Social Exclusion, Ethnicity and HIV in Estonia: A Case for a Visit from the UN Special Rapporteur on the Right to Health?

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The Historical Emergence of the HIV Epidemic in Estonia

Table 1. HIV positive cases in Estonia 1988 - 2000
Table 2.

HIV positives in Estonia (1988-2001)
• The per capita figures for HIV in Estonia are higher than anywhere in Eastern and Western Europe, and also the Russian Federation (UN AIDS 2002) – and impact even more per capita upon the Russian-speaking population in Estonia (Downes 2003).

• It was only in the UN Report on the global HIV/AIDS epidemic (2002) that international reports highlighted, not only that HIV infections in Estonia “soared” Between 1999 and 2001, but that Estonia was the country with the highest cumulative reported HIV infections per million population in Eastern European countries 1993-2001, including Russia and the Ukraine.
• The beginning of a recognised HIV epidemic situation on November 1st 1999 of 612 cases in St. Petersburg was still almost 3 times lower than the HIV epidemic in Estonia for 11 November 2001 which had 1808 cases.

• Given that the population of Russians in St. Petersburg is approximately 4.7 million and the population for all of Estonia is 1.5 million, the proportionate rate of HIV infection was at least 9 times higher than in the St. Petersburg of November 1999 – 9 times higher than a city which was recognised by its own AIDS centre as having the beginning of epidemic level of HIV infections.
• The exponential rate of increase in HIV in Estonia in 2000 and 2001 slowed to some extent in 2002, with 823 new cases registered by the end of November 2002 (Tallinn Aids Prevention Centre Statistics).

• An important factor in this slowing down regarding new cases was the wide needle exchange programme in the epidemic regions – such programmes have also had a beneficial impact on the levels of new Hepatitis B and C cases in Estonia (Kalikova 2003).
The following statistics date from 19th of August 2005 according to Tallinn Aids Prevention Centre.

Table 3.

In 2000 Russian was the first language for 93% of the population of Narva.
• In 2001, there were more registered HIV cases in Estonia (1,940) than Latvia (1,725), not simply as a proportion of the population but in real terms despite the fact that the Latvian population is significantly larger (2.4 million in Latvia as of December 31, 1999 compared to 1.5 million in Estonia as of February 1, 2000).

• The rate of increase of HIV in Estonia between 2000 and 2001 was fourfold – a significantly higher rate of acceleration than in Latvia where nevertheless cases almost doubled during this time.
• In response to the HIV crisis situation, the Estonian government doubled the budget in 2002 to tackle HIV (Kalikova 2003) and this made some impact on the crisis situation.

• Another reason for the decrease in new registered cases was that many injecting drug users did not want to be tested as the HIV test is perceived as bringing them additional problems without the possibility to solve such problems. In other words, many of those at risk did not have medical insurance and could not therefore afford to receive treatment if they were HIV positive (Kalikova 2003).
The Concluding Observations of the United Nations Committee on the Elimination of Racial Discrimination (2006) outlined its concern regarding the higher prevalence of HIV among the minority population in Estonia:

• While acknowledging the State party’s efforts to implement programmes and projects in the field of health, in particular, for prevention and treatment of HIV/AIDS, the Committee is concerned at the high rate of HIV/AIDS amongst persons belonging to minorities.
It is also entering South-Estonia regions, like Tartumaa. HIV positive cases have been found in all Estonian counties with recent suggestions that ‘the disease also appears to have spread from injecting drug users and into the general population, with reports of growing infection levels amongst university students in Tartu’ (Alas 2006).
Social Marginalization of Russian-speakers in Estonia: ‘Aliens Syndrome’

18 year old Russian-speaking heroin user in Estonia in 1998 (Downes 2003):

I'm 18 years old and I don't have a future. My parents lost their jobs, they have so many problems that my presence makes them upset. They could not take care about me when I was little, and now... I prefer to come home as rare as possible. I don't have education. Of course, it's my fault but when I was 7 or 8 it was funny to play games, to smoke... Teachers are busy with 'good boys and girls', I understand them. After all, their salary is too small and they have a right to forget about guys like me. I went to technical school and there I met hundreds of guys with the same problems like me. Do you think some of them know Estonian? Maybe one or two... I cannot write in Russian without mistakes, what can I say about Estonian? I will not get a passport, I will never have a job. I cannot go to Russia - there are thousands of unemployed. I don't care what happens tomorrow, I want to have something to forget that I live for nothing and I'm not good enough for society. I know I will die but it's good

- Injecting heroin use in Estonia is overwhelmingly and disproportionately among the Russian-speaking minority, with approximately 90% of heroin addicts being Russian-speakers whereas Russian-speakers are approximately 35% of the total population in Estonia.
- The language of the State Integration documents describe Russian-speakers as non-Estonian or non-Latvian – even though many are in fact legally Estonian or Latvian citizens – thereby categorizing them as second-class citizens.
- The narrow conception of ‘social competence’ for Russian-speakers, in the Estonian programme in particular, leads to a failure identity for many among the minority group.
The narrow conception of social competence which is identified with State language competence overlooks the fact that social competence is a multi-faceted conception which cannot be reduced to simply one dimension.

