

# TRANSITIONING FROM DONOR SUPPORT **FOR TB & HIV** IN EUROPE

## **ESTONIA:** A HEALTH SYSTEM APPROACH TO TB & HIV RESPONSE<sup>1</sup>



## CONTEXT

Estonia is the smallest Baltic state with a population of 1.3 million. It has been a member of the European Union (EU) since 2004. According to the World Bank country income classification, Estonia has been classified as a high-income country since 2006.

Although Estonia has successfully reduced its burden of tuberculosis (TB) and HIV in the last 15 years, the country is still undergoing a series of problems in tackling the diseases. While TB mortality and incidence has significantly decreased between 2000 and 2015 (Graph 1), Estonia is facing high rates of

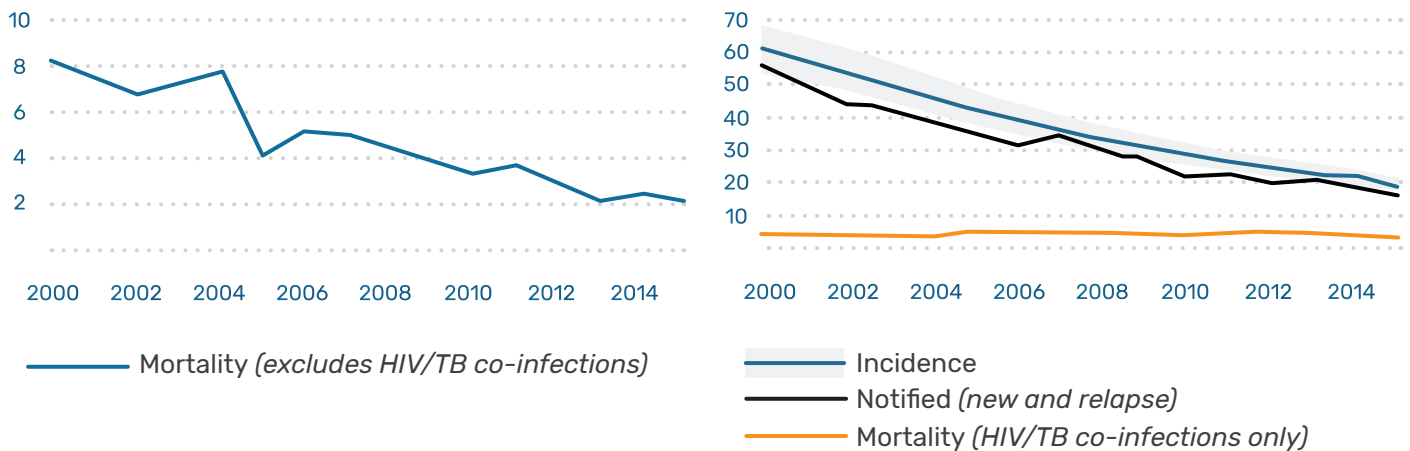
multidrug-resistant tuberculosis (MDR-TB)<sup>2</sup>. On the other hand, although HIV incidence has decreased since 2001 (Graph 2), the proportion of HIV-positive individuals among those infected with TB remains problematic. According to WHO's Estonia TB profile, in 2015 12% of tested TB patients were HIV positive.<sup>3</sup> Although the HIV epidemic has been historically concentrated among key populations,<sup>4</sup> particularly among people who inject drugs, it is increasingly affecting the general population.<sup>5</sup>

