tallinn Central Hospital[9]**.** In 2004 Tallinn City Government allocated in total of EUR 128, 516.5 (128 516.6 EEK) to the West Tallinn Central Hospital's Drug Treatment Centre for the provision of detoxification and substitution treatment to adult drug addicts[10]. The aAbove- mentioned Centre providedoffers medically- –assisted treatment toaltogether to 60 drug addicts (30 in substitution treatment for 30 and 30 in the detoxification treatment for 30 clients). Tallinn City Government allocated also EUR 16, 771 (EEK 262, 300 EEK).

6. Health Correlates and Consequences

After the peak in 2001, when 86 drug- related deaths wereas registered the number of drug-related deaths decreasedgrew down close to about 2.4 times (see the cChapter on drug-related dDeaths and mMortality). However, Contrary with this, induring the reporting period therre was a dramaticbig growth (3.,2 times) in the number of drug-related overdoses is we commented on describe hereafter in this chapter. On the whole, limited data enableds us to make assumptions, rather than draw reliable conclusions on the decreased in the number of casesnumber of drug-related deaths and increase ind the number of casesnumber of drug- related overdoses.

[9] Tallinn Social and Welfare Board has provided the West-Tallinn Central Hospital with additional funds outside Independently to the namedthis treatment provision contract Tallinn Social and Welfare Board is funds additionally the West – Tallinn Central Hospital.

[10] The cCost of treatment induring the period 01.01.04 – 28.02.2005 was included into the total cost of the project. The Aactual expenditure cost offor treatment in 2004 was 1,270,468 to which was added expenses made of for the provision of treatment induring the period of 01.01.2004 – 28.02.2005 have been added

After the peak in 2001, the number of newly registered HIV- – infected personsions showeds a falling trend. Still mMost of the HIV- infected people wereare young people. In terms of gender males contributed to the majority of newly registered HIV-infectedion,, however,but the proportion of females among HIV-infected shows a slight decrease. Also, a decreasing trend was observed in case of hepatitis B and hepatitis C in 2004 (sSee chapter on Drug- – related Infectious Diseases).
Psychiatric co- morbidity has been a topic of discussion among experts,, so far no any routine data collection system has been set up in this issue.
As we stated noted in the previous reporting period, it is necessary to improve the quality of data in the area of health correlates and consequences needs to be improved. In 2003 it was not possible any longer to provide data on drug-related deaths and mortality of drug users, thus we providedwill present theseis data in our 2004 National Report 2004. Unfortunately, data on drug- related deaths wereis not readily available yet,, thus we will present theseis data in our next report. This delay is was mainly the result ofrelated with legal problems we described in- – depth in our 2004 National Report 2004last report (see 2004 National Report 2004).

Direct drug-related mortality

Total of 36The absolut cases ofe number of direct drug-related deaths (DRD) were recorded in Estonia inwas 36 in 2 2003 accounting for more than fifty per cent decrease in the number of deaths since , which is less than a half of 2002's number (86)[11]. In order to justify the decrease in On the whole, to explain an increase inthe number of casess of drug-related deaths, we have need to check thelook consistency ofbetween indicators. Limited data available on other indicators (e.g. drug-related overdoses), absence of the data on prevalence of the Pproblem Ddrug Uuse and treatment demand etc) enableds us to make estimatesassumption, rather

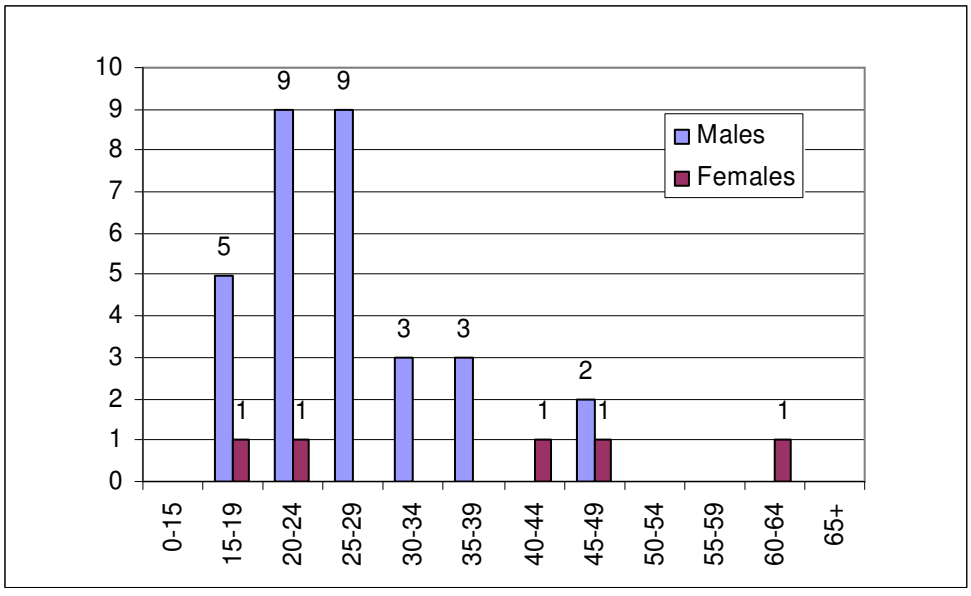
[11] The mMethodology for the collection of DRD has not changed. Estonia uses the EMCDDA definition for General Mortality Registers, "selection B". A possible cause of underreporting couldwould be incorrect certification or coding, thus, the to check that mortality database was were searched for all cases ofany mention of mental and behavioural disorders as a result of the use of due to psychoactive substances use excluding alcohol (ICD-10 codes F11-F19). Only 1 additional case was found under the referencewith mention of "opioids", 5 more cases under the reference with mention of "other and unspecified substance". In these cases the deaths were given an underlying Underlying cause of death in these cases were reported infectious diseases (incl.. 1 case of AIDS), encephalitis, lung and liver diseases. Thus,So, even if some of these 6 cases should have been reported as drug-related deaths, due to drug use, the sharp significantd decrease in of direct drug-related deaths was still is the actual case likely to rather than be "real", not resulted froma result of the data processing methodology of data processing.

than draw reliable conclusions on the decrease in the number of cases ofof drug-related deaths (see cChapter 4 on the pProblem dDrug uUse and the data on dDrug -related overdoses above afore). We couldan assume that delivery of services targetinged to IDUs over the during last few years, such as sSyringe eExchange, and HIV testing hasve had some positive impact on the to reduction of – drug-related deaths in Estonia. However, as we stated earlier, that limited data enableds us to make assumptions, rather than draw reliable conclusions.

All these 36 cases of drug-related deaths cases were certified by forensic medical experts baseding on the autopsy results of autopsy. However, 18 of the casesthem were reported to bedue to "other and unspecified psychodisleptics" – T409, 10 cases were specified asdue to "other and unspecified narcotics" – T406, 5 cases of death were attributed to opioids, 2 to methadone, 1 to cocaine. Such a distribution of codes suggesteds that a toxicological test either hads either not been done in the majority of cases or its result wereas not available to the mortality registry. Vast majority of cases (31) were reported as accidental poisonings, one case – suicide, four cases – events of undetermined intent.

Distribution of the deceased by age and sex is shown on fFigure 71. The mMajority of them wereare young men aged 15-29 years, only five cases out of 36 cases are were female deathswomen.

Figure 7.. Number of direct drug-related deaths by gender and age in 2004.

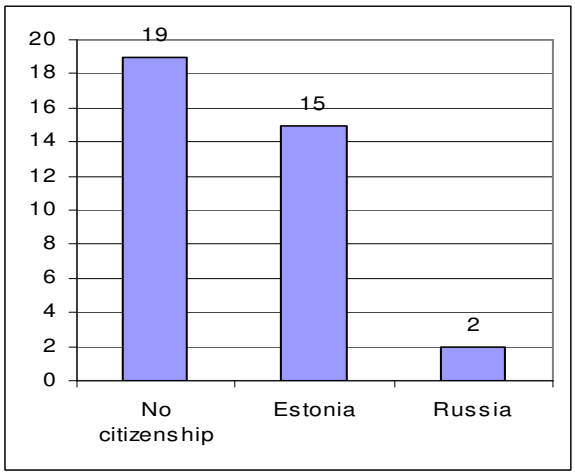


Source: Estonian Statistical Office of Estonia, 2005.

Vast majority of them died due to drug use were rReesidents of Tallinn, the capital city of Estonia, Tallinn (23 cases)accounted for the majority of cases of drug-related deaths, residents of the surrounding area (Harju County) has contributed towith 8% of the cases. Only two cases of drug-related deaths (6%) were registered in Tartu, the second largest city of Estonia. Residents of Narva, the third largest city located locating near the border ofwith Russia contributed towith 11% of the cases.

Citizenship and ethnic origin are iImportant background indicators are citizenship and ethnic origin. Non-citizens accounted for Mmost of these drug-related deaths, users who died due to drug use were stateless persons, 42% Estonian citizens accounted for 42% and, citizens of Russia for only two cases (6%) of drug-related deathscitizens of Russia. According to the 2000's Population Census 2000 the share of non-citizensstateless persons of in the totalgeneral population of Estonia was 12,4%, Estonian citizens – accounted for 80,0% and , Russian citizens for 6,3% of the total population. In the age group 20-29 the respective shares wereshares are 14,0%, 81,1% and 3,5% respectively.. The data shows that As we can see the nthe share umber of statelof non-citizens of the total population was marginal (see figure 8).ess persons in direct drug-related mortality is disproportional.

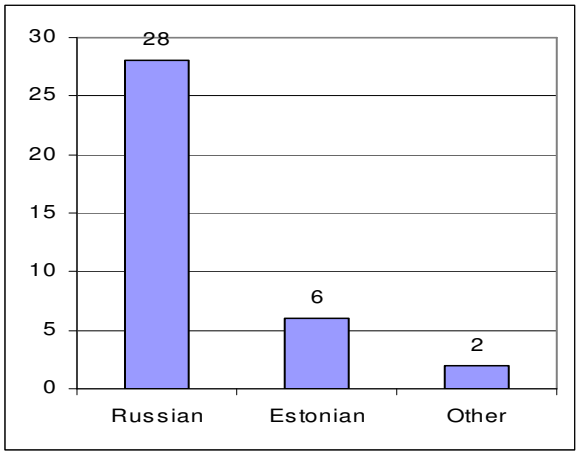
Figure 8. Direct drug-related deaths by citizenship.



Source: Estonian Statistical Office of Estonia, 2005.

Figure 9 … shows the distribution of drug-related deaths by ethnic origin: 77% of the deceased were ethnic Russians, 17% - ethnic Estonians, in two cases (6%) the deceased belonged to were attributed to other ethnic groups, likely Russian-speakers (a Mari and a Belarusian), both Russian-speaking persons. According to the 2000's Population Census 2000 the share of ethnic Russians of the totalin general population was 25,6%, the share of ethnic Estonians – 68,0%.

Figure 9.. Direct drug-related deaths by ethnic origin.



Source: Estonian Statistical Office of Estonia, 2005.

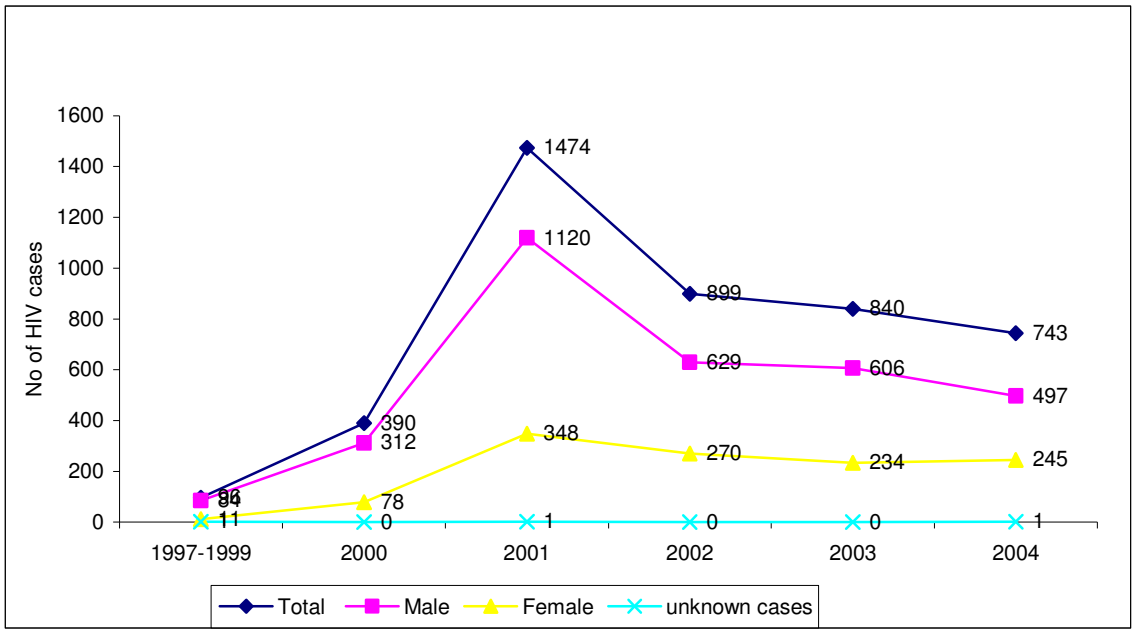
To conclude, this Chapter we can say that a typical case of direct drug-related death in 2003 was accidental poisoning (overdose) of happened to a young (20-29 year-s old-) man of Russian ethnic origin, a resident of Tallinn, a non-citizenstateless. In cComparison withed to the previous year the number of direct drug-related deaths has decreased by more than 50%twice.