Neither Estonian nor Latvian Integration documents contain a strategic plan for the success of less academic Russian-speaking youth to give them a role in Estonian or Latvian society if they cannot cope with learning a second language. Concern with the labelling of students as failures if they have difficulty learning in classes in their second language.

A central goal of these respective State Integration documents is the abolition of Russian-speaking schools without genuine consultation of parents of Russian-speaking children.
• The Estonian document ignores these problems of early school drop-out almost completely through its framing the terms of its document in terms of linguistic integration and postponing any discussion of socio-economic and political integration until after 2007 as it is supposedly “too complicated”.

• The per capita figures for HIV in Estonia are higher than anywhere in Eastern and Western Europe, and also the Russian Federation (UN AIDS 2002) – and impact even more per capita upon the Russian-speaking population in Estonia
• Conditions of 27 Russian-speaking prisoners in one room in Rummu prison in Estonia in 2000 highlight the need for increased vigilance and transparency in the Estonian prison system to prevent HIV cases rising to levels comparable to prisons in the Ukraine, especially given the fact that over 5% of prisoners in Rummu/Murru prison are now HIV positive.

• Concern at early age of hard drug use in Estonia and Latvia.
On July 12 1993, the OSCE High Commissioner Van der Stoel ‘took the unusual step of issuing a public statement in which he listed the assurances he had received’ (Kemp 2001) from the Estonian government and from representatives of the Russian community after the controversy of the Parliamentary vote on June 21 1993 ‘overwhelmingly in favour of a Law on Aliens that was designed to formalize the ‘alien’ status of approximately 400,000 (mostly ethnic Russian) long-time residents of Estonia’ (Kemp 2001). One of these was ‘an assurance to improve the economic situation in North Eastern Estonia’ (Kemp 2001), namely, in largely Russian-speaking areas of Narva and Ida-Virumaa.
Gil-Robles’ (2004) report on Estonia observed the following consequences for members of the Russian-speaking population of being given ‘alien’ status:

The lack of citizenship deprives these persons of a number of rights, mainly in the field of political rights, and carries an increased risk of social exclusion. Although non-citizens have the right to vote in local elections, they do not have the right to vote in national elections, establish political parties, or become members in political parties. Moreover, the enjoyment of the rights guaranteed under the Framework Convention for the Protection of National Minorities, was limited by Estonia to those who have Estonian citizenship when it ratified the Convention. It is also to be underlined, that non-citizens, like citizens, contribute to the society in a similar manner as taxpayers.
Mikecz (2008):

- The life expectancy of men in Estonia was the lowest in the EU in 2004
- In 2002, per capita income tax revenues in North Eastern Estonia were only half of that of Northern Estonia
- In 2005, 1.453 million tourists visited Estonia. 71% of them stayed in Tallinn and did not visit any other regions. Less than 1% stayed overnight in North Eastern Estonia
Kalikova, Kurbatova & Talu (2002, p.34) refer to ‘so-called “alien’s syndrome”’ among Russian-speakers, whether citizens or non-citizens, as ‘they feel they are second-rate people in Estonia, that their knowledge and competence is not required by society’.
The language used to refer to Russian-speakers as non-Estonian and non-Latvian is not the language of integration but of separation and exclusion of Russian-speakers from Estonian or Latvian society. Terms ‘non-Estonian’ and ‘non-Latvian’ define these groups not by what they are, but by what they are not, by a lack of some attribute, namely, Estonian/Latvian ethnicity. These terms do not connote a parity of esteem in the eyes of the State. (Downes 2007)
It is remarkable that Estonian and Latvian State documents which purport to be about integration adopt such non-inclusive language regarding its ethnic minority citizens. Moreover, it is arguable that the dimensions of ‘alien’s syndrome’ apply not only to those with ‘alien’s’ passports but to many other Russian-speakers who are socially marginalized in Estonia – and are considered as alien in the sense of being ‘non-Estonian’ despite obtaining Estonian citizenship. ‘Alien’s syndrome’ … the lack of parity of esteem is a mental health issue (Downes 2007).
Current Situation

