**Analysis of the Estonian, Ukrainian, and Thai Response to the HIV Epidemic Within Their Injected Drug User Communities**

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**Abstract**

This analysis explores the similarities and differences between the policies and approaches to Estonia, Thailand and Ukraine in combating the HIV epidemic amongst injected drug users. The purpose of this piece is to determine where the strengths and weaknesses of each response lie and compare them with one other. To complete this, research into the history and patterns of each country’s response was recorded and analyzed. Analysis of the literature revealed that Estonia was successful in relying on its own funds for its response, Ukraine had the highest prevalence of needle exchange and opioid substitute therapy sites per injected drug user capita and Thailand had the biggest decrease in injected drug user prevalence. In addition, the implications of the Portuguese Government’s decision to decriminalize drugs as a response to its growing HIV epidemic was looked at and suggests how decriminalization may be a key step in reducing drug use.

**Virology and Transmission of HIV/AIDS**

The Human Immunodeficiency Virus (HIV) is a retrovirus that infects human T-cells, a key component of the immune system. Unlike other viruses, however, HIV cannot be effectively cleared by the human immune system. If left untreated, the virus will eventually kill enough T-cells to lead to Acquired Immunodeficiency Syndrome (AIDS). AIDS is a condition that results in a weakened immune system, making the victim susceptible to deadly opportunistic infections such as tuberculosis and pneumonia. As of today, there is no known cure or vaccine for HIV or AIDS, but anti retroviral medications can be given to slow the viral replication process and delay the progression of the disease.[[1]](#footnote-1)

HIV is spread through the uptake of infected bodily fluids such as blood, semen, vaginal fluids and breast milk. HIV/AIDS is known as being a dual epidemic disease, with transmission through unprotected sexual intercourse (vaginal or anal) and intravenous drug use being the primary means of transmission. As such, high-risk populations include sex workers, men who have sex with men (MSM), those in concurrent relationships and injected drug users (IDUs).[[2]](#footnote-2)

**Demographic and Health System Overview of the Selected Countries**

***Estonia***

As of 2012, Estonia had a population of 1.29 million people with 70% of the population living within an urban environment. Like many European countries, Estonia has an aging population, where 23.92% of the population is aged 60 and the 15 and younger age group constitutes a lower percent of the population, at 15.69%.[[3]](#footnote-3)

Regulated and operated under the Ministry of Social Affairs (MOSA), the Estonian Health Insurance Fund (EHIF) is a compulsory social insurance system. The system guarantees that a person will not pay more than a 5 Euro copayment for out-patient care or specialized care and no more than 2.50 Euro a day for up to ten days for in-patient care. There is no visit fee for pregnant women, children below the age of 2 and emergency hospitalization. Additionally, there is no in-patient fee for pregnancy related cases, persons under the age of 18 and in the case of intensive care. The amount of compensation for medical products (pharmaceuticals, medical devices, etc.) depends on the product, with the EHIF compensating a minimum of 50% of the cost and a maximum of 100% compensation. Dental service is free up until the age of 19. All persons over the age of 19 are expected to pay the full amount for dental service except in the case of an emergency.[[4]](#footnote-4)

In 2012, 79.9% of healthcare funding came from general government expenditures with the majority (86.4%) being made up of social security funding. The rest of the funding comes from private expenditures, with 91.7% of those expenditures being out-of-pocket (OOP) expenditures. Private insurance schemes are not common (1.4% of private expenditure). In this same year, the Estonian government spent about 5.9% of the total GDP on health and spent approximately $807 (USD) per capita on health.[[5]](#footnote-5)

***Ukraine***

In 2012, Ukraine had a population of 45.5 million, with 69% of inhabitants living in urban environments. Similar to Estonia and other European nations, Ukraine has an aging population, where 20.76% of the population is aged 60 and over while 14.18% of the population is aged 15 and below. Additionally, Ukraine follows the typical Eastern European trend of a rapidly declining population, with an annual growth rate of only .6% and a crude death rate of 15.1 compared to a crude birth rate of 10.9.[[6]](#footnote-6)