Drug -– related infectious diseases

In Estonia the HIV incidence rose to peaked in Estonia at rate of 107.8 cases per 100, 000 inhabitants population in 2001, in 2002 it started to fallbeing fallowed by decline in 2002, the decline continueds in 2003 toand currently, in 2004, the HIV incidence remain very high – 54.9 cases per 100, 000 inhabitantspopulation in 2004 (HPIEpiNorth, 2004).

In 2004 the Health Protection Inspectorate registered a total ofaltogether 743 newly registered HIV cases, which was accounted for 97 cases less than previousprevious year (HPI, 2004) (sSee fFigure 10).

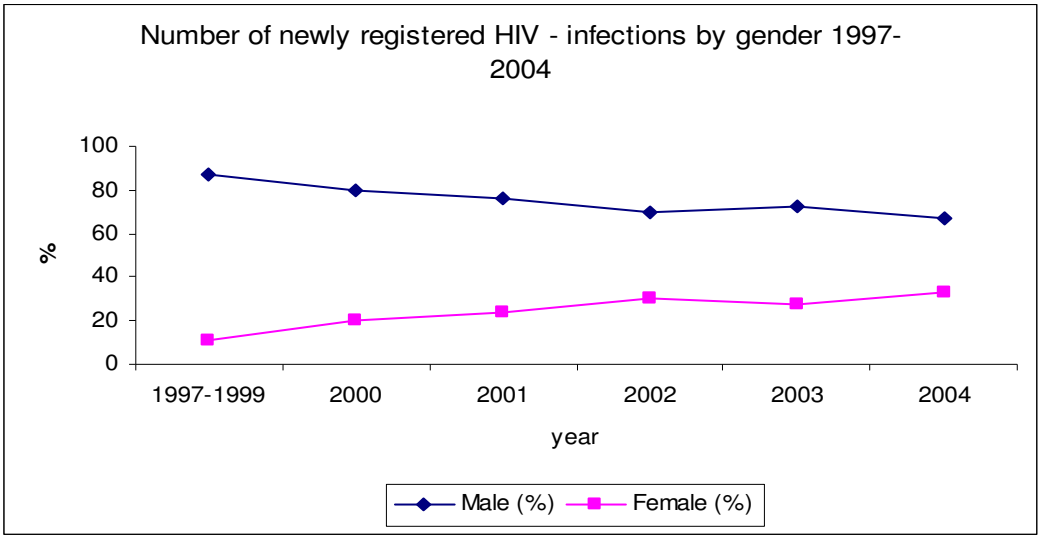
Figure 10. : The nNumber of newly registered HIV infections in 1997-2004.



Source: HIV Reference Laboratory, Tallinn Merimetsa Hospital, 2004.

Still HIV infected persons wereare still maledominatedpredominantly male but the proportion of women ofamong all HIV infected showed an increasing trend growing tendency -– in 2004 almostclose to one – third of the persons (32.9%) diagnosed as HIV positives were female compared to versus 27,9 % in 2003 (see fFigure 11).

Figure11.: Number of newly registered HIV- infections by gender 1997-2004.

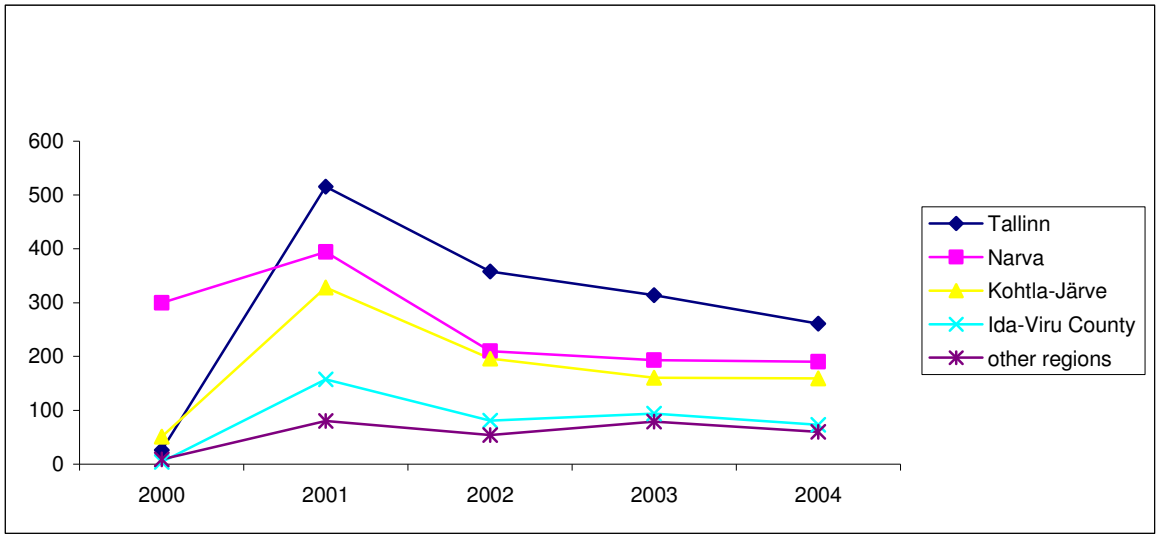


Source: HIV Reference Laboratory of Tallinn Merimetsa Hospital, 2004.

Since 1988, the year when the first1st case newly registered of HIV infection was registereddiagnosed,, to 31 December, 31st 2004 overallaltogether 4,442 new cases of HIV infections were registered., 4,277 persons with HIV infection reported of which had Estonia as their a permanent place of residence. It is rRemarkable is that one- third (33,2%) of all HIV cases registered during the period 1997 – 2004 in Estonia were registered in 2001.

Similar to the previous year the majority of newly diagnosed cases of HIV infections were registered in Tallinn, Narva and Kohtla- Järve and Ida-Viru cCounty foallowed by other places in Estonia (see Ffigure 12).

Figure 12:. Breakdown of newly registered cases of HIV infection by regions of Estonia in 2000-2004.

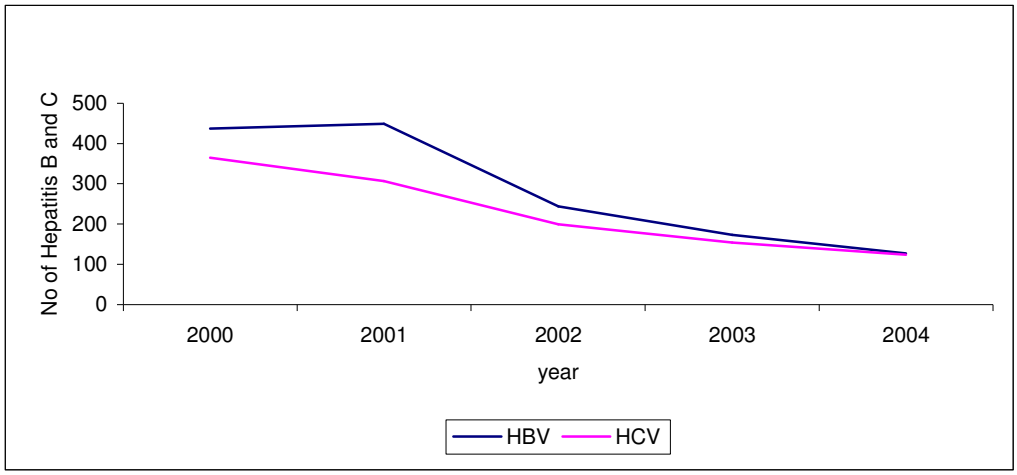


Source: HIV Reference Laboratory, Tallinn Merimetsa Hospital, 2004.

Nation- – wide surveillance data of HIV Reference Laboratory of Merimetsa Hospital shows that during the period 1887- – 2004 total ofaltogether 2,285 drug users were screened for HIV of which 35,7% were detainees tested for HIV in prison (n=818) and 36,2 % (n=830) were tested anonymously. The dData shows that during the period 1987 – 2004 altogethertotal of 2,022 newly diagnosed HIV infectedions persons were tested in prison of which more than half were newly registered cases of tested to be HIV infectionHIV positive first time..

According to the surveillance datda gathered, the number of cases of hepatitis B and –C cases show a continuously falling trend (see Ffigure 13). In 2004 total of 124 acutecases of acute hepatitis C and 127 cases of hepatitis B cases were registered in Estonia (Health Protection Inspectorate, 2004; Standard Table No 9). Data shows that thethe high rate of HCV and HBV infection among IDUs was high -– 71.,1% and 70.6%, respectively (Standard Table No 9).

Figure 13.: Number of notified cases of Hepatitisc B and C 2000-2004.

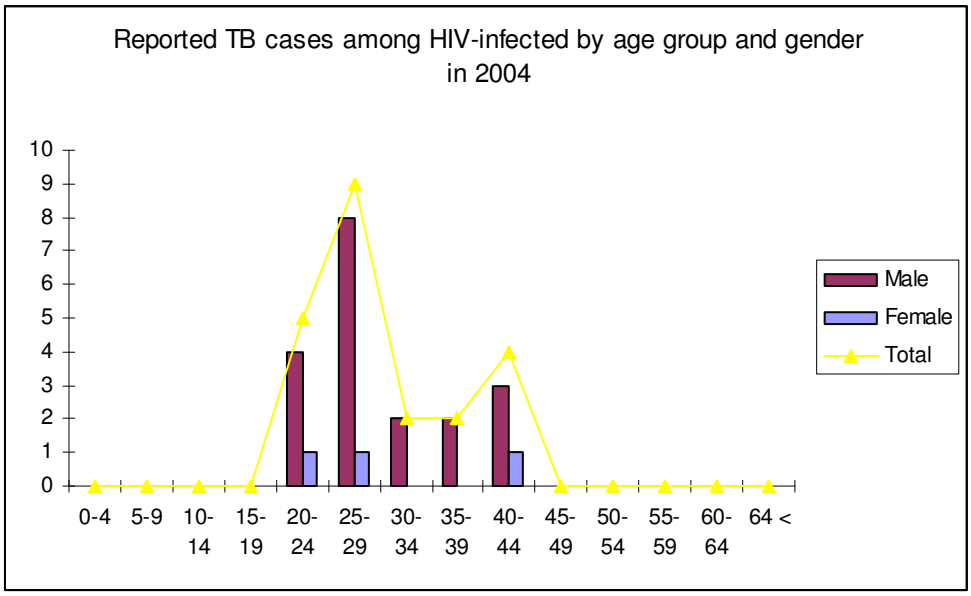


Source: Health Protection Inspectorate, 2005.

There was a further increase in the number of TB cases among HIV-infected. In 2004 22 TB cases (M=19, F=3) were reported among HIV-infected compared to 13 TB cases registered last year[12]. The majority of TB infected HIV positives were young people, predominantly male (M=19, F=3) (see figure 14). Surveillance data on prevalence of TBC among IDUs were not available.

Figure 14. Reported TB cases among HIV-infected by age group and gender.

[12] In December 2005 a total of 561 TB infected people were registered in Estonia of which 445 were tested for HIV antibodies. In 116 cases the results of HIV antibodies are unknown



Source: Estonian Tuberculosis Registry, 2005.

Psychiatrivc co-morbidity

As we statednoted in the summary, so far a no any routine data collection system has been set up iofn psychiatric co-mortbidity has not yet been set up in Estonia. It has been is pplanned to open a specialized centre of dual diagnoses for drug users a on the basis of the Psychiatric Centre of Tallinn Regional Hospital ispecialised centre of dual diagnoses centre for drug users nat the second half of the year 2005.

Other drug-related correlates and consequences

Availability of Regarding other drug- related health correlates and consequences, then ddata on this areaother drug- related health correlates and consequences was is very limited. In 2004 TTallinn City Government supported the organisation of a Conference on pPregnant drug users and children having given birth byborn to drug users. Establishment of a specializsed centre in Tallinn for pregnant drug users and children ofborn to drug users in Tallinn hasve been a topic of discussion.

7. Responses to health correlates and Consequences

- Prevention of drug- related deaths
- Prevention and treatment of drug- related infectious diseases.
- Interventions related to psychiatric co-morbidity

No new information available

- Information related to other health correlates and consequences

No new information available

7. Responses to Health Correlates and Consequences

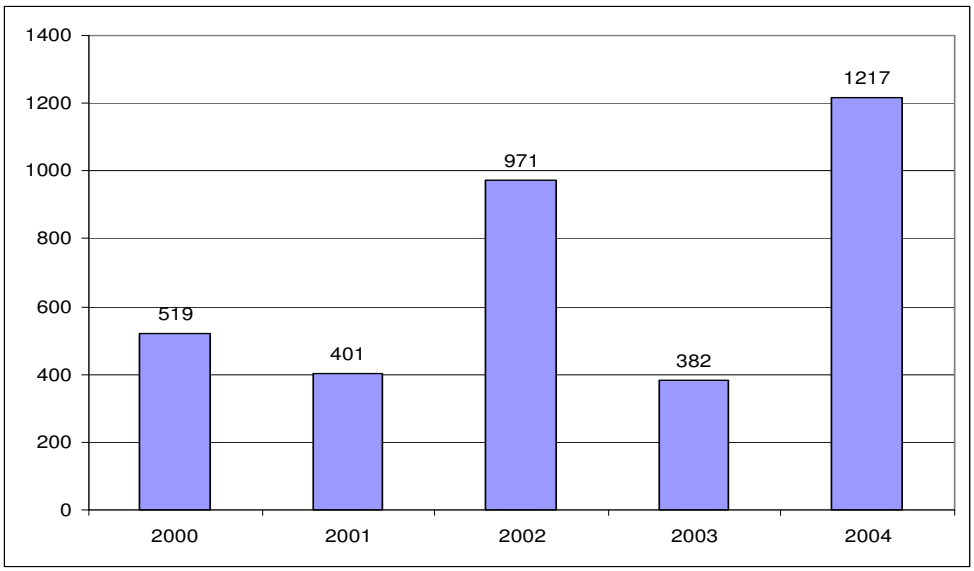
Responses to health correlates and consequences in Estonia over the last reporting period include interventions focusing mainly on drug-related infectious diseases (e.g syringe exchange, testing and voluntary counseling, information on safer sex, distribution of condoms etc). In our previous report we highlighted problems related to the quality of HIV surveillance data, however, it is necessary to improve other data on health correlates and consequences. In Estonia a system has not been set up for the collection of routine nation-wide data on drug-related overdoses to give information on the extent of the problem as well as the profile of IDUs in need of assistance due to overdoses. During the reporting period provision of data on evidence-based interventions improved; also, the NIHD continued the development of the evaluation and monitoring system in Estonia managed by the Evaluation and Monitoring Unit of the GF Programme. However, there is a need to assess the impact of the intervention on national and local level. Provision of information of overdose risks and management is not common practise in Estonia, however, taking into account the fact that the number of cases of drug-related overdoses increased three times, there is obviously a need for the provision of such type of information (see Prevention of Drug-Related Overdoses)[13]. During the reporting period the number of operating SEPs in Estonia increased from 19 to 21. Almost all of them (20 out of 21) were funded by the GF Programme. The work of SEPs were monitored by the NIHD, the principal recipient of the GF in Estonia.