Poleshchuk (LICHR 2010, personal communication). From 1 October 2009 the Register of Communicable Diseases started to collect data on HIV-positive population:
From 1 October 2009 - 7 June 2010, 115 new persons were registered as HIV-positive (Estonia/Ministry of Social Affairs, e-mail of 7 June 2010 – see attached). Among them:

**Ethnic origin**
- 90% - ethnic Russians
- 8% - ethnic Estonians
- 2% - others

**Region**
- 13% - Tallinn (capital city)
- 70% - Ida-Viru County

**Non sterile syringe as a source of HIV**
- 33%

**Social-economic status**
- 3% - students of higher education institutions
- 44% - prisoners
- 1% - do not work, stay at home
- 2% - on maternity leave
- 18% - working
- 30% - unemployed
- 2% - disability pensioners
- 1% - age pensioners

• With 1.52% of the adult population using them, only Scotland has a higher use of opiates (1.54%) in Europe than Estonia.

• The rest of the countries of the European Union do not reach 1%. 
Major risk groups are intravenous drug addicts and prostitutes. Ethnic minorities are considerably overrepresented in both groups (Estonian Health Board 2010).

In 2008 545 new HIV positive people have been diagnosed. This is an increase compared with the 2004-2005 figure of 417.

- **52** AIDS cases
- From them **60** prisoners
- Through the years **250** people have been diagnosed with AIDS
- Between 1988 and 2008 **6,909** people have been diagnosed with HIV in Estonia
The high number of HIV positive persons in prisons can be attributed to the fact that many prisoners coming from Ida-Viru County have been infected with HIV before coming to prison. HIV/AIDS prevention in prisons takes place in accordance with the national HIV/AIDS strategy (Estonian Ministry of Justice 2007).
A Preventable Epidemic: Contrasts with Other Countries

The epidemic among intravenous drug users in North Eastern Estonia was predicted by Tallinn Aids Prevention Centre as early as 1996 but due to lack of financing preventive measures were not introduced prior to the epidemic (Kalikova 2001).
• The contrast between Slovenia and the Baltic States is regarding methadone substitution treatment. It is widely available in Slovenia and has been established there since 1991 (EMCDDA 2004), whereas Estonia and Latvia in particular have been slow to react. For the Baltic States in the recent past, intravenous drug users have constituted 73% of HIV cases in Estonia (Official statistics December 2000), 70% of HIV cases in Latvia and 54.5% in Lithuania (2000). The contrast with Slovenia is stark.

• Current rates of HIV among IDUs is less than 1% in Slovenia with figures from local studies in Estonia and Latvia estimating that rates of HIV among IDUs is still as high as 40% in Estonia and 20% in Latvia (EMCDDA 2004).
In Romania, the Ministry of Health is the body providing funds for a detoxification programme and post-detoxification support programme, as well as a planned methadone programme for 2002 (Romano 2001).
In Croatia, the Croatian Parliament established special centres for drug treatment at county and at city level where treatment of drug addicts includes counselling, detoxification, methadone treatment, needle exchange and is covered by the national health insurance (Kuzman 2001).
In contrast to Romania and Croatia, the Concluding Observations of the Committee on the Rights of the Child for Latvia (2001) noted the limited availability of programmes and services in the area of adolescent health, including mental health, and in particular treatment and rehabilitation programmes for alcohol and drug addiction as well as prevention programmes.
The Estonian Drug Monitoring Centre National Focal Point Report (2002) observed that drug treatment funding from the Estonian State was decreased. This decrease was despite the recognised outbreak of the HIV epidemic in Estonia in 2001, predominantly among Russian-speaking intravenous drug users.
Problem Recognition and Intervention Strategies Aided by the International Community

The following account of the new strategy is given in Estonia’s Second Report on the implementation of the Council of Europe Framework Convention for the Protection of National Minorities:

• In April 2004, the national drug prevention strategy until 2012 was adopted. The strategy is aimed at strengthening the rehabilitation system and treatment for drug addicts, and improving the quality and accessibility of services. The strategy emphasizes regional differences in creating a drug-free environment.
The following principles will be implemented within the strategy:

- In planning the prevention activities and implementing the methods, the specific characteristics of target groups need to be taken into account (age distribution, sex, ethnic origin, social, cultural and economic background, experience and expectations, availability of drugs, etc.);

- All information materials, study aids and handbooks are developed depending on needs of the target group (including national minorities) and are tested on the relevant target groups;

- Information for drug prevention is available for all population groups in Estonian and Russian;

- Services must be oriented to the age, sex, ethnic origin and socio-cultural background of persons coming for treatment and/or rehabilitation.
Despite the progress made by the development of this strategy on paper, the strategy in 2005 ‘only received about a quarter of the government funding it needs’ (Charles 2005).
Amnesty International (December 2006)