The Ukrainian health system indicates that the system closely mimics the Soviet Semashko model, a highly centralized state-run system. Although the Ministry of Health oversees all health related matters, there has been a shift towards a decentralized system by placing the responsibility of administration and financing on the regional and local governments. Formally, the system provides universal healthcare funded by general taxation. However, low paid staff and poor government financing result in large copayments and service fees. There is a small but increasing number of private medical providers that consists mostly of pharmacies and some inpatient and outpatient facilities staffed by private doctors. Payment for these institutions is mostly OOP as private insurance schemes are not common, despite the growing private sector.[[7]](#footnote-7)

In 2012, 54.9% of health expenditure came from the government, with a very low portion (0.6%) of that number being from social security funds. The rest of the funding comes from private expenditures, with 93.9% of expenditures being comprised of OOP payments. As mentioned above, private insurance plans are not common and only make up 2.1% of private expenditures on health. In the same year, Ukraine spent about 7.6% of its GDP on health, yet only $160.6 (USD) was spent per capita.[[8]](#footnote-8)

***Thailand***

As of 2012, Thailand had a population of 66.8 million people, with less than half (34%) living within an urban environment. Unlike the aforementioned countries, Thailand is at the cusp of reaching the demographic transition equilibrium with 18.47% of the population aged 15 and under and 13.96% of the population aged 60 and over. Thailand’s growth rate is near zero (-0.3) and as such, is expected to reach demographic transition equilibrium if these demographic trends continue.[[9]](#footnote-9)

The Thai healthcare system is organized into three different systems: the Civil Servant Medical Benefit Scheme, Social Security Scheme and the Universal Coverage Scheme. Combined, all three systems ensure 98% health insurance coverage of all residents of the country. The OOP expenditures vary between plans and can be affected by factors such as benefits, financing mechanisms and reimbursements. The private sector in Thailand has remained small but there remains a concern that doctors will go private due to the better pay (up to 11times greater than the salary of a public doctor). Lastly, there is a large gap between the number of physicians in rural and urban areas that leads to health disparities in the former.[[10]](#footnote-10)

Thailand is in the process of transitioning from a primarily private funded system to a publically funded system. In 2010, public health expenditures made up 42% of total health expenditures.[[11]](#footnote-11) As of 2008, Thailand has spent approximately 4.76%[[12]](#footnote-12) of its GDP on health, making the provision of equitable and affordable universal coverage a greater challenge.

**HIV/AIDS Amongst IDUs in the Selected Countries**

Southeast Asia and Eastern Europe have high prevalence of IDUs, due to their strategic locations near or within the Golden Triangle (Thailand, Laos, Vietnam and Myanmar) and the Golden Crescent (Iran, Pakistan and Afghanistan). It is estimated that there are 4.5 million IDUs in the South, East and Southeast Asian regions and 3.7 million IDUs in the Russian, Eastern European and Central Asian regions alone. Furthermore, it is estimated that 13.1% of all global IDUs are infected with HIV/AIDS, although this number can be lager or lesser in other countries.[[13]](#footnote-13)

***Estonia***

As of 2013, the number of adults between the ages of 15-49 living with HIV in Estonia was approximately 8,600. When compared to the entire population, the result is an HIV prevalence of 1.3% amongst adults ages 15-49[[14]](#footnote-14).

As of 2009, it was estimated that 0.9% (0.7%-1.7%) of the adult population aged 15-44 were injected drug users. This is a significant decrease from the 2005 estimate of 2.7% (1.8%-7.9%) of adults abusing injected drugs, indicating an annual reduction of 1,700 IDUs.[[15]](#footnote-15) Regardless of the progress, it is estimated that the HIV prevalence amongst this community is anywhere between 54-90% (2012)[[16]](#footnote-16) highlighting a very serious epidemic within this population group.

***Ukraine***

As of 2013, the number of adults between the ages of 15-49 living with HIV in Ukraine was approximately 210,000. When compared to the total population, the result is an HIV prevalence rate of 0.8% within this group, a moderately lower rate when compared to its regional neighbor Estonia[[17]](#footnote-17).