Prevention of drug-related deaths

In 2004 a total of 57,503 calls to emergency aid were made of which 2.1 % (n=1217) were about drug-related overdoses (see figure 15). In comparison with the previous year the number of drug-related overdoses increased 3,2 times suggesting that there is a need for carrying out activities aiming at the reduction of drug-related overdoses.

[13] Nation-wide data on drug-related overdoses is not available; therefore we can only use data provided by Tallinn Emergency Service

Figure 15. Number of calls to emergency aid for drug addicts 2000-2004.



Source: Tallinn Emergency Medical service, 2004.

In this chapter an insight into the drug policy is given focusing on interventions undertaken for the reduction of drug-related overdoses and deaths and integration of these issues into the main policy documents in the field of drugs – the National Strategy for Prevention of Drug Dependency 2012 (NSPDD) and its annex - Targeted Action Plan of the National Strategy for Prevention of Drug Dependency 2004-2008 (TAPNSPDD). Reduction of drug-related deaths has been identified as one of the main targets in three areas of the drug strategy: in relation to the activities on the EU level (p. 1 of the Introduction); concerning the need to provide officials fighting against drug use with access to the database on drug-related deaths caused by overdose (chapter 5, Supply Reduction, p. 31 of the NSPDA); also, reduction of drug-related deaths has been referred to as an indicator used for monitoring the drug situation in Estonia (the chapter on monitoring and evaluation, p. 34,) and as a performance indicator for the implementation of the national strategy (the chapter on monitoring and evaluation, p. 36)[14]. Objectives related to overdoses have been defined in two areas of dug-related activities in the National Strategy – as a performance indicator intended to measure responses to drug problem, p. 35. In the

[14] The need to ensure access to the DRD data has been integrated into the strategy due to the problems related with the collection of personal data. New Personal Data Protection Act entered into force 11 October 2003 prohibiting the Statistical Office of Estonia (SOE), the leading institution providing annual statistics (e.g on drug-related deaths), the collection and processing of personal data. In May 2004 the Riigikogu (Estonian Parliament) passed the Official Statistics Act Amending Act to enable the SOE to conduct official statistical surveys and collect private personal data. However, it has taken a long

NSPDA 2012 specific target groups have not been identified in relation to the reduction of drug-related deaths. The revised Targeted Action Plan of the National Strategy for Prevention of Drug Dependency 2004-2008 neither provides any intervention aiming at the reduction of drug-related overdoses and deaths nor refers to the need for developing and implementing a targeted programme for the reduction of drug-related overdoses and deaths[15].

Revision of the Tallinn Drugs and HIV/AIDS Action Plan for 2003-2007 shows that prevention of drug-related deaths and mortality is mentioned once in the named local policy document as a performance indicator indirectly measuring the effectiveness of drug treatment (p.13). The first information campaign on the reduction of overdose targeting recreational drug users was implemented by the Estonian Foundation for Prevention of Drug Addiction (EFPDA) in 2000. During the information campaign leaflets on different types of drugs (e.g Amphetamine, Ecstasy, Cocaine, LSD, Cannabis) predominantly used in recreational settings were published to provide information on the harm associated with these drugs and measures to be taken to avoid overdoses. This campaign was strongly criticized and a question was raised in media and among policy- and decision-makers weather it was ethical to carry out a harm reduction (HR) activity targeting recreational drug users. The necessity for taking HR measures targeted at recreational drug users is acknowledged in the national drug strategy, however, the Action Plan for 2004-2008 does not provide any activities for the reduction of overdoses among recreational drug users and other drug users (NSPDA until 2012; TAPNSPDD 2004-2008). In 2001 a booklet consisting of true stories of drug users on how they had become addicts and the problems they had encountered in their drug-using career (incl. overdoses) was compiled by Dr. Loogna and published by the EFPDA. There is some information about nightclubs having set certain in-house rules for their staff for handling drug-related overdoses, however, this issue needs to be studied further. In 2005 the NIHD organised trainings for the staff of Syringe Exchange Points (SEPs) on handling overdoses as well as trainings for drug users. In Estonia the practice of emergency aid includes use of antagonists to reverse opiate or benzodiazepine overdoses (Standardised Questionnaire 29)[16]. Treatment of drug users with opiate antagonists is not available on "take-home" basis in Estonia as is the case in some other EU countries. During the reporting period discussions of any kind on this issue have not been carried out

time for the SOE to take all necessary technical measures to comply to the strict criteria set up for the institutions collecting personalised data.

[15] Targeted Action Plan of the National Strategy for Prevention of Drug Addiction 2004-2008

on decision-making level. Supervised consumption rooms have not been established in Estonia and it has not been even discussed on political or decision-making level. In 2004 the number of syringes and condoms distributed to IDUs rose remarkably, however, there is a need to increase the extent of services targeted at IDUs.

Prevention of drug-related infectious diseases

Prevention of drug-related infectious diseases was described in-depth in our last report, focusing on the activities of HIV/AIDS prevention within the framework of "National HIV/AIDS Programme for 2002-2006"and the GF Programme (e.g goals and tasks of the programmes, expenditures etc) and the interventions having taken place or planned within the framework of these 2 programmes (see National Report 2004)[17]

In 2004 the NIHD continued with the activities of the GF programme[18] – prevention work targeting young people and reduction of risk behaviour, targeted interventions for IDU's, men having sex with men (MSM), sex workers, prisoners, improvement of the quality of life of HIV-infected people and capacity building of the agencies involved in the fight against HIV.

Vaccination

In 2003 Estonia started to vaccinate all newborns against HBV within the framework of the national immunization plan (RTL, 2003, 115, 1827). In 2005 the Minister of Social Affairs adopted an immunization programme on vaccination of children against infectious diseases (decree of the Minister of Social Affairs no 94 RTL, 25.08.2005, 92, 1392, 2005). With the adoption of the decree the previous immunization plan was repealed.

---

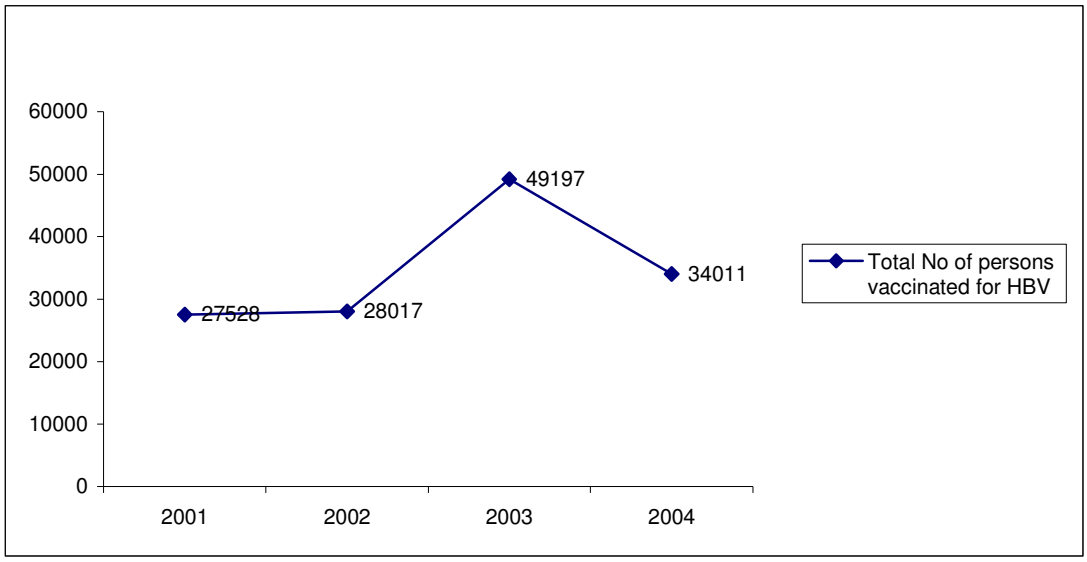
16 Flumazenil and naloxone are widely used medicaments in case of overdoses.

17 The National HIV/AIDS Programme 2002-2006 provides activities such us improvement of availability of condoms, methadone treatment, distribution of sterile syringes for IDUs, provision of councelling and HIV testing for people belonging to risk groups (incl. PLWHAs and their partners)

18 Since 2003 the NIHD is responsible for the implementation of the Global Fund to Fight AIDS, Malaria and Tuberculoses, a 4-year programme "National Partnership to Increase the Scale of Estonia's Response to a Concentrated and Rapidly developing HIV/AIDS Epidemic" in Estonia. The main aim of the programme is to stop progressive spread of HIV/AIDS. The main target groups of the programme are young people aged 10-24, IDUs, female sex workers, prisoners, men who have sex with men (MSM) and PLWHAs. The programme is divided into 2 periods – 1.10.2003-20.09.2005 and 1.10.2005 – 30.09.2007.

The number of persons vaccinated against HBV fell considerably from 49,197 in 2003 to 34,011 in 2004 of which 31,701 were children aged 0-14 and 131 schoolchildren aged 13-14 (see figure 16).

Figure 16. Total no of persons vaccinated against HBV in 2001-2004.



Source: Health Protection Inspectorate, 2005.

During the reporting period 3,170 adult persons were vaccinated and 78 were revaccinated.

The vaccine coverage is better among 13-14-year old children – 94.7% of them have been vaccinated against HBV. The level of immunity achieved with vaccination against HBV in 2-year old children is about 46.3%. The level of immunity against HBV in schoolchildren aged 13-14 varies substantially by regions being lower in Tallinn and Harju county – 92.5% and 89.5% respectively, and higher in Rapla, Põlva and Lääne county – 98.2%, 97.5% and 97.4% respectively. Approximately one third of the children from 7 months to 14 years of age have been vaccinated against HBV, however, it varies substantially by regions being higher in Tallinn (43.6%) than in other regions of Estonia. The coverage of vaccination against Hepatitis B among children from 7 months to 14 years of age is lower in Lääne-Viru and Valga county – 25.35 and 25.6% respectively[19].

[19] In Estonia there are 12,783 2-year-old children of which 5,918 were vaccinated during the period 1 January 2004 to 31 December 2004 and 17,439 children aged 13 of which 16,442 were vaccinated during the period 1 January 2004 to 31 December 2004 (94.3%). In 2004 there were a total of 19,718 children aged 14 of which 18,707 have been vaccinated against HBV (94.9%)(HPI 2005).

Syringe provision

In 2004 syringe exchange improved not only in terms of quantity but also quality. In 2004 altogether 21 syringe exchange points (SEPs) were operating in Estonia of which 6 in Tallinn, 5 in Narva, 5 in Kohtla-Järve, 1 in Jõhvi, Sillamäe, Kiviõli, Puru and Tapa. However, SEPs were operating mostly in 2 areas – Harju and Ida-Viru county and such services were not provided in rural areas. All SEPs were managed by 4 NGOs – AIDS Support Centre, "Convictus Estonia", "Me aitame sind" (*We will Help You*) and Narva Rehabilitation Centre for Drug Addicts and Alcoholics "Me ei jäta sind üksi" (*You will not be Left Alone*). Narva Rehabilitation Centre for Drug Addicts and Alcoholics is the biggest NGO in Estonia providing syringe exchange and other type of services for IDUs (7 stationary, 2 mobile and 1 outreach SEPs).

According to the data of the NIHD based on the report of the GF Programme 3,264 persons visited SEPs for the first time and a total of 57,145 visits took place in 2004. During the reporting year the number of syringes increased from 283,572 in 2003 to 519,753 in 2004 (NIHD 2005). Availability of condoms and related information improved in 2004 – 307,433 condoms were distributed among the target group (154,312 in 2003) and 53,053 (32,352 in 2003) copies of information material were distributed free of charge (NIHD 2005). More information on syringe exchange (e.g. rules for the provision of syringe exchange services etc) was provided in our previous National Report (see National Report 2004). NIHD continued to organize trainings for the staff of SEPs within the framework of the National HIV/AIDS Programme. In 2004 two trainings were carried out on first aid and effective counselling supported by the NIHD within the framework of HIV/AIDS Prevention Programme (NIHD, Report on HIV/AIDS Prevention Programme 2005). In 2004 a media campaign was carried out to promote HIV testing on HIV testing sites in Estonia.