- Persons belonging to the Russian-speaking linguistic minority do not enjoy internationally recognized minority rights; current employment policies mean that Russian-speakers are disproportionately affected by unemployment and by extension often by social exclusion; upcoming secondary school reforms risk increasing the number of Russian-speakers who drop out of school and thus put them at risk of further social exclusion; and current provisions and practices in place are not able to guarantee that no one is discriminated against in the work place.
Recommendations to Estonian government:
* monitor levels of drop-out rates in secondary schools where Russian is replaced by Estonian as the language of teaching;
* take concrete measures to combat any potential increase in drop-out rates in secondary schools where Russian is replaced by Estonian as the language of teaching;
* take concrete measures to reduce the risk of Russian-speakers who drop out of secondary schools become socially excluded and marginalized.
Ms. Kristiina Luht (September 2006, personal communication), Chief Specialist Ministry of Social Affairs, Estonia notes that ‘around half of the women trafficked into Tallinn come from Ida-Virumaa according to the unofficial opinion of the policemen who work with those cases’.
In the report in February 2004, by Alvaro Gil-Robles, Council of Europe Commissioner for Human Rights on his visit to Estonia, the Commissioner recognised that Estonia is:

‘the country with the highest reported number of HIV infections per capita in Europe. The majority of those infected are children or young adults. In response, the Estonian Government adopted in January 2002 a National HIV/AIDS prevention programme for 2002-2006, which aims at stopping the spread of the virus and at ensuring the high-quality treatment and other care and social services for those infected with HIV’.
Estonia’s Second Report on the implementation of the Council of Europe Framework Convention for the Protection of National Minorities (2004) gave the following account of the budget provided for fighting HIV/AIDS:

‘In the state budget for 2003, there were approximately 12 million [Estonian] kroons for the fight against HIV/AIDS. Five million were spent on purchasing of medicines and the remaining sum was spent on prevention activities. In the budget for 2004, the amount of funds is the same, but in addition to the state budget funds also other resources are used for the fight against HIV/AIDS. The world Global Fund gives 52 million kroons to Estonia for fighting HIV/AIDS. According to the agreement, this sum should last until October 2005. In total, the Fund will provide approximately ten million USD (or 136 million Estonian kroons) for AIDS prevention to Estonia in the period of four years’.
Estonia’s Second Report on the implementation of the Council of Europe Framework Convention for the Protection of National Minorities, in June 2004, recognised the ethnic minority dimension of its HIV and intravenous drug use problem:

‘Problems relating to drug addiction and HIV are mostly concentrated to areas like Ida-Virumaa county and Tallinn. Approximately 80% of all HIV positive people are Russian speakers, mostly at the age of 15-25. The spreading of HIV is closely connected with the problems of drug abuse; the virus is most widespread among intravenous drug users’.
Quite significantly, this report amounted to Estonian State recognition of the need to target prevention and treatment programmes to its Russian-speaking national (and arguably also ethnic) minority:
• As HIV/AIDS are most widespread among young people and first and foremost among Russian speakers, the activities for the prevention of HIV/AIDS and drug addiction are also targeted to the relevant age group. Publications and information materials for prevention are available both in Estonian and Russian.

• Public services for drug and HIV/AIDS treatment and rehabilitation and for the reduction of costs are organised on uniform bases and are accessible for all people who need them, the decisive factor is the health condition of the person and the specific needs arising from this.

• Due to the large proportion of drug addicts and HIV positive people in regions where the population consists mostly of persons belonging to national minorities (Ida-Virumaa region), the development and implementation of services for the treatment and rehabilitation and for the reduction of costs are promoted intensively there.
Against the backdrop of 382 HIV cases in Estonian prisons at the end of 2001 (Tallinn Aids Prevention Centre Statistics 2002), a further issue arises concerning conditions of at least some prisoners in Estonia in the recent past. Kaur (2000), an ethnic Estonian, describes the conditions of Rummu prison in Estonia:

‘During the visit to Rummu Prison, there were 27 inmates in one room. According to [the] prisoners’ story there have been times where the same room contained around 40-44 prisoners. Basically the room was full of beds side by side. All inhabitants of this room were Russian-speakers. Is it a coincidence that Russian-speakers live in these conditions? It seems that inmates are accommodated according to the preferences of those who are in power’.
Gil-Robles’ (2004) report made the following statements regarding HIV and prisoners in Estonia:

‘The spread of infectious diseases in prisons and detention facilities continues to be an issue of significant concern. The Director of the Maardu prison informed that 29 of the 131 detainees were known to be infected with HIV. He