As of 2009, it’s estimated that there were 290,000 people who inject drugs within Ukraine. About 12.6% of IDUs in Ukraine have reported to share syringes amongst each other, highlighting an increased risk of HIV transmission and suggesting a need for clean syringes or a lack of knowledge of the risks of needle sharing.[[18]](#footnote-18) In 2012, it is estimated that the HIV prevalence amongst injected drug users is 22%.[[19]](#footnote-19)

***Thailand***

As of 2013, the number of adults ages 15 and up living with HIV is about 430,000. When compared to the total population, the result is an HIV prevalence rate of 1.1% amongst all adults ages 15 and up.[[20]](#footnote-20)

In 2001, it was reported that there were 160,528 injected drug users in Thailand. In this same year, it was estimated that 42.5% of IDUs were infected with HIV.[[21]](#footnote-21) As of 2009, however, the prevalence of IDUs has decreased dramatically as it was estimated that there were 40,300 IDUs across the country.[[22]](#footnote-22) In 2012, it was estimated that 22% of IDUs are infected with HIV.[[23]](#footnote-23)

**Policies and Providers**

***Estonia***

Recognizing the increasing risk to public health that HIV poses, the Estonian government launched a comprehensive national HIV/AIDS strategy to be implemented between the years 2006-2015. Organized and managed under the Governmental HIV and AIDS Committee (operating under the Ministry of Social Affairs), the program was designed to combat the growing crisis.[[24]](#footnote-24)

Out of six objectives posed by the program, two specifically target HIV in the IDU community. The first goal was to stabilize the spread of HIV amongst IDUs by 2009 and by 2015, reach an HIV prevalence of 62% within this community. The second IDU specific goal was to see to an increase in the number of IDUs infected with HIV receiving opioid substitute therapies (OST). Starting with the first one, it was found that in 2013 there was a 58% prevalence of HIV amongst the IDU community in Tallinn, a modest decrease from the expected level. As for the second objective, the target of 900 IDUs receiving OST was surpassed with 1,157 IDUs receiving OST in 2012. A pertinent but not directly IDU specific objective saw to 100% ART coverage of people living with HIV (PLHIV). However, only 2,691 PLHIV out of 4,400 were receiving ART treatments. A large portion of those not receiving treatment are people within the injected drug using community.[[25]](#footnote-25)

Treatment for HIV is conducted following European and WHO guidelines. Specifically, these guidelines instruct Estonian health workers on how to provide ARTs, prevent mother-to-child transmission and pediatric guidelines for ART. National guidelines exist for the counseling and provision of services to prevent perinatal transmission. A national commitment has been made to ensure that those in need have no institutional barrier to receiving ART. As a result, hospitals, in addition to specialized clinics, are ART dispensaries.[[26]](#footnote-26)

HIV testing is recommended but not mandatory (unless donating blood or organs) for people in high-risk situations. Such persons include pregnant women, prisoners, persons with histories of injected drug use and persons with multiple sexual partners. Persons with medical insurance can get free testing within a general practitioner or specialist’s office. For the uninsured, there is the option of visiting clinics and counseling services (11 total across the country) for free testing. As of 2013, about 150,000 people received an HIV test however; the majority of this group (100,000 peoples) were pregnant women and blood donors, people who don’t fit the typical “high-risk” category.[[27]](#footnote-27)

Currently, there is a small presence of civil society and NGO workers that provide services to underserved and marginalized populations. As of 2011, civil society and NGO groups received 11% of the budget designated to combat HIV. Additionally, 50% of the harm reduction program budget (needle exchange programs and OST) was spent by civil society groups. One important note is that civil society and NGO groups that provide harm reduction programs typically do not offer HIV testing, but often refer individuals to testing centers.[[28]](#footnote-28)

***Ukraine***

As of 2008, the Ukrainian government’s approach to addressing HIV within IDU groups has not been entirely clear. There remains confusion over who has the responsibility of addressing this epidemic: health providers or law enforcement agencies. This ambiguity not only confusion on an administrative level, but also reduces the uptake of services due to fear of legal repercussions for IDUs.[[29]](#footnote-29)

The Ukrainian government has been successful in its provision of ART and of treatment services for HIV infected persons, including IDUs. Despite this success, there has been a lack of government support for preventative services. As a result, a lot of the burden to provide such service falls on regional NGOs that receive external funding and resources (often donations by citizens and global organizations).[[30]](#footnote-30)

Medication assisted treatment (MAT) programs have been implemented by the government since 2004 with buprenorphine and the more commonly used methadone as of 2008.[[31]](#footnote-31) Also known as OST, MAT consists of orally consumed opioids that eliminate the need for syringes, thus reducing the risk of HIV transmission to near 0%. Although the government has implemented programs, there is a need of significant service expansion to match the demand for these services.[[32]](#footnote-32)