A study conducted on risk behaviour and knowledge of HIV transmission among SEP visitors in 2004 (Trummal & Lõhmus 2004) showed that 80% of visitors were male. The average age of primary as well as regular visitors was 23.3. In terms of nationality 80.2% of primary visitors (PVs) of SEPs and 84.8% of regular visitors (RVs) of SEPs belonged to the Russian-speaking population. Over half of the PVs and RVs of SEPs did not work or study. Nearly one third of the sample of RVs had been visiting SEPs over a year; 28.5% of the RVs up to 6 months, nearly one third of the RVs of SEPs from 1 months to 6 months (36 % of the sample).

The study showed that 5.2% of the PVs of SEPs had been injecting drugs for over 10 years, 40% for 2-4 years, 27.1% for 5-10 years, 14.4% had been injecting for a year

and 13.3% less than a year. Over half of the repeated visitors of SEPs had been injecting amphetamine (54.3%), 46.7% had been injecting heroine and 35.8% poppy liquid. The visitors of SEPs in Tallinn had predominantly been injecting heroine while injection of poppy liquid was more common among the visitors of SEPs in Ida-Viru County[20].

79.6% of RVs and 61.8% of PVs reported not having shared syringes over last month. However, almost one third of primary visitors and 16.3% of SEPs reported to have rarely shared syringes over last month and 7.5% of PVs and 4.1% of RVs reported they had repeatedly shared syringes. 49.5% of PVs and 57.1% of RVs reported to have been tested for HIV antibodies last year. Over one third of the sample (36%) reported to have received 2-5 clean syringes and 32% of the respondents reported to have received 6 to 10 clean syringes from SEPs.

Provision of information

The NIHD funded the training of schoolchildren, vocational school students and conscripts from the budget of the GF Programme to reduce risk behaviour of children and young people aged 10-24 and increase their knowledge of HIV/AIDS[21] Altogether 6 NGOs were carrying out activities to meet the first goal of the GF Programme. One of the NGOs, the Estonian Family Planning Association (EFPA) was responsible for the provision of training targeting schoolchildren. The EFPA has got 17 Youth Counselling Centres providing free testing and counselling services for young people under the age of 18 (see http://www.amor.ee/17226). The EFPA also provides information on HIV/AIDS and other STDs over the Internet (see http://www.amor.ee/28753)[22].

Two other NGOs were responsible for the training of vocational students to meet the first goal of the GF Programme – the AIDS Prevention Centre (http://www.aids.ee/) provided trainings on HIV/AIDS issues targeted at students of vocational schools in Northern Estonia. The Anti-AIDS Association (http://www.hot.ee/antiaids/) provided trainings for the same target group in North-Eastern, Central, Western and Southern Estonia. The Anti-AIDS Association was responsible for the provision of training to conscripts focusing on the reduction of risk behaviour and increasing their knowledge of HIV/AIDS issues. Five NGOs – Estonian Family Planning Association (EFPA),

[20] Unfortunately the study report does not provide data analysis by areas

[21] The main priority of the GFTFAMT Programme in Estonia is to reduce risk behaviour among young people aged 10-24 and increase their knowledge of HIV/AIDS issues.

AIDS Support Centre, Living for Tomorrow, Kohaliku Regionaalarengu Partnerid (*Local Regional Development Partners*) and 1 Foundation (SA Anti-Liew ja Hingehooldus) provided training on HIV/AIDS issues to 27,352 young people of which the majority (22,616) were schoolchildren of classes 5-12; 4,309 were students of vocational schools and 337 of the trainees were conscripts (NIHD, GF Programme Goal No 1, 2005). Trainings "*From Youth to Youth"* were delivered within the framework of the GF Programme. The NGO Living for Tomorrow was responsible for "*From Youth to Youth"* trainings in Northern and Central Estonia, SA Anti Liew ja Hingehooldus provided trainings in Northern and North-Eastern Estonia and Kohaliku Regionaalarengu Partnerid carried out trainings in Western and Southern Estonia. According to the report of the GF Programme all NGOs delivering the Youth to Youth programme were responsible for the monitoring of the results of the programme. The NIHD compiled questionnaires within the framework of Goal No 1 of the GF Programme (Questionnaires were distributed among the trainees – schoolchildren and vocational school students twice: the first round was organised in Spring 2004 and the second in Autumn 2004 The latter showed improvement of knowledge of HIV/AIDS transmission routes among both groups of respondents[23].

Comparison of the results of the study showed that the level of knowledge of the trainees of both groups had increased after the completion of the training. Increase in the knowledge of the trainees was more significant in case of schoolchildren when compared to the students of vocational school – 29% and 16 % in the Spring round

[22] The Estonian Family Planning Association was renamed in 2005 and is currently known by the name Estonian Sexual Health Union. In this report the former name is used.

[23] Pre- and post-training questioning of schoolchildren from grade 5 to 12 and vocational school students was conducted in spring and autumn 2004. The pre-training questionnaire for schoolchildren of classes 5-12 consisted of 2 separate questionnaires: a pre-training questionnaire for classes 5 to 7 consisting of 9 questions and a questionnaire for classes 8-12 including 10 questions. In the post-training questionnaire one additional question had been included for both groups of respondents. The pre-training questionnaire for vocational school students consisted of 10 questions and the post-training questionnaire included one additional question. In order to assess the impact of training and test the knowledge of trainees a set of 5 additional questions was included in the questionnaire: Can a person protect him/herself from getting HIV by using a condom every time he/she has sex? Can a person protect him/herself from getting HIV by having sexual relations with one certain uninfected partner? Can a person get HIV by injecting with a syringe that was used by someone else before him/her? Can a person get HIV from mosquito bites? Can a healthy-looking person have HIV? The answer was considered to be right when the respondent answered correctly to all 5 sub-questions.

and 20% and 13% in Autumn, respectively (Trummal & Lõhmus 2005 a,b,c,d).[24] [25] [26] [27]

During the reporting period within the framework of the GF Programme the NIHD allocated finances for a media campaign "For the Sake of Love" targeting at young people aged 15-24. This media campaign was carried out by the EFPA and included social advertising, organization of charity events, club events and an exhibition of social advertising with the purpose of promoting safer sex among young people. A study carried out to monitor the effect of the campaign showed that 87% of the respondents reported to have noticed the campaign and 94% of those having noticed the campaign reported to have understood the purpose of the campaign and 97% of those who had noticed the campaign were aware that during an intercourse with a casual partner a condom had to be used.

Counselling and testing

Issues concerning testing and counselling in Estonia were described in-depth in our previous National Report (see National Report 2004). Testing of risk groups is voluntary and it is allowed only in case a person has given his/her consent for testing. However, an HIV test is obligatory for 2 groups – foreigners seeking to obtain a residence permit and donors of blood and organs. Conscripts and detainees are recommended to get tested for HIV on voluntary bases[28]. HIV testing of pregnant women during the routine medical examination was initiated in Estonia in 2003. In the previous reporting period the cost of HIV testing of persons who did not have health insurance was covered by funds from various sources including the GF Programme and National HIV/AIDS Prevention Programme. In 2004 the number of HIV tests made annually increased to 126,970 (see figure 17). However, the majority of HIV tests were made to screen organ and blood donors and pregnant women. The number of donors of blood and organs tested for HIV increased from 61,964 to 62,040 in 2004, the number of pregnant women tested for HIV increased by 20.8%. The number of HIV tests made by the AIDS Prevention Centre providing information, counselling and voluntary and anonymous HIV testing in Estonia decreased from

[24] Pre-training sample in Spring consisted of 568 and post-training sample of 340 students from classes 5-12 selected by systematic sampling

[25] Pre-training sample in Autumn consisted of 875 and post-training sample of 1078 students from classes 5-12 selected by systematic sampling

[26] Pre-training sample in Spring consisted of 385 and post-training sample of 180 students from classes 5-12 selected by systematic sampling

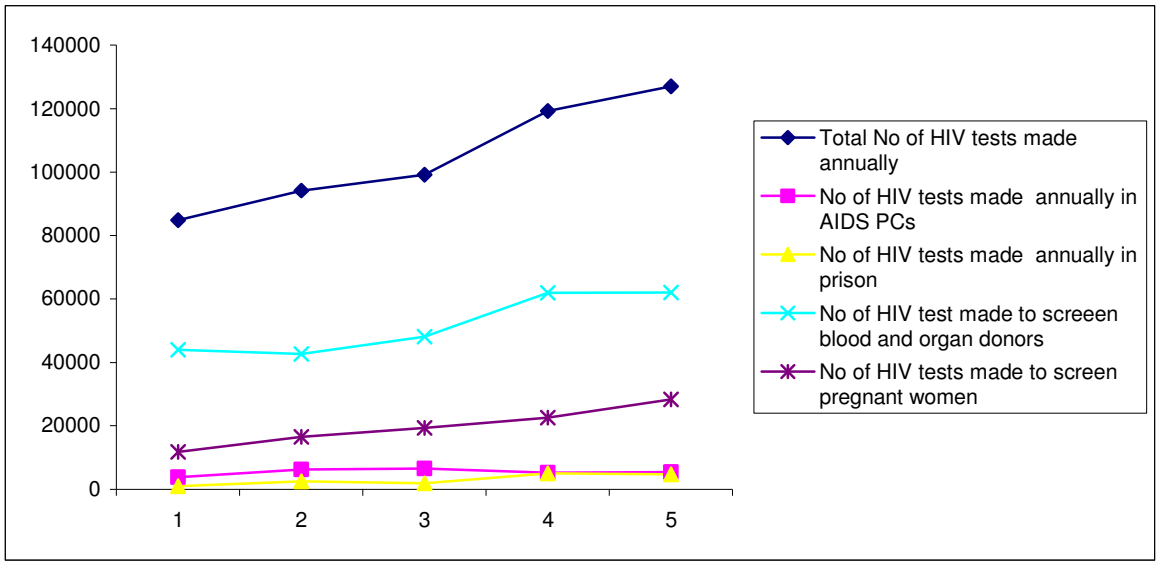
[27] Pre-training sample in Spring consisted of 407 and post-training sample of 359 students from classes 5-12 selected by systematic sampling.

[28] Testing is obligatory only for conscripts taking part in the International Mission

6,507 in 2002 to 5,223 in 2003 and increased again to 5,456 in 2004[29]. Reasons for the drastic decrease in the number of HIV tests made in AIDS Prevention Centres were discussed in our previous report (see National Report 2004). However, AIDS Prevention Centres in Tallinn, Narva, Puru, Pärnu and Tartu are playing an important role in the provision of risk groups (e.g. IDUs) with anonymous counselling and over one third of HIV infections were detected by the above-mentioned institutions (NIHD, 2005).

The more so, the named centres are mobile and provide services across Estonia, including areas in Estonia where AIDS Prevention Centres have not been established yet. In 2004 the NIHD drafted guidelines for carrying out HIV testing and anonymous testing to increase the quality of the provision of these services. The guidelines for the provision of the services will be updated annually.

Figure 17. Number of HIV tests made annually by AIDS Prevention Centres 2000-2004 by selected risk groups.



Source: Tallinn Merimetsa Hospital, 2005

Within the framework of the GF Programme the NIHD supported the provision of voluntary counselling by the AIDS Support Centre in Tallinn to reduce risk behaviour among sex workers. During the reporting year a total of 669 visits of sex workers

[29] In Estonia there are 6 AIDS Prevention Centres of which 2 are in Tallinn, 1 in Narva, Tartu, Pärnu and Puru offering anonymous and free testing for HIV. The main task of the AIDS Prevention Centres is the provision of counselling on STDs and other serious drug-related risks (e.g. drug-related overdoses, drug-related infectious diseases etc).

were registered of which 272 were primary and 397 repeated visits to the AIDS support Centre. Within the framework of the provision of the service of voluntary counselling 15,549 condoms, 11,860 lubricants and 1,652 copies of information material were distributed among sex workers (NIHD, GF 2005). Day centres were allocated 13,253 condoms, 11,720 lubricants 2,112 copies of information materials (NIHD, GF 2005).

In 2004 the NIHS funded the establishment of the Information Centre for Gays and Lesbians. 663 visitors of the centre, 1,539 information inquiries by phone and 670 by mail have been recorded since June 2004 (NIHD, GF 2005). In 2004 the target group was provided with 85,900 condoms, 59,500 lubricants and 9,680 copies of information leaflets. According to the report of the NGO Convictus (see more information at http://www.convictus.ee/), the leader of 12 support groups of HIV positive prisoners in 7 prisons, a total of 2,312 prisoners participated in the thematic monthly lectures given by Convictus. Convictus organized seminars for prison staff and detainees quarterly. According to the activity report of target 4 of the GFFAMT Programme managed by the NIHS 5,023 condoms and 1,106 copies of information material on HIV and risk behaviour were distributed in prisons.