## TB MORTALITY AND INCIDENCE RATES IN ESTONIA BETWEEN 2000 AND 2015

SOURCE: WHO'S ESTONIA TB PROFILE

Rate per 100 000 population per year

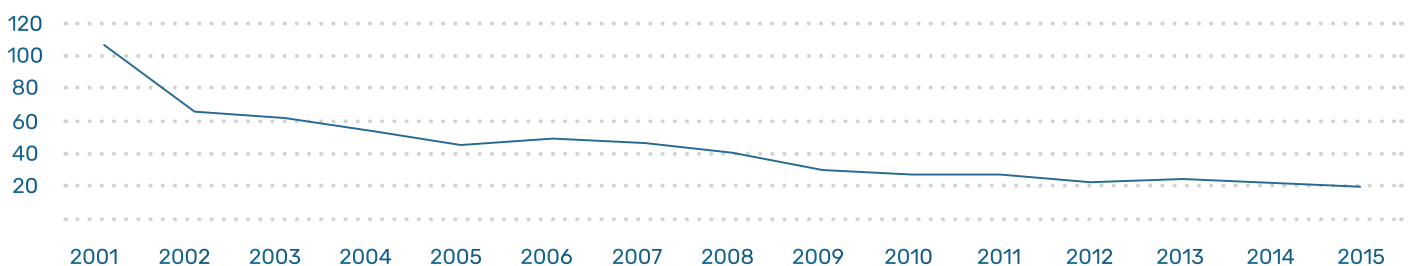
Graph 1



## INCIDENCE RATE PER 100 000 INHABITANTS OF HIV INFECTION

SOURCE: NATIONAL INSTITUTE OF HEALTH DEVELOPMENT

Graph 2



Like most countries in Eastern Europe & Central Asia, Estonia was a beneficiary of the Global Fund to fight AIDS, TB and Malaria (Global Fund), which supported the country's HIV response with a \$10 million grant from 2003 to 2007. The TB response, on the other hand, has always been funded by domestic resources.<sup>6</sup> The Principal Recipient of the Global Fund HIV grant was the National Institute of Health Development (NIHD) under Estonia's Ministry of Social Affairs. In 2007 Estonia lost its eligibility to Global Fund support because of an increase of its GNI per capita and its classification as a high-income country. The withdrawal of Global Fund financing from Estonia was well anticipated and a detailed transition plan was drafted, ensuring a successful takeover of the

Global Fund financed services by domestic resources. A contributing factor for this success was the efforts to adopt a health system approach to the TB and HIV response.

This case study discusses the main determinants that allowed Estonia to successfully transition from Global Fund support, and sheds light on the importance of an integrated health system approach in the context of transition. Progress made so far towards a health system approach in Estonia, as well as the remaining problems and challenges to adopt a systemic approach in effectively tackling the diseases will also be presented.

# SMOOTH TRANSITION FROM THE GLOBAL FUND

Smooth transition from Global Fund support in Estonia was made possible due to several factors. First of all, Estonia took a **proactive approach** to transition. As soon as the second phase of the HIV grant was approved – which covered the years 2006–2007 – the question of eligibility to receive a new grant after 2007 was raised within the Country Coordinating Mechanism (CCM), the national multi-stakeholder committee applying for and overseeing the country's Global Fund grants.<sup>8</sup> As it became clear that an expected increase in GNI per capita and a decrease in disease burden would most likely lead Estonia to lose its eligibility for the Global Fund financing for HIV, the country started to prepare for a national takeover of donor-funded activities. During this time, the Estonian government began drafting the country's 2006–2015 national HIV strategy which included plans to integrate the delivery of HIV services originally funded by the Global Fund.

Transition and HIV strategy discussions were **multi-sectoral**, meaning they took place across different Ministries (Ministries of Social Affairs, Education and Science, Justice, and Defence) and included civil society, allowing for better awareness, coordination and ownership of the process across different stakeholders. **Predictability of the process, coupled with strong coordination and ownership** from all stakeholders, led to drafting of a comprehensive, costed and detailed transition plan, which clearly designated responsible entities for each activity and service, as well as implementers and cost.

The success of transitioning out of Global Fund support was also made possible by the Estonian government's **high-level political and financial commitment** towards HIV programmes. The former Minister of Social Affairs also served as the chairman of Estonia's CCM. This helped secure the engagement of the highest health authority in the transition process. Coupled with the multi-sectoral nature of the mechanism, this made the CCM a strong advocate to put the right

measures in place for a smooth transition. Moreover, HIV was seen as a priority public health issue at both the national government and community levels. This created a good basis to ensure financial commitment by the government to take over activities funded by the Global Fund using domestic resources. When the 2007–2009 financial crisis hit Estonia, European structural and social funds were reallocated to those services from 2010 to 2015 in order to ensure continuity of financial protection for the population without eroding the benefits package.<sup>8</sup>