Although the implementation of ART services has been a relative success, there remain pressing issues in their provision. First, ordering delays are painfully common and result in hospital and clinic “stock outs” that interrupt the treatment cycles. Secondly, the vertical system of the Ukrainian health system emphasizes specialization and a sole focus on said specialization. As such, comprehensive HIV care is hindered due to a lack of general providers that can provide ART treatment. As of today, ART treatment is left into the hands of special doctors and community health workers. Preventative measures are almost exclusively left to NGOs and community health workers. One of the last issues with ART provision are barriers between IDUs and treatment. In 2009, 60% of all HIV infected people were IDUs yet only 7.9% of this population was receiving ART. Although it the HIV infected rate amongst IDUs has decreased over the years, this remains a concerning theme that will make overall elimination of the disease a greater burden.

***Thailand***

Since 1991 the Ministry of Public Health to the National AIDS Prevention and Control Committee oversaw the first of a series of 5-year plans to combat the epidemic[[33]](#footnote-33). With a massive public health awareness campaign and treatment and prevention (namely the “100% Condom Program”[[34]](#footnote-34)) measures, Thailand has enjoyed a steady decline in the incidence and prevalence of new cases.

While Thailand’s public health campaigns have proven to be effective at reducing the incidence and prevalence of sexually related HIV cases, there has been less attention paid to combating the epidemic in the IDU community. Similar to commercial sex, there has been little attention given to forming preventative policies though it is possible to purchase unused syringes from pharmacies. As of 1995, there has been at least one harm reduction program aimed at providing OST and syringe exchange programs as a means to prevent the spread of HIV and other blood borne diseases in high-risk areas within the north. Additionally, there are a series of methadone clinics available in high-risk areas, which could easily be utilized as gateways to providing HIV counseling and treatment.[[35]](#footnote-35)

In 2003, the Thai government began a stern crackdown on drug based criminal activity. Although recent enforcement has been successful in reducing the number of IDUs, fear of legal consequence has been a lethal side effect. For IDUs infected with HIV, the fear of arrest when utilizing available resources becomes a barrier in taking initiative to receive treatment and reduce one’s risk of infection. However, as of 2010, the National AIDS Committee has approved harm reduction policies with the goal of counteracting harsh law enforcement practice.[[36]](#footnote-36)

**Funding and Service Fees**

***Estonia***

The majority of HIV prevention and treatment program funding is left to the responsibility of MOSA. Through MOSA, both insured and uninsured persons are able to receive free ART treatments (although this differs with testing services as mentioned earlier) and free or inexpensive OST or clean needles from registered NGOs. In the past, Estonia has received funding from the Global Fund with the intent of setting examples on proper program monitoring and evaluations. After this four-year period of receiving aid, Estonian health providers (namely, NGOs) have the necessary expertise in allocating funds for program implementation. Lastly, municipal governments also provide some financial support to organizations working within their municipality, but an increase in these funds is necessary to keep up with the standards set by the Global Fund.[[37]](#footnote-37)

***Ukraine***

Since 2003, the Global Fund has heavily supported IDU specific HIV programs, with an initial grant of $90 million (USD). Although funds were frozen temporarily in 2004 due to slow program mobilization, Ukraine has been successful in effectively allocating funds to servicing this population. One area of concern in regards to the funding of IDU HIV programs is an almost complete reliance on international donations. Strides have being taken as of the 2012 Global Fund grant to Ukrainian Government involvement in the financing of IDU specific programs to guarantee sustainability.[[38]](#footnote-38)

***Thailand***

As of 2011, 85% of funding for HIV programs in Thailand came from domestic sources. Due to large-scale expansion for universal ART support in 2001, ART procurement is either free or inexpensive. While most of the domestic funding was directed towards ART and sexually transmitted prevention programs, IDU specific programs supported by Civil Society Organizations were heavily funded by the Global Fund. Unfortunately, as of 2011 Thailand has lost its qualifications for receiving Global Fund aid, due to its status as an upper-middle income country.[[39]](#footnote-39)

Although direct government funding by the Global Fund has been eliminated, the Global Fund continues to provide funding for Comprehensive HIV Prevention Among MARPS (most-at-risk-populations) by Promoting Integrated Outreach and Networking (CHAMPION) programs implemented by NGOs like the AIDS Access Foundation, Population Service International and the Raks Thai Foundation. In the past, funding has been directly allocated towards prevention, care and support programs of the Raks Thai Foundation, although funding for this has been halted.[[40]](#footnote-40)

**Analysis**

***Similarities***

One theme the three countries share when approaching the HIV epidemic in their respective IDU communities is their usage on NGOs to deliver harm reduction programs. As stated earlier, harm reduction programs are those that provide safe solutions for injected drug users, with needle exchange programs and OST being the most common interventions. The formal hospitals and general outpatient services of each country does not provide any notable harm reduction service to IDUs. As such, the responsibility has been placed upon specialized NGOs to provide preventative measures.