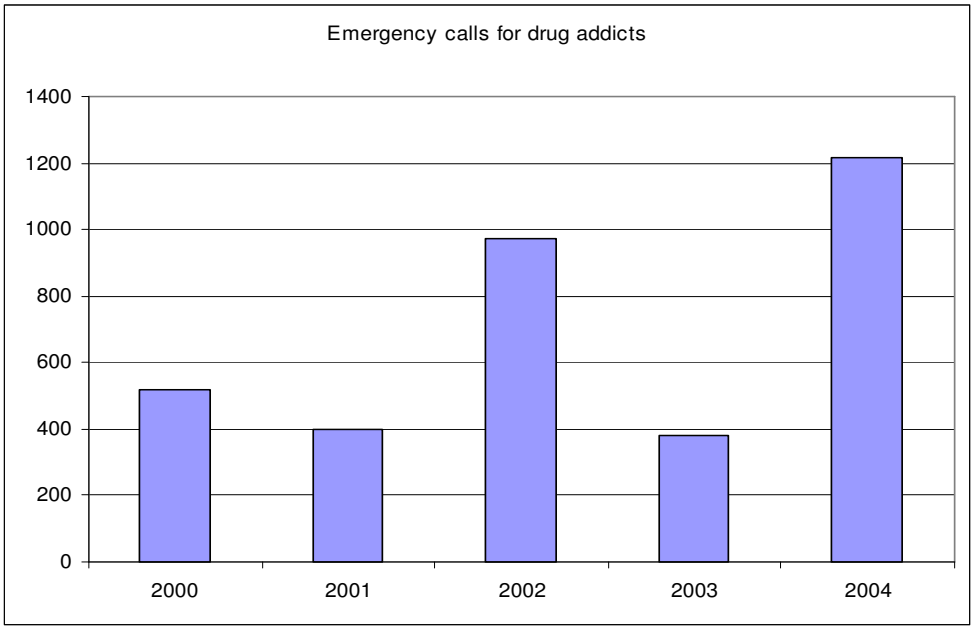
Treatment of Infectious Diseases

Unfortunately data on treatment of infectious diseases in the reporting period is not available. In Estonia 4 hospitals – West-Tallinn Central Hospital, the Foundation Clinic of the University of Tartu, East-Viru Central Hospital and Foundation Narva Hospital – provide antiretroviral (ARV) treatment for persons who do not have medical insurance. Provision of ARV treatment for 120 clients was funded from the GF Programme (NIHD, GF 2005e).

Interventions related to psychiatric co-morbidity

In the second half-year of 2005 a specialized drug treatment centre will be set up on the basis of the Clinic of Psychiatry of Tallinn Regional Hospital. More detailed information on interventions related to psychiatric co-morbidity will be presented in next National Report.

Figure: Number of calls to eEmergency aidcalls for drug addicts 2000-2004



Source: Tallinn Emergency Medical service, 2004

8. Social Correlates and Consequences of Social Exclusion

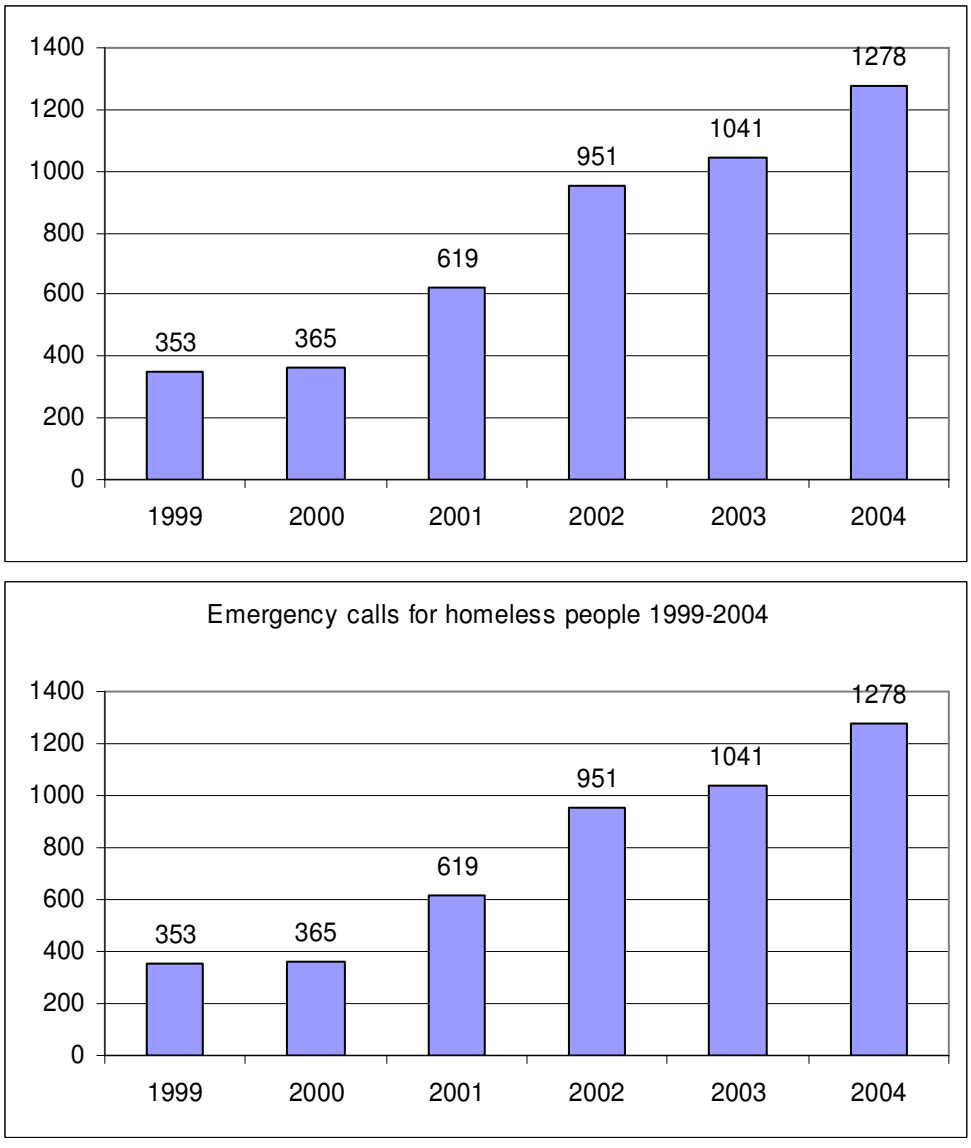
Homelessness

In Estonian context the dData on homeless people wasis not readily available in Estonia.difficult to find. LegalThe official definition ofn homeless people does not exist in Estonia, however,is not availab le but as a result of comparison of the definition of homeless people with other countries we have concluded that the Swedish definition on homelessness used in Swedenis more is most suitable infor Estonian conditions.local use. The Swedish ddefinition offor a homeless personness in Sweden provides that a homeless person isis for someone who cannot afford does not have a privatepersonal or rented dwelling or permanent accommodation possibilities and is provided with directed to a temporary alternative place to stay or is someone who stays outside. (Hallik 2001)

In 2004, 2,600 persons were accommodated in staying in the shelters and rehabilitation centresers in 2004. The main reason for staying there was the release from prison (Statistical Yearbook of Estonia, 2005). AnotherThe other source of statistics regarding homeless people is the Tallinn Emergency Medical

serviceService. WIt can be here we can seenfind that the number of calls to emergency aid for emergency calls for homeless people hasve increased constantly (see figure 18…)).

Figure 18:. Nnumber of calls to emergency aid for homeless people Emergency calls for homeless people 1999-2004.



Source: Tallinn Emergency Medical service, 2004.

Unemployment

The unemployment rate in Estonia has been steadily decreasing since 2000, it reachinged 9,7% in 2004 and beingwas 1,4 times lower than in 2000. In 2004 tThe

unemployment rate was the highest in Ida-Virumaa county -–17,9% and the lowest in Saare county -– 4,1%.

The unemployment rate of non-Estonians was twice as high as than that of Estonians. Despite the overall decrease inof the unemployment rate, the number of long-term unemployed person (persons having lookeding for a job a year or longer) increased from 30, 500 in 2003 to 33, 000 in 2004 (Statistical Yearbook of Estonia, 2005).

School drop- outs

A sThe significant proportion of schoolchildren repeatingrepetition their class and the dropout rate dropouts at the end of their basic educationat lower level of full time general schools continueds to be a matter of concern. 5.,7% of boys and 3.,2% of girls ofwho began their studies in the grades 7-9 at the beginning of the school year were had to compelled to repeat their class.grade and 1.,7% of boys and 0,.8 % of girls discontinued their studies in 2003/2004, i.e. total of In absolute numbers it made 2,922 schoolchildren repeated their class and repeaters and 831 pupils dropped out. This was somewhat less than in the2003/2004 school year 2002/2003 when the figures were 3,307 and 986,, respectively. However, tThese two figuresindicators were related as have semantic connection as the reason forlions´s share dropping out of drop outs infrom classesgrades 7-9- 80% for 2003/2004-was in most cases caused by passing the compulsory schooling age (80% in 2003/2004). Consequently, tThose schoolchildren pupils must hadve already previously repeated their class in previous grade years. SThe significant proportion of drop-outs rate has have increased the share of 15-24-year- olds without lower secondary education in the labour force (from 15, 000 in 1997 to 20, 000 in 2004). Naturally the unemployment rate among low educated the young peopleth with low education is quite high, it was 30% in 2004, i.e or one and half times higherbigger than the average for the total age group (Statistical Yearbook of Estonia, 2005).

Financial problems

The disposable income per household member in 2004 was the highest in households including a working-age couple without children (41% higher than the average) and in a household of a single working- age person (31% higher than the average). The disposable income per household member was the lowest in a

household of an adult with at least two children (57% lowerof than the average inof Estonia). The dDifferences in disposable income by type of household increased. (Statistical Yearbook of Estonia, 2005).

Social network

The number of marriages has remained near 5,600 in 1996-2003, at the same time the number of divorces has decreased.
In terms of From the children point of view the family structure in Estonian in 2004 was the following: 13% of the young peopleth under the age of 18 were raised in households with a single parent, 61% in households with both parents and a quarter in households that contained grandparent(s) apart fromside parents contained grandparent(s) (Statistical Yearbook of Estonia, 2005).

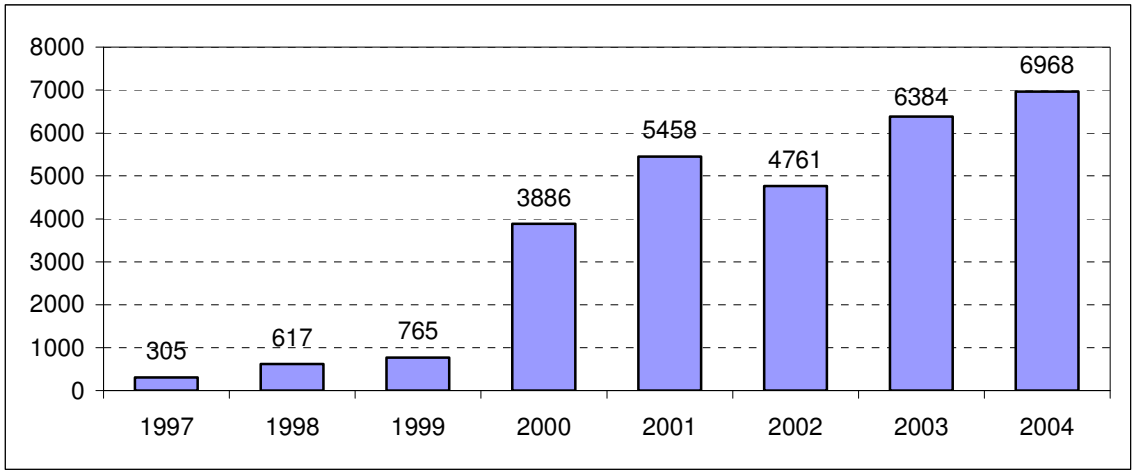
4.Drug- related crime (ANDRI)

Drug offences

Total number of drug offences registered by the police increased from 6,384 in 2003 to 6,968 in 2004 (9% increase) (see figure 18). Those numbers included both criminal offences and misdemeanours.[30] Criminal offences accounted for 16% of all drug offences in 2004 (see table 2).

Figure 19. Total number of drug offences registered by the police (crimes and administrative offences or misdemeanours) in 1997-2004.

[30] Criminal offences: drug possession with intent to supply, drug trafficking, etc. Misdemeanours: drug abuse or possession of a small amount for personal use.



Source: Police Board, 2005.

Table 2. Number of drug crimes (main types) registered by the police, 2004.

§183. Unlawful handling of small quantities of narcotic drugs or psychotropic substances	518
§184. Unlawful handling of large quantities of narcotic drugs or psychotropic substances	467
§185. Providing of narcotic drugs or psychotropic substances to persons of less than 18 years of age	23
§186. Inducing person to engage in illegal use of narcotic drugs or psychotropic substances	11
§187. Inducing minors to illegally consume narcotic drugs or psychotropic substances or other narcotic substances	5
§188. Illegal cultivation of opium poppy, cannabis or coca shrubs	30

Source: Police Board, 2005.

In 2004 about 77% of all drug offences were registered in Tallinn, followed by Ida-Viru county (13%). The police apprehended 4,500 persons who were under the influence of drugs (41% more than in 2003 and two times more than in 2002, the increase can be explained by more active police work, particularly in Tallinn).

Drug-related crimes

Drug abusers were committing a significant proportion of property crimes (especially thefts from cars, shoplifting, pick-pocketing, robberies). According to the police statistics about 1/3 of cleared property crimes were committed by persons who had been charged for committing a drug offence in last four years.

There were no reliable data on offences committed under the influence of illicit drugs (including driving offences).

About 80% of apprehended persons having committed a drug offence in recent years recommitted drug offences or other offences (property crimes, violations of public

order etc). More than 50% of drug offenders committed their first drug offence at the age of 18-24[31]

5.Drug use in prison

No new information available

6.Social costs

No new information available

9.9. Responses to Social Correlates and Consequences

- Social reintegration

No new information available

Prevention of drug- related crime

At the moment Estonia has lLimited resources were available in Estonia to providehave alternatives to the prison in Estonia in 2004. According to By law *criminal code § 75* of the Criminal Code (see the chapter on legal framework) it is possible to choose between prison and treatment in certain cases of a drug crime, however, but due to the lack of treatment possibilities the practice of using alternatives to prison have hardly ever usedis rare..

In the framework of National Strategy for Crime Prevention until the year 2005 TheNSCP Ministry of Justice and Police Board are allocateing annuallyyearly the resources forto carrying out crime prevention projects within the framework of the National Strategy for Crime Prevention until the year 2005. Like with universal prevention projects iIt is very difficult to differentiate drug-related crime divide crime prevention projects from other type of prevention projects as is the case with all prevention projects.to the drug related crime prevention projects and others. In 2004 the Ministry of Justice allocated totally of EUR 31,960 EUR was given by the Ministry of Justice forto the crime prevention (including drug- related crime) and the Police Board allocated EUR 58,312 EUR from the Police Board tofor carrying out 58 prevention projects in police prefectures. In general the main focus of the NSCP in 2004 was youth and youth- related issues. Projects of the Police Board were mostly targetingabout youngsters and most of them were focusingdirected to on drug prevention of drug and minor crimes related to minors and family violence.

[31] Source: Police Board (Narkosüüteod ja nende mõju kuritegevusele Eestis 1999-2004 – Tallinn, 2005).

Also iIn 2004 risk assessment methodology was developed to assess the probability danger and possibility to commit new crimes byof people under the probation and in prison, also, andan intervention plan on the in accordance withbasis of the risk assessment was compiledthe needed intensity of intervention (Report on the Implementation of National StrategyRiikliku strateegia täitmise aruanne 2004).

10. Drug Markets

- Availability and supply (ANDRI)
- Seizures (ANU)

In Estonia the most commonly used illicit drugs were the same as in previous years – amphetamine type stimulants (ATS), cannabis products and opiates. In 2004 amphetamine type stimulants accounted for the biggest number of overall seizures of illicit substances. Cannabis become more popular and production of cannabis herb in local plantations increased. Consumption of heroin and the price of heroin decreased whereas the purity of heroin increased during the reporting period. Methylfentanyl accounted for the majority of seizures of opiates. In 2004, drug trafficking through and from Estonia had a similar pattern with previous years.

Availability and supply

In 2004, three clandestine laboratories were discovered by the police: two in Harju county (for producing MDMA and amphetamine respectively) and one in Pärnu county (for tableting MDMA and manufacturing amphetamine).

The Police registered 27 cases of illicit cultivation of cannabis (of which 12 included at least 6 plants).

In the reporting period Customs authorities confiscated 14 mail deliveries of *Psilocybin* mushrooms or their spores or mycelium and 5 mail deliveries of mescaline cactus.

In 2004, drug trafficking through and from Estonia had the same pattern as in previous years. Synthetic drugs were smuggled most actively. The majority of synthetic drugs produced in Estonia was targeted at the Nordic countries, however, an increasing trend to smuggle synthetic drugs to Russia was observed. Smuggling of hashish increased due to the use of new smuggling routes through Spain and Germany, as a result, smuggling through Estonia to Russia increased. Import of cocaine from Central America and Spain increased.

According to the Central Criminal Police the main routes of illicit trafficking of drugs through or from Estonia in 2004 were the following:

• amphetamine from Estonia (local production), or from other countries (Lithuania, the Netherlands) via Estonia to the Nordic countries and Russia;

• ecstasy from the Netherlands and Belgium via Estonia to Finland and Russia, or from Estonia (local production) to the same countries;

• hashish from Spain via Estonia to Finland and Russia;

• heroin from Afghanistan, Tajikistan and Uzbekistan via Russia and Estonia to the Nordic countries;

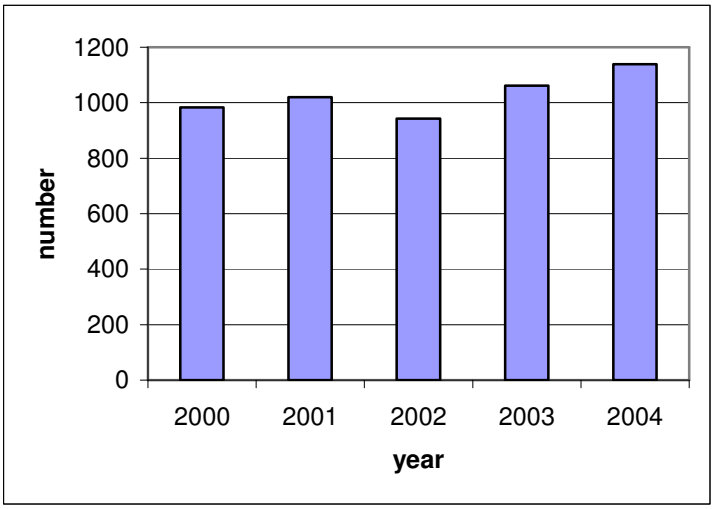
• cocaine from Central America via Estonia to Russia and Finland.

According to the expert estimates transit accounted for about two thirds of all drug trafficking. Smuggling of drugs to Russia has increased in recent years as a result of increased prices on Russian markets.

Seizures

The Estonian Forensic Service Centre being responsible for the identification of the narcotic drugs and psychotropic substances, made a total of 1,139 analyses of drug seizures in 2004 compared to 1,060 analysis in 2003 (see figure 1).

Figure 20. Total number of drug analysis in 2000-2004.

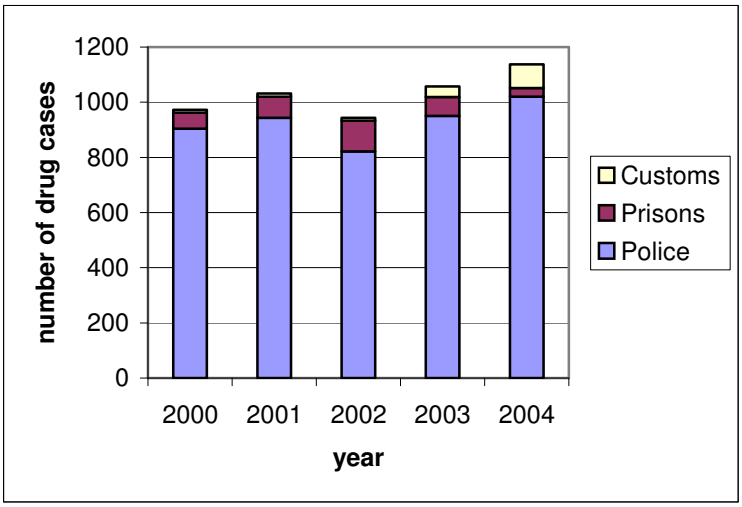


Source: Estonian Forensic Service Centre

About 89.5 % of the analysis of seizures was ordered by the Police, ca 7.5 % by the Customs Board and ca 3% by the Prison Board (see figure 21). Number of analysis of seizures of narcotic drugs made for different authorities).

The majority of drug analysis of the seizures – 70% (712 cases) of the total number of drug analysis ordered by the Police was ordered by the Northern Police Prefecture, 10% (100 cases) by the Eastern Police Prefecture, 9% (91 cases) by the Southern Police Prefecture, 5.8 % (59 cases) by the Western Police Prefecture and 5% (52 cases) by the Central Criminal Police

Figure 21. Number of analysis of narcotic drugs made for different authorities in 2000-2004.



Source: Estonian Forensic Service Centre, 2005.

In 2004 amphetamine type stimulants accounted for the biggest number of analysis of the substances submitted to the Forensic Service Centre for the analysis - stimulants were analyzed 680[32] times: amphetamine type stimulants 418 and ecstasy type narcotic drugs 262 times (MDMA, MDEA, 2C-B, MDA) (see figure 22).

Total of 53.8 kg of amphetamine and methamphetamine was seized in 2004 which was about two times less than in 2003 (109.3 kg) and 72.6 kg of ecstasy type substances, which was about 11 times more than in 2003 (6.7 kg).

The number of seized ecstasy type tablets was quite big – 296,145. This was over 14 times bigger than in 2003 (20,770 tablets). The big quantity of tablets can be explained by one major seizure – 294,895 tablets. In 2004 seizure of 2C-B (Nexus)

[32] Number of occurrence does not include traces of the substance

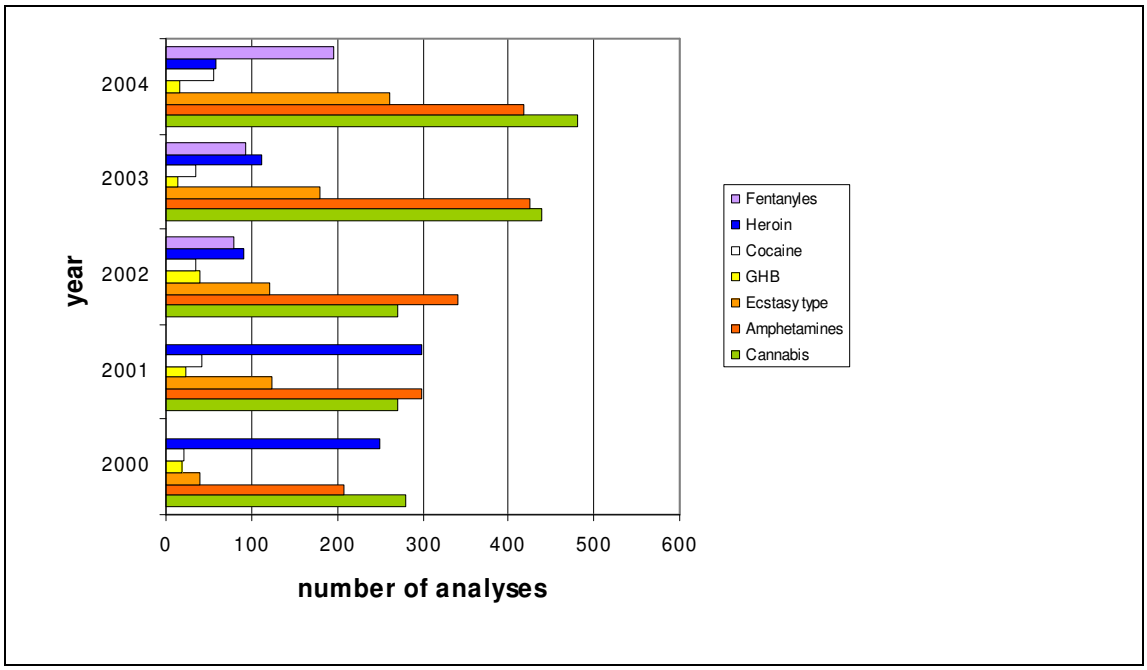
was registered being the first time over 13 years. The seized tablets (15 seizures, total of 122 tablets) contained either 2C-B or 2C-B with MDMA.

416[33] seizures involving cannabis and products made from cannabis were made. 186 seizures of cannabis plants, 108 seizures of marihuana and 122 seizures of hashish, 2 seizures of hashish oil were made in 2004.

Total quantity of seizured cannabis was 95.1kg compared to 41.5kg of seized cannabis in 2003. About 38 kg of hashish was the biggest quantity of that drug seized at a time. According to the police estimates about 80% of used cannabis was produced in Estonia. In recent years a new trend has developed – producers of cannabis plants use state-owned land (e.g. in forest areas) for the cultivation of cannabis.

The third group of seized drugs was opiates – heroin, poppy and poppy straw products, methylfentanyl and morphine - 306 seizures of these substances were made overall in 2004. Unlike 2003, in 2004 methylfentanyl accounted for the majority of seizures of opiates – 164 times compared to 91 times in 2003. Mixed powder – methylfentanyl mixed with heroin was seized 33 times and heroin was seized 6 times.

Figure 22. Number of analyses of some type of narcotic drugs in 2000-2004.



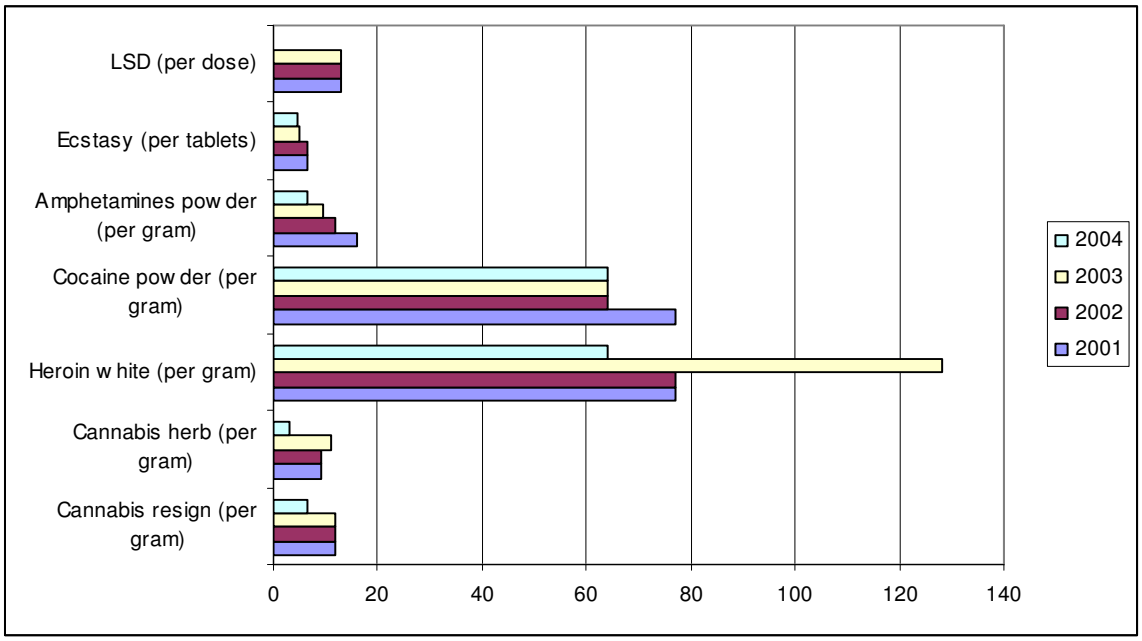
[33] Number of occurrence does not include traces of the substance

Source: Estonian Forensic Service Centre, 2005.

Price and purity

The average price of heroin has decreased over the reporting period from 128 EUR 128 per gram in 2003 to 63 EUR 63 per gram in 2004. The price of heroin varied from min 51 EUR 51 to Max 76,7 EUR 76,7 in 2004. The price of cocaine has remained the same as in 2003 and there wasis no difference inbetween the price of heroin and the price of cocaine in 2004. The price of amphetamine has showedn a constant decreasing trend over the period 2001-2004. In 2004 the price of amphetamine was the lowest withan an average of EUR 6 EUR per gram. Also, the price of ecstasy and cannabis products has decreased in 2004. In 2004 there were no LSD seizures in Estonia and the price of LSD was not availableis not .estimated.

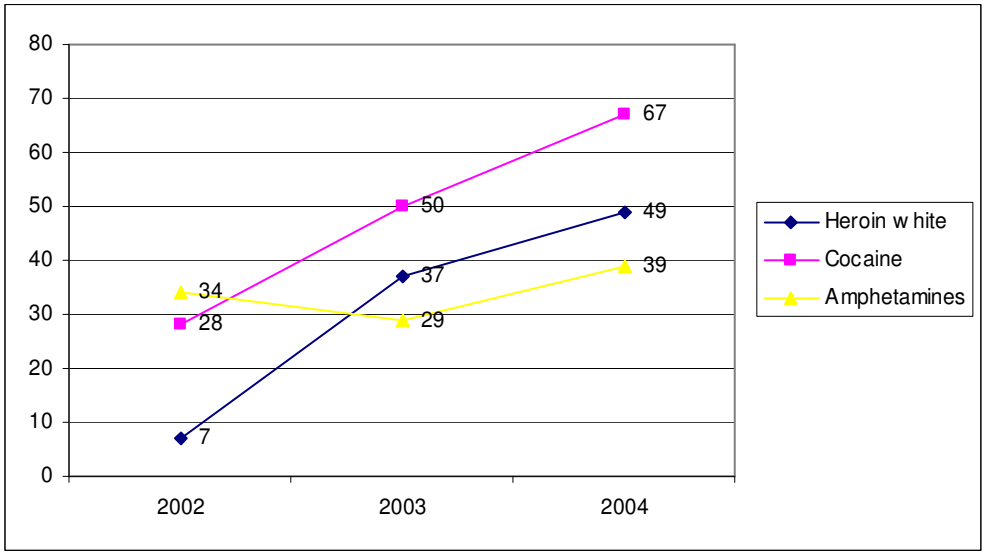
Figure 23 …. Price in Euros Sat street prices of level of some illegal substances in euros.

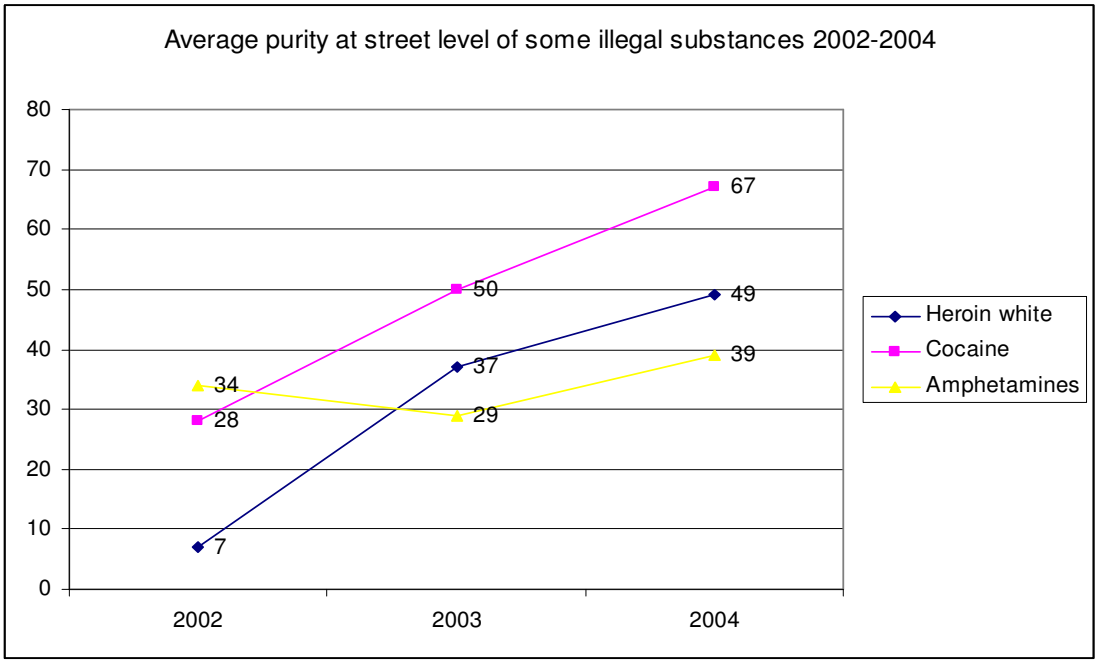


Source: Forensic Service Centre, 2005.

Concerning tThe purity at street level of some illegal substances likethe purity of heroin (white), amphetamine and cocaine has significantly increased significantly during the reported period. The purity of varied quite drastically within the substances was quite unstable. In case of heroin the purity varied from min 3,2 to max 71.

Figure 24. . Average purity at street level of some illegal substances 2003-2004.





Source: Forensic Service Centre, 2005.

PART B: Selected issues

11. Gender Differences

Studies having been conducted in Estonia indicate that generally the share of men using drugs is bigger than the share of women using drugs (ESPAD 1995, 1999, 2003; Population surveys, Norbalt 1994, Estonia 1998, Estonia 2003). The same trend was observed in the study conducted by Lõhmus, Trummal and Harro in 2003. According to the findings of the study results 47.4 % of young men aged 19-24 and

27.,4% of young women and 35.3 % of young men aged 25-29 and 15.,6% of females had tried illicit drugs at least once (Lõhmus et al. 2003).

In terms of gender, the study provided that showed no statistically significant the difference amongst 14- and 15- year- old school students was statistically insignificant, in 2 older age groups the proportion of young men that havingd used drugs was 20% higher than that for young women. Also, young men had started to use narcotic substances earlier – the average age of boys having started smoking drugs was 14.7 and the average age of girls that had having started using drugs was 15.3. The proportion of female respondents reporting to have used drugs at least once was higher amongst female schoolchildren aged 16-18 and young female respondents aged 19-24 – 27.9 and 27.4%, respectively (Lõhmus et al. 2003)

All the mentioned studies referred to in this Chapter wereare describedpresented i in the National Report 2004. In this chapter Only thea short overview of gender specific issues offrom theose studies is providedis given here..

According to theBased on data of the population survey data the significant difference in lifetime prevalence for male and female was observedappeared in 2003. In the age group 15-24 the lifetime prevalence of any illicit drug was 53% among males and 28% among females, in the age group 25-34 it was 28% among males and 95% among females and in the age group 35-44 19% among males and 4% among female, respectivelys (see National Rreport 2004).

Regarding different substances the last 12 months prevalence and 30 days prevalence was mostly higher among males in case of most illegal substances. In terms of gender the prevalence of last 30 days in case of amphetamines in the age group 25-34 was higher for females. The prevalence of last 12 months amphetamine use among 25-34 years old females was higher than among men of the same age (females 0,5% and males 0%). Considerable differences appeared with the use of sedatives and tranquilizers where females had a higher prevalence than men. Last 12 months prevalence of sedatives and/or tranquilizers was 12,9 % among men and 26,2% among female in the age group 15-64. The only exception was the last 30 days prevalence of sedatives and/or tranquilizers in the age group of 15-24 were the prevalence among men was 8,1% among men and among females 7,7% among females (see National Rreport 2004).

Based on the ESPAD survey 2003 it can be observed that the higher level of cannabis use among males was higher among males than among females can be observed. 28% of boys aged 15-16 had used cannabis at least once in their life

compared to the 18 % of girls. TShe similar trend appeared in 1999 were the lifetime prevalence of cannabis use was among boys 17% among boys and 7% among girls 7%. However, there were no gender differences in the use of ecstasy in 2003. The use of amphetamine was slightly higher among girls than boys in 2003 (see National report 2004).

As toIn the case of drug-related deaths it is better to see the Chapter 6 twhat gives a more comprehensive overview ofn mortality. In terms of case of gender issues the majority of cases of drug-related deaths were related towith young men aged 15-29 years, women accounted for only five cases out of 36 cases were women.
With respect to the gender perspective of infectious diseases Regarding gender issues in case of infectious diseases it is known that thethe number of newly registered HIV infections among females wasere 245 among females and 497 among males 497. HIV infected persons were are predominantly maledominated, however, but the proportion of women among HIV infected shows a growing tendency -– in 2004 nearlyclose to one- – third of the persons (32.9%) diagnosed as HIV positives were female compared to the versus 27,9 % in 2003 (sSee cChapter 6)

To concept of gGender specific responses in the fieled of drug prevention were notis not widely spread in Estonia. In 2004 Tallinn City Government supported provision aof gender specific intervention bywith implementing athe specializsed treatment programme tailored forto f female drug users (sSee cChapter 5).

12. Implementation of National Drug Strategy

Government of the Republic of Estonia approved the National Strategy on Prevention on Drug Dependency (NSPDD) 2004-2012[34] on 22 April 2004. The NSPDD includes 2 introductory chapters introducing the goals, tasks and principles of the strategy, institutional and legal framework and 6 chapters - primary prevention, treatment (incl. sub-chapter on rehabilitation), harm reduction, drugs in prison, supply reduction and monitoring and evaluation. The national drug strategy includes an action plan for four years (2004-2008). The strategy provides an integrated approach to both drug demand and drug supply.

[34] The Alcoholism and Drug Abuse Prevention Programme 1997-2007 remained in force until the end of 2004.

It is difficult to compare the NSPDD and ADAPP as the background of the two policy documents is different. The ADAPP was developed at the time when drug-related problems were relatively new in Estonia and the knowledge of the nature of drug problems and responses to the problems was quite limited. The NSPDD is a more comprehensive and balanced policy document clearly reflecting changes in the dug situation and including new approaches and issues not targeted in the previous policy document (e.g. harm reduction, monitoring and evaluation as tools for evidence-based policy and decision-making). Development of the ADAPP was probably more difficult because of limited availability of data on the drug situation, also, approaches were different (e.g. harm reduction was not tolerated etc).

The revised National Drug Strategy reflects recent changes in the field of drugs. Indicators of the drug situation have been used as the benchmark of the current situation to set up goals for the strategy. The National Strategy on Prevention on Drug Dependency (NSPDD) 2004-2012 includes the management component which was missing in the first drug policy document.

The NSPDD focuses on illegal drugs but takes into account the connection between illegal and legal drugs. Analysis of the drug strategy shows that more substances have been included in the revised strategy, the rationale of this key issue is discussed later in this chapter.

The drug strategy provides measures to substantially reduce drug use among children and young people, also, reduction of harm associated with drug use is clearly outlined in different activities. The strategy focuses on most widely spread drugs and the necessity of supporting measures for targeting alcohol and drug problems *(*p. 5); also, on the characteristics of the current drug problems (e.g. constant increase in the use of tobacco, alcohol and drugs among children and young people as well as the high number of IDUs) (p. 5). Institutional and legal framework of the strategy gives an overview of the legal acts regulating the area of narcotic drugs, psychotropic substances and precursors (p. 6). Chapter on primary prevention focuses on the relation between drug use and alcohol consumption and emphasises the need for carrying out prevention activities (p. 10). The NSPDA provides a general term *illicit drugs* when referring to drugs. For example, the term *illicit drugs* is used when describing short- and long-term performance indicators of primary prevention for the year 2008 and 2012 respectively (p. 11-12). Chapter on harm reduction provides the term *injecting drug users* and *drug addicts*. Experts involved in the drafting of the national drug strategy have agreed on the revision of the terminology and definitions provided at the end of strategy document. All illicit

drugs such as amphetamine, ecstasy, GHB, hashish, heroin, cocaine, marihuana, black heroin, opiates are listed in alphabetical order. LSD is the only drug not listed separately, this hallucinogen is mentioned in the definition of synthetic drugs.

Genesis and Rationale

Limited data enabled us to make assumptions rather than draw reliable conclusions on the rationale behind the inclusion of certain type of substances in the strategy. Estonian drug strategy is a policy document drafted after reaching consensus among local and foreign experts on drug demand and supply reduction as well as policy- and decision-makers (e.g. representatives of the relevant ministries, research institutions, organisations, NGOs in Estonia, experts of Phare-Twinning Programmes etc.) Drafting of the strategy was a lengthy process, however, not very well recorded. Therefore, it was difficult to assess the grounds for making certain changes in the drug policy document. The EU Drug strategy and action plan have had a clear impact on the Estonian drug strategy as all 6 targets of the EU drug policy are reflected in the Estonian drug strategy.

Chapters on evaluation and monitoring and harm reduction which were missing from the previous drug strategy have been included in the revised strategy. The reasons for including a management component in the new strategy and provision of the expenditures of the implementation of the strategy in a separate document *Targeted Action Plan for the Implementation of the National Drug Prevention Strategy 2004-2008* are probably related to the lessons learned during the implementation of the Alcoholism and Drug Abuse Prevention Programme 1997-2007 (ADAPP). The Targeted Action Plan for the Implementation of the National Drug Prevention Strategy 2004-2008 includes activities to be carried out to meet the goals of the strategy as well as an estimated budget for every activity.

The analysis of both policy documents reveals that the ADAPP is focusing on a more restricted field of activity than the NSPDA. In the course of reviewing both documents it was concluded that no indicators to measure the performance of the strategy and allocation of funds for the implementation of the activities of the programme had been specified.

The previous programme drafted to fight against dugs was seeking to create a drug-free society. Comparing this aim with the objectives of the revised drug strategy approved by the government in 2004 it is obvious that the current policy document gives a more realistic picture of the drug situation in Estonia (e.g. increase of drug

problems in the general population and risk groups, rapid spread of HIV infection among IDUs, increase in the number of drug-related offences, hence the need to fight against drug-related crime more effectively etc). Currently the goal of the previous drug strategy defined in the ADDAPP – establishment of a drug-free society – has been replaced by a new approach which is reduction of drug-related harm. The new approach is reflects recent changes in the extent and nature of drug problems in Estonia (e.g increase in the availability of different types of drugs). At the beginning of nineties opiates were the only wide-spread illicit drugs on the market, however, opening of borders obviously enabled other drugs, especially synthetic drugs, to appear on the drug market causing the spread of the drug problem in Estonia (National Report 2002). As a result, it was necessary to take measures to effectively target the drug problem. During the preparation phase of the strategy Estonia started to monitor the drug situation, responses and policy development and will continue the implementation of these activities next year[35]. The drug problem has become more visible in the society and availability of data on the extent of the problem and measures taken has increased the awareness of the public of the problem. Drug problems are considered to be social and health problems, therefore, have to be targeted properly. The scope of the drug and HIV/AIDS problems in Estonia and the relatively limited measures taken to tackle the problem (e.g. services such as treatment, rehabilitation, syringe exchange etc targeted at drug users) have been taken into account and the experts involved in the drafting of the new drug strategy have include specific chapters to target the issues not covered in the previous strategy (e.g. harm reduction, evaluation and monitoring, drugs in prison etc) as well as performance indicators and a management component. Also, specific target groups (and the age, gender, nationality, social and economic background, experiences and expectations of drug users, availability of drugs etc) have been taken into consideration in the revised drug strategy (NSPDA 2004 – 2012).

Responsibilities and competences

Estonian drug strategy includes six fields of activity - prevention, treatment-rehabilitation, harm reduction, supply reduction, drugs in prison and monitoring of drug situation and evaluation. The Ministry of Social Affairs is responsible for the implementation of most of the activities.

[35] The strategy defines that the Estonian Drug Monitoring Centre is responsible for the collection, analysis and dissemination of drug information

The NSPDD includes an action plan for four years (2004-2008) defining the measures, activities, responsibilities, term of implementation and finances needed for the implementation of the activities (see also Estonian Drug Situation 2004). Implementation of the National Drug Strategy belongs to the competence of the Ministry of Social Affairs. The Minister of Social Affaires is obliged to inform the government on the progress of the implementation of the NSPDD annually. In May 2003 the National Institute for Health Development (NIHD) was appointed as the institution responsible for the coordination of all national health programmes. Before the adoption of the NSPDD, the HIHD was responsible for the coordination of the implementation of the previous strategy as well.

The structure of co-ordination of the drug programmes has not been fully developed yet. The national co-ordinator has been appointed, however, her current role is limited and does not enable her to co-ordinate the activities provided in the Action Plan of the National Drug Strategy within different ministries. Therefore, an effective co-ordination mechanism for the implementation of the drug strategy must be developed, also, the position of national drug-coordinator should be strengthened.

Evaluation of HIV/AIDS prevention was carried out in 2004 by the centre of policy studies PRAXIS to assess prevention work in Estonia, however, the authors of the study also focused on „burning problems", for example on the implementation of the National Drug Strategy in Estonia (Kruuda et al. 2004). In the findings of the study by PRAXIS it was stated that the NIHD – a research and development institution working under the area of government of the Ministry of Social Affairs was not authorized to coordinate the activities of the co-operation partners of the programme (Kruuda *et al*, 2004). As we mentioned earlier in this report, it is also the case with the Ministry of Social Affairs which has limited authorities for the coordination of the activities of other ministries to ensure effective implementation of the drug strategy.

It is necessary to tackle another crucial aspect of the strategy, namely funding. Kruuda, Jesse and Mänd (2004) have recommended to allocate an adequate amount of resources for the implementation of the National Drug Prevention Strategy to ensure meeting of the goals and objectives defined in the national strategy and programme by the government.

10.European Drug policies (AVE)

11.13. Developments in drug use within recreational settings

No new data available

PART C:

14) Bibliography

15) Annexes

PART C: Bibliography, Annexes

14) References

EMCDDA Standard Reporing Table 9. Prevalence of hepatitis B/C and HIV infection among injecting drug users (IDUs). Version 04-181203-1800

Hallik, L. (2001). Kodutus kui marginaliseerumise tulemus - põhjusi ja lahendusi. Bakalaureusetöö. Tartu

Ustina, V. (2005) HIV nakkus Eestis aastatel 1987 – 2004 seire statistiline ülevaade AS Lääne – Tallinna Keskhaigla HIV-nakkuse Referentslaboratoorium.

Laastik, L. (2005) Narkomaania representatsioonid Eesti suuremates päevalehtedes 2004. aastal. (avaldamata).
Loogna, B. (2000). Narkootikumide ohud.Eesti Uimastipreventsiooni Sihtasutus.

Lõhmus,L., Trummal, A., Harro, M. Knowledge, attitudes and behaviour related to HIV/AIDS among Estonian youth. Tallinn. 2003 (avaldamata))

Lõhmus, L., Trummal, A. (2005) Süstlavahetuspunktide külastajate HIV/AIDS-iga seotud riskikäitumine ja teadmised. TAI.

Mark, M. (2005) Uimastiennetus koolis - sotsiaalsete toimetulekuoskuste õpetuse rakendumine inimeseõpetuse ainetsüklis ja seosed õpilaste uimastitarbimisega. Tartu Ülikool. (2005)

Immuniseerimiskava. Sotsiaalministri 30. oktoober 2003 määrus nr. 114 „Immuniseerimiskava“ RTL, 2003, 115, 1827).

National Report on Drug Situation (2002). Estonian Drug Monitoring Centre. Institute of Experimental and Clinical Medicine. Tallinn 2003

National Report on Drug Situation (2003). Estonian Drug Monitoring Centre. National Institute for Health Development. Tallinn 2003.

NIHD. Alkoholismi ja narkomaania ennetamise riikliku programme aastateks 1997-2007. Tervise Arengu Instituut. 2004.a. tegevuskava aastaaruanne.

Statistical Yearbook of Estonia 2005 Statistical Office of Estonia.(2005) Tallinn.

Trummal, A ., Lõhmus, L (2005a) 5-12 klasside õpilaste HIV/AIDS-I temaatilise koolituse 2004. aasta kevade eel- ja järelküsitluse kokkuvõte. TAI. (unpublished)

Trummal, A ., Lõhmus, L (2005b) 5-12 klasside õpilaste HIV/AIDS-I temaatilise koolituse 2004. aasta sügise eel- ja järelküsitluse kokkuvõte. TAI. (avaldamata)

Trummal, A ., Lõhmus, L (2005c) Kutsekoolide õpilaste HIV/AIDS-I temaatilise koolituse 2004. aasta kevade eel- ja järelküsitluse kokkuvõte. TAI. (avaldamata)

Trummal, A ., Lõhmus, L (2005d) Kutsekoolide õpilaste HIV/AIDS-I temaatilise koolituse 2004. aasta kevade eel- ja järelküsitluse kokkuvõte. TAI. (avaldamata)

Veimer, A. (2005) Ülevaade Global Fund`I 1. tegevusperioodist. 23.september 2005. NIHD

Tallinna Sotsiaal- ja Tervishoiuameti uimasti ja AIDSi ennetusalaseks tegevuseks eraldatud toetused (2005). Tallinna Sotsiaal- ja Tervishoiuamet.

Internet sources:

Eesmärk 1: Vähendada 10-14 aastaste laste ja noorte riskikäitumist ning suurendada HIV/AIDSi temaatikaga seotud teadlikkust

http://www.tai.ee/failid/E1_tulemused_20042.pdf

Eesmärk 2: Vähendada riskikäitumist alla 25-aastaste süstivate narkomaanide hulgas

http://www.tai.ee/failid/E2_tulemused_2004.pdf

Eesmärk 3: Vähendada prostitutsiooni kaasatute riskikäitumist

http://www.tai.ee/failid/E3_tulemused_2004.pdf

Eesmärk 4: Ennetada HIV-i nakatumist vanglates

http://www.tai.ee/failid/E4_tulemused_2004.pdf

Eesmärk 5: Vähendada riskikäitumist meeste hulgas, kes seksivad meestega (MSM) ja suurendada nende teadlikkust HIV/AIDSi temaatikast

http://www.tai.ee/failid/E5_tulemused_2004.pdf

Eesmärk 6: Parandada HIV –positiivsete inimeste elukvaliteeti suurendades juurdepääasu tervishoiu - ja tugiteenustele

http://www.tai.ee/failid/E6_tulemused_2004.pdf

Eesmärk 7: Suurendada programmi elluviimisesk osalevate organisatsioonide suutlikkust arendada omavahelist koostööd tõhusalt saavutamaks programmi eesmärke

http://www.tai.ee/failid/EESM_304RK_7_.pdf

Health Protection Inspectorate http://www.tervisekaitse.ee

Immuniseerimiskava. Sotsiaalministri 18. augusti 2005. a. määrus nr 94 RTL, 25.08.2005, 92, 1392 https://www.riigiteataja.ee/ert/act.jsp?id=933437

Kruuda R, Jesse M, Viik K(2004), ”HIV/AIDSi ennetustegevuse hindamine Eestis 2004”. PRAXISe Toimetised 16/2004.

http://www.praxis.ee/data/toimetised_16_2004_templatis0.pdf

Laste immuniseerimine B-viirushepatiidi ja tuberkuloosi vastu 2004.a
http://www.tervisekaitse.ee/Dokumendid/Vakts2004.htm

Narkomaania ennetamise riiklik strateegia aastateks 2004 -2012

http://www.sm.ee/est/pages/index.html

NIHD. Eesmärk 2; Vähendada riskikäitumist alla 24-aastaste süstivate narkomaanide hulgas (2005). National Institute for Health Development
http://www.tai.ee/failid/E2_tulemused_2004.pdf

Riikliku immuniseerimisprogrammi täitmine. 2-aastaste laste hõlmatus immuniseerimisega (%) 2004.a
http://www.tervisekaitse.ee/Dokumendid/Vakts2004.htm

Riikliku strateegia täitmise aruanne 2004.

http://www.kuriteoennetus.ee/14860

(http://www.riik.ee/brf/index.php?id=24604&tpl=1006).

15. List of abbreviations:

ADAPP- Alcoholism and Drug Abuse Prevention Programme

AIDS- Acquired Immunodeficiency Syndrome

AISC- AIDS Information and Support Centre

ARV- Anti-retrovirus

ATS- Amphetamine type stimulants

DRD – drug-related death

EDMC- Estonian Drug Monitoring Centre

EFPA- Estonian Family

EFPDA – Estonian Foundation for Prevention of Drug Addiction

EHIF- Estonian Health Insurance Fund

EMCDDA- European Monitoring Centre for Drugs and Drug Addiction

ESPAD- European School Survey on Alcohol and Other Drugs

GTC- Gambling Tax Committee

GF – Global Fund
GHB- Cammahydroxybutyrate

HAV – Hepatitis A Virus

HBV – Hepatitis B Virus

HCV – Hepatitis C Virus

HIV- Human Immunodeficiency Virus

HPI- Health Protection Inspectorate

HR – harm reduction

IDU- Injecting Drug User

MDA - 3,4 Methylenedioxyamphetamine

MDEA - 3,4 Methylenedioxyethylamphetamine

MDMA - 3, 4 Methylenedioxymethamphetamine

MEC Ministry of Education and Science

MSM - men having sex with men

MoSA - Ministry of Social Affairs

NIHD-National Institute for Health Development

NSCP-National Strategy for Crime Prevention

NSPDD - National Strategy on the Prevention on Drug Dependency 2002-2012

PC - Penal Code

PDU_-Problem Drug Use

PLWHA- People living with HIV and AIDS

RV - Repeated Visitor

PV- Primary Visitor

SEP - Syringe Exchange Point

SOE – Statistical Office of Estonia

STI- Sexually Transmitted Infectious

TB – Tuberculosis

TDI -Treatment demand indicator

TAPNSPDD - Targeted Action Plan for the National Strategy for Prevention of Drug Dependency 2004-2008 (PAPNSPDA)

UNDCP - United Nations Drug Control Programme

Part D- Standard Tables and Structured Questionnaires

16. List of Estonian Standard Tables and Structured Questionnaires of 2005.

Standard Table 05. Acute/direct drug related deaths (2003)
Standard Table 06. Evolution of acute/direct related deaths (2003)
Standard Table 09. Prevalence of hepatitis B/C and HIV infection
Standard Table 11. Arrests for drug law offences
Standard Table 13. Number and quantity of seizures of illicit drugs
Standard Table 14. Purity at street level of some illicit drugs
Standard table 15. Composition of tablets sold as illicit drugs
Standard Table 16. Price in Euros at street level of some illicit drugs
Structured Questionnaire 29. Reduction of acute drug-related deaths.