The fact that the NIHD was the Principal Recipient of Estonia's HIV Global Fund grant facilitated **organisational sustainability**, as knowledge developed throughout the duration of the grant was maintained within the national system and integrated more broadly in areas beyond HIV. It is worth noting that many challenges experienced by other transitioning countries are due to strategies that build the entire HIV and TB programmes and structures around Global Fund support without embedding them within national public systems. In Estonia, however, the Global Fund supported the country's HIV response for only four years. In addition, only the HIV programme received donor support, while the TB response was fully funded domestically. At the same time, reforms in Estonia's public health structure prior to the Global Fund grant also played a role in smooth transition. The NIHD was created in 2003 as the result of a merger of different smaller Estonian public health organisations in order to overcome some aspects of health system fragmentation and optimise governance by bringing different public health programs under the same roof.

Financial transition and the successful takeover of the funding of services by national resources were accompanied by a more programmatic transformation towards a health system approach to the TB and HIV response.

## Box 1: Importance of an integrated approach to TB & HIV in the transition context

Integration of TB and HIV services is crucial from an epidemiological standpoint, and particularly relevant in the context of transitioning out of Global Fund support. The dual burden of HIV and TB is alarming as people living with HIV are 29 times more likely to develop TB, and TB accounts for 1/5 of HIV-related death.<sup>9</sup> HIV and TB affected people also often suffer from other conditions such as viral hepatitis or diabetes or often find themselves in situations of vulnerability such as drug or alcohol use. This highlights the importance of integrating services within the rest of the health system in order to ensure an effective continuum of care.

Community-based services, which have proved to be an effective strategy in tackling epidemics among key populations,<sup>10</sup> are often mainly donor-funded. This can be explained by the fact that key populations are not prioritised in government funding programmes due to marginalisation, stigma and/or criminalization in some cases. Thus, key populations are often most at risk of losing access to services during and after transition from Global Fund or other donor support. These groups also suffer the most from the fragmentation

of health systems at the service delivery level. When TB, HIV and harm reduction services are located in different geographical locations, people with co-infections have to travel to separate locations to get the needed services. This creates additional hurdles for these groups, who already experience challenges accessing care, and may result in treatment interruption. **People-centred approaches, in which multiple health services are offered together to achieve integrated treatment delivery in a location convenient to those affected is vital for better treatment outcomes.**

**In order to ensure care is adapted to communities and centred around people's needs, a system-wide approach to TB and HIV is often necessary to reduce fragmentation.** Work towards integrating services within the entire health system should be undertaken as far ahead of transition as possible. The transition period can also be used to optimise allocation and use of resources across the whole system, including by reduction of fragmentation at both the financial and institutional level.

## CONTEXTUALISING THE TB AND HIV RESPONSE: A FRAGMENTATION CHALLENGE

Historically, one of the main obstacles to effectively tackling HIV and TB in Estonia has been the fragmentation of the response to these two epidemics. In 2006, the World Health Organization conducted a study on HIV and TB interventions in the three Baltic countries and found that HIV and TB services suffered from several levels of fragmentation in Estonia.<sup>11</sup> Because they

were considered to be public health issues necessitating a "health promotion and education" approach, HIV and TB responses were kept separate from the rest of national health services and fell outside of the remit of the Estonian Health Insurance Fund (EHIF) mandate, which is tasked with purchasing personal medical services (Box 2).

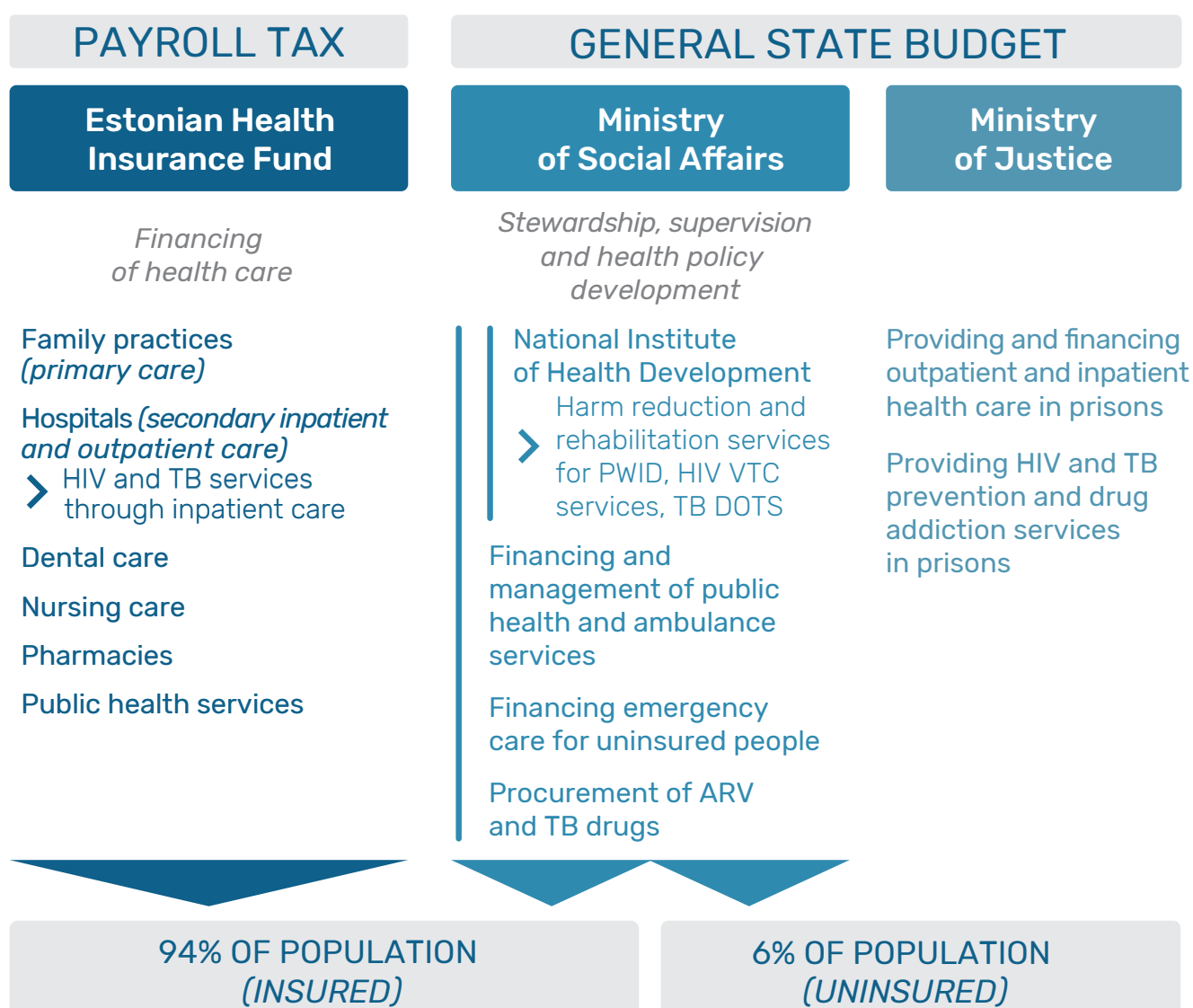
## Box 2: Zooming in on the Estonian health system

The Ministry of Social Affairs oversees the stewardship of Estonia's health system, while the financing of health care falls under the Estonian Health Insurance Fund (EHIF) through a mandatory payroll tax. Approximately 94% of the Estonian population is covered under the EHIF, which is responsible for contracting health care providers, paying for health services, reimbursing pharmaceutical expenditures and financing temporary sick leave and maternity benefits.

The Ministry of Social Affairs, through the state budget, finances public health and ambulance services, as well as TB and HIV services through the National Institute of Health Development (NIHD),

a research and development public health agency. The Ministry of Social Affairs also centrally procures antiretroviral drugs and TB drugs, which are then distributed to TB-affected people and people living with HIV with no additional out-of-pocket payments. The NIHD provides, among others, harm reduction services, counselling and rehabilitation services for people who inject drugs, HIV voluntary testing, as well as TB directly observed treatment services – all free of charge at the point of care.

The Ministry of Justice is responsible for providing and financing TB and HIV prevention and harm reduction services in prisons.





Disease-specific programmes for HIV, TB and drug abuse were considerably fragmented, with each programme having its own budget line with no ability to pool funds and no incentives for joint planning.<sup>12</sup> Each programme had its own strategy, with timelines that often did not match, and its own governance body, and very little coordination across programmes. Donor funding further increased this fragmentation, as the Global Fund-financed HIV programme, while falling under the NIHD and therefore being led by a national authority, was managed separately from the national HIV/AIDS strategy, thereby bypassing the existing national mechanism and creating a parallel system with its own programmatic, financial and operational guidelines. This led to duplications and overlaps in the contracting of services. TB and HIV programmes were often separately contracting the same providers, resulting in inefficiencies at the administrative level, and ultimately at the level of care for patients.<sup>13</sup>

In recent years, Estonia has made attempts to integrate the TB and HIV response into its health system. Following the recommendations from the WHO's 2006 study on HIV and TB interventions in Baltic countries, the NIHD made progress in integrating its provided services (Box 2) in 2006-2007. **Service delivery was organised based on a target group approach,** instead of the previous vertical approach to TB and HIV programmes. This helped to avoid some overlaps within the service delivery, as HIV and TB programmes shared common target populations. For instance, the West-Tallinn Central Hospital's opioid substitution therapy

programme provides directly supervised antiretroviral dispensing, thereby increasing treatment adherence for people who inject drugs. When necessary, directly observed treatment for TB is also available. In addition, the transition from donor to domestic funding and the financial crisis pushed for better coordination and pooling of TB and HIV programme resources, which resulted in common contracting arrangements across both diseases to ensure a continuum of HIV, TB and drug use-related services for patients. However, as will be discussed below, despite progress towards the integration of HIV and TB services under the NIHD, challenges remain in integrating those services with the bulk of services purchased by the EHIF.

The adoption of **the National Health Plan (NHP) for 2009-2020**, on the other hand, enabled the integration of several previously independent health plans at the policy level, including HIV and TB strategies. The multi-stakeholder Steering Committee of the NHP is made up of representatives from several ministries, the government, the main political parties, local municipalities, and academia. The multi-sectoral character of this platform is highlighted as one of the key enablers for coordination across the whole health system. Although the NHP approach provides an umbrella for vertical programmes and is regarded as a step forward towards a health system approach, our respondents have suggested that there have been missed opportunities to look for areas where cross-programmatic coordination at policy and financial levels would result in effective progress in service delivery integration.

## TEN YEARS LATER: A SUCCESS STORY?

Despite some progress towards integration of HIV and TB services, the reforms within the NIHD and bringing all programmes under one national health plan, the issue of integration of TB and HIV services within the whole health system remains problematic today. For example, some services related to HIV, TB, and drug abuse, such as directly observed treatment, voluntary testing and counselling and prevention activities, are financed and contracted by the NIHD. The EHIF, in turn, pays for a large share of these services through its role as a financier of inpatient hospital services (Box 2). This fragmentation on both financial and management levels results in insufficient coordination between the NIHD and the EHIF, which in turn leads to inefficiencies at the service delivery level, affecting the continuity of care.

The Estonian Parliament is currently discussing a law to reform the revenue base of the EHIF. It will allow the integration of some of the HIV and TB contracting into the EHIF. This is another sign of Estonia's willingness to reduce the fragmentation between the EHIF and the NIHD. However, **pooling funds alone will not solve all these challenges. Much more needs to be done to better integrate different levels of care and services within the health system in order to assure a collaborative service delivery model.**

The examples below highlight how fragmentation and weak integration between different levels of care can create obstacles for better treatment outcomes for people living with HIV and those affected by TB.

## Better response to TB & HIV at the primary health care level

A strong primary health care system with integrated TB and HIV services, that can deliver services close to patients and communities, is an important precondition for an effective people-centred response to TB and HIV. This seems to remain problematic in Estonia. For example, Estonian civil society reported that family doctors often refer patients to hospitals to get tested for HIV and TB related conditions (though it was also reported that additional funding options<sup>14</sup> in place since the beginning of 2017 have improved to some extent HIV testing by general practitioners).

Referrals between infectious disease specialists, pulmonologists and psychiatrists, as well as financial concerns regarding hospital care may increase the risk of patients lost to follow-up after diagnosis, especially among those who are co-infected. Referrals can be associated with a lack of sufficient capacity and training of family doctors, as well as stigma towards those

affected by TB and HIV. According to a study led by Eurasian Harm Reduction Network (EHRN), about a third of respondents living with HIV reported that they had been subjected to one or more discriminatory practices by governmental, legal and/or medical institutions within a time span of one year.<sup>15</sup> Another recent study shows that the situation around stigma is improving while the accessibility of treatment (long distance and waiting list) in specific regions remains problematic for some people living with HIV.<sup>16</sup> Transportation fees to hospitals, as well as current €5 specialist consultation fee may also create obstacles for patients seeking care. That is why integrated services at primary health care level, closer to patients and communities are key for achieving better treatment outcomes. Comorbidities between HIV, TB and drug-related conditions further indicate the need for progress in this area, as primary health care allows for the provision of care in a “one-stop-shop”.

## Better integration with psycho-social services

Another important element of effective people-centred care for TB and HIV is strong collaboration between all care providers – social, psychological, and medical. People-centred care goes beyond only medical interventions and takes into consideration also the psychological and social needs of a patient, which are crucial for treatment adherence.

According to Estonian civil society, a high rate of HIV patients are lost to follow-up, which they explain is often tied to lack of sufficient psycho-social support. Although in major infectious disease clinics psycho-social services are available for people living with HIV, there is either a shortage of these services in the community setting or they are not well linked with hospital based services. High MDR-TB rates in the country indicate that treatment adherence is also an issue for TB-affected communities.

For people living with HIV, this issue is of particular concern for key populations, especially people who inject drugs, for whom social and psychological support are vital to stay on treatment. For patients with MDR-TB, the lengthy and toxic treatment causes various adverse drug reactions and can result in catastrophic costs while patients seek care. The delivery of social and psychological support services is critical to ensure patients successfully complete MDR-TB treatment.

The lack of sufficient integration between health and social services, as well as the lack of integration within health service delivery, mirrors the same fragmentation at the policy level. While health falls under the remit of the state, social care falls under municipal responsibility, making the delivery of services dependent on the capacity, interest and size of the municipalities.

# LESSONS LEARNT

The Estonian case has shown that anticipation, strong coordination among all stakeholders, high-level political commitment, and a comprehensive and costed transition plan were key factors for a successful financial and programmatic transition out of external donor financing for HIV services. However, further efforts are needed to bring political and financial reforms at the service delivery level and ensure better access to care for people affected by TB and HIV.

Successful transition goes well beyond countries taking over financing of services. Programmatic and structural changes are also necessary to ensure sustainability and efficiency of the HIV and TB response. Integration of TB and HIV services, both together and within the entire health system, can be one of the key measures to mitigate the risks of withdrawal. This is especially important for key populations to ensure a more efficient allocation and use of resources across the whole system, leading to an effective continuum of care for all.

The fragmentation between HIV programmes within the NIHD during Global Fund support highlights the fact that donors cannot consider sustainability as solely a national responsibility. On the contrary, it shows that some of the donors' mechanisms and models themselves can create barriers to future integration of the TB and HIV response within the rest of the health system. Sustainability needs to be thought through from the very beginning of donor support.

Challenge of integrating TB and HIV at the service delivery level to ensure an effective response in Estonia proves that the process of integration cannot be undertaken in a short time frame. But continuous political will towards this goal can result in concrete progress in curbing the disease burden, as has been the case in Estonia. Continuous reforms and policy dialogue have proven to be key success factors in working towards better integration.

<sup>1</sup> The case study has been prepared based on a literature review and on information gathered via interviewing various in-country stakeholders. It is not intended to be a comprehensive or in-depth study, but rather to highlight some of the successes and challenges during the transition from donor to domestic funding for the TB and HIV response from a civil society perspective.

<sup>2</sup> According to WHO's Estonia TB profile, MDR-TB cases accounted for 16% of new TB infections in 2015, WHO's Estonia TB profile, [https://extranet.who.int/sree/Reports?op=Report&name=%2FWHO\\_HQ\\_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&LSO2=EE&LAN=EN&outtype=html](https://extranet.who.int/sree/Reports?op=Report&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&LSO2=EE&LAN=EN&outtype=html)

<sup>3</sup> Idem.

<sup>4</sup> According to UNAIDS, gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs are considered the four main key population groups, but it acknowledges that prisoners and other incarcerated people also are particularly vulnerable to HIV and frequently lack adequate access to services. Countries should define the specific populations that are key to their epidemic and response based on the epidemiological and social context. See UNAIDS Terminology Guidelines, 2015, [http://www.unaids.org/sites/default/files/media\\_asset/2015\\_terminology\\_guidelines\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf)

<sup>5</sup> WHO Europe, Center for Health & Infectious Disease Research and WHO Collaborating Centre on HIV and Viral Hepatitis, "HIV/AIDS treatment and care in Estonia", Evaluation report, June 2014, [https://www.sm.ee/sites/default/files/content-editors/Ministeerium\\_kontaktid/Uuringu\\_ja\\_analusiid/Tervisevaldkond/hivaid-treatment-and-care-in-estonia.pdf](https://www.sm.ee/sites/default/files/content-editors/Ministeerium_kontaktid/Uuringu_ja_analusiid/Tervisevaldkond/hivaid-treatment-and-care-in-estonia.pdf)

<sup>6</sup> WHO's Estonia TB profile

<sup>7</sup> Country Coordinating Mechanisms are national committees in each country that submit funding applications to the Global Fund, foresee the implementation of the grant and ensure the linkage between the GF grants and other national programmes. They usually include representatives from government, the private sector, technical partners, civil society and communities living with the diseases. Source: The Global Fund, <https://www.theglobalfund.org/en/country-coordinating-mechanism/>

<sup>8</sup> Taavi Lai, Triin Habicht, Kristiina Kahur, Marge Reinap, Raul Kiivet, Ewout van Ginneken, "Estonia, Health system review", European Observatory on Health Systems and Policies, Health systems in Transition Vol. 15 No. 6 2013, [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/231516/HiT-Estonia.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0018/231516/HiT-Estonia.pdf?ua=1)

<sup>9</sup> World Health Organization, "A guide to monitoring and evaluation for collaborative TB/HIV activities: 2015 revision", [http://www.unaids.org/sites/default/files/media\\_asset/2015\\_guide\\_monitoring\\_evaluation\\_collaborative\\_TB-HIV\\_activities\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/2015_guide_monitoring_evaluation_collaborative_TB-HIV_activities_en.pdf)

<sup>10</sup> World Health Organisation, "Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations", 2016 update, p.113, <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf?ua=1> & World Health Organisation, "Global Tuberculosis Report", 2017, p.82, [http://www.who.int/tb/publications/global\\_report/en/](http://www.who.int/tb/publications/global_report/en/)

<sup>11</sup> Anita Alban and Joseph Kutzin, "Scaling up treatment and care for HIV/AIDS and TB and accelerating prevention within the Baltic States (Estonia, Latvia, Lithuania). Economic, health financing and health system implications", World Health Organization, January 2006, <http://www.euro.who.int/en/countries/latvia/publications/scaling-up-treatment-and-care-for-hiv-aids-and-tb-and-accelerating-prevention-within-the-health-system-in-the-baltic-states-estonia-latvia-lithuania-economic-health-financing-and-health-system-implications>

<sup>12</sup> Idem.

<sup>13</sup> Idem.

<sup>14</sup> Since 01 January 2017 general practitioners can use so-called therapy fund for HIV testing that has no ceiling, instead of using the fixed per patient budget that they receive to cover the cost of HIV testing

<sup>15</sup> Estonian Network of PLHIV, Global Network of PLHIV, "The people living with HIV stigma index - Estonia", February 2012

<sup>16</sup> Kristi Rützel, Liis Lemsalu, "Reasons of loss to follow-up among people living with HIV. Summary of in-depth interviews", [https://intra.tai.ee/images/prints/documents/150788098874\\_Reasons\\_of\\_loss\\_to\\_follow-up\\_among\\_people\\_living\\_with\\_HIV\\_summary.pdf](https://intra.tai.ee/images/prints/documents/150788098874_Reasons_of_loss_to_follow-up_among_people_living_with_HIV_summary.pdf)

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**Design:** Julien-Guénolé François [www.guenolefrancois.com](http://www.guenolefrancois.com) - NOVEMBER 2017



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Co-funded by the Health Programme of the European Union

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