For the most part, the NGOs within each country have been successful in implementing safe interventions regarding injected drug consumption. In 2012, Ukraine had approximately 1667 needle exchange sites (clinics, vending machines, etc.) and 131 OST providing locations.[[41]](#footnote-41) Also in 2012, Estonia reported to have 36 available sites (clinics, vending machines, etc.) for needle exchange and 10 locations that provide OST.41 Lastly, Thailand reported having 10 available sites (clinics, vending machines, etc.) that provide needle exchange services and 147 OST sites in 2012.[[42]](#footnote-42) Despite differences in the numbers of available providers, all three nations provide comprehensive harm reduction programs that aid in the prevention of HIV amongst IDUs.

Another similarity between the three countries is the widespread availability of ART. All three nations prioritized the provision of free or affordable ART in multiple healthcare settings. The ubiquity of these drugs has allowed for wide scale treatment of HIV positive individuals, with varying success and equity amongst the IDU community.

Lastly, each country has demonstrated some form of stigma aimed at the IDU community. Eastern Europe, and East and Central Asia all have harsh cultural attitudes regarding IDUs and drug addiction. As mentioned previously, Thailand has begun to implement harsher surveillance and punishments on illicit drug abusers. Similarly, new legislation in Ukraine is threatening international donations that fund NGOs that support HIV treatment and prevention amongst the IDU communities.[[43]](#footnote-43) Although the recent and quickly escalating conflict within Ukraine can be seen as a catalyst for such policy changes, the lack of concern for the wellbeing of IDUs within the country is evident. Lastly, while Estonia may not have punishments as harsh as the other two nations, societal stigma and negative attitudes towards IDUs are still present and cause feelings of shame and embarrassment for the IDU community, even though they are looking tor help.

***Differences***

One of the first differences between the three countries is income level. According to the World Bank, Estonia is classified as a high-income country with a membership within the OECD.[[44]](#footnote-44) Estonia’s status as a high-income country with a universal and equitable healthcare system suggests that the country has the capacity to provide comprehensive services without the cost being as large of a concern. This is not to say Estonia is able to allocate lucrative amounts of funds to programs or that cost effectiveness is not a factor, but what it does suggest is that Estonia would not face as many institutional and logistical challenges as Thailand and Ukraine would. This is a key reason for Estonia’s well-organized programs for IDUs.

Thailand and Ukraine are also in different economic positions. According to the World Bank, Thailand is ranked as an upper-middle income country while Ukraine is a lower-middle income nation.[[45]](#footnote-45) [[46]](#footnote-46) While the economic status of both nations is similar, Thailand’s slightly better status suggests that there are more funds that can be allocated towards program implementation and support. Of course, a larger GDP does not equivocate efficient spending but the idea remains that Thailand would hypothetically be in a better financial position.

A second difference lies between the funding for the Estonian, Thai, and Ukrainian responses. As mentioned previously, all three nations make use of NGOs to deliver HIV prevention methods to their IDU communities, with funding coming from the Global Fund at some point. As of today though, Estonia has completely moved off of Global Fund financial support and Thailand is in the process of becoming entirely independent. Ukrainian health providers, and specifically Ukrainian NGOs, are the only providers of the three countries that continue to receive significant funding from the Global Fund due to its economic status. The Ukrainian Government, like Thailand and Estonia’s, has been able to provide funding for some ART and other treatment programs, however a large portion of funding for these and nearly all preventative program funds come from international donors. The reliance on international sources has been used effectively but is not a completely reliable source of funding as the amount can vary with the international market economies. Furthermore the escalating conflict along the Russian border poses a potential threat to international donations as allegiances are created and destroyed and donors grow weary of investing in a warring nation.

Moving on to Estonia and Thailand, both nations have shifted from receiving heavy international aid to becoming either fully or nearly independent. Estonia’s NGO funding is almost completely domestic where as a few NGOs working in Thailand are not. One reason for this is that Thailand has only recently begun weaning off of Global Fund aid and still receives some other sources of international funding. Estonia has been without heavy international financial support for a longer period of time. A second reason for heavier domestic funding on Estonia’s part goes back to its status as a high-income country. As a high-income nation, Estonia theoretically has a larger fund pool at its disposal than the high-middle income nation of Thailand. The difference in funding grants Estonia the ability to directly fund its own programs without as large of a financial impact as it would in Thailand. Despite this, Thailand will have to adjust its funding methods due to the slow removal of Global Fund support.

One of the last pertinent differences between the three approaches is the number of available facilities that provide prevention options. Ukraine has the largest gross number of needle exchange and OST providing facilities amongst the three countries. Ukraine also comes in first when comparing the ratio of facilities to the population served (IDUs) with a ratio of 1:161. Thailand is second with a rate of 1:256 and Estonia is third, with a rate of 1:300.

**Decriminalization and Its Implications**

A common theme within the IDU community is fear of legal repercussion and social stigma when seeking and utilizing harm reduction programs. Though fear of societal judgment is a complex and multilateral issue, there is a feasible solution to this issue: decriminalization of illicit drugs. Often confused with legalization, drug decriminalization would eliminate criminal punishment and legal restrictions surrounding illicit drugs. The goal of a policy like this would be a reduction in fear experienced by IDUs when seeking health services, which would then result in a decline of HIV cases amongst this group.

An example of a country that has had success with decriminalization is Portugal. On July 1, 2001, the Portuguese government declared that the possession, consumption and purchase of no more than ten weeks’ worth of drugs would be illegal. As of today, Portugal is still the only EU nation to have implemented such policy.[[47]](#footnote-47) While there are various reasons for Portugal’s unique policy, one of the effects has been a massive uptake of addiction related services. For instance, the number of people enrolled in substitution therapies increased from 6,040 in 1999 to 14,877 in 2003.[[48]](#footnote-48) As a result, newly diagnosed HIV rates within drug using communities decreased from approximately 1,400 cases in 2000 to approximately 400 cases by 2006.[[49]](#footnote-49)

On the immediate surface, the results of Portugal’s response suggest a positive correlation between decriminalization and HIV reduction in IDU communities. However, one must note that decriminalization was not the sole reason for the decline in HIV incidence. Portugal already had a well functioning health system and institutions designed with the purpose of providing alternatives to IDUs. With that said, Estonia, Ukraine and Thailand all can theoretically decriminalize illicit drug usage and possession. In order to get the results that Portugal got, however, a strong and already highly functioning healthcare system is necessary to support the increased usage of IDU services that would come with such change. Of the three, Estonia would be the most likely country to be able to support such a policy change. Despite this, the example set by Portugal should be discussed amongst policy makers in Thailand and Ukraine as a way to increase the uptake of services for IDUs.

**Final Words & Recommendations**

All three countries have seen some indication of success in combating HIV within their respective IDU communities. If looking at self-efficiency and funding of programs, Estonia could be considered the most successful due to its reliance on its own economy to finance its NGOs and responses. If looking at the number of available services to IDUs, Ukraine would be crowned as having the most successful response due to the better ratio of persons to the number of services. Lastly, if one were to look toward a general decrease in IDU prevalence, Thailand’s dramatic change between the years of 2001 and 2009 would place it at the top (although it must be noted that the reduction in IDU prevalence is not the sole result of a health system intervention but also an increase in legal enforcement).

Despite the current successes of each country, adjustments will be required within each country to maintain the recent positive trends. Thailand’s biggest challenge will be allocating funds to its programs once support from the Global Fund ceases entirely as well as shifting the focus from sexually transmitted HIV to injected drug use. For Ukraine, developing strategies to become more self sufficient in financing its preventative programs coupled with the growing instability and fighting will pose significant threats to the financial (both domestic and international) and administrative security of its programs. Lastly, Estonia will have to determine the most cost-effective way to scale up to programs while not putting a significant on its social healthcare system. To conclude, each country will have to adjust some aspect of its response in order to get closer to eradicating HIV from IDU communities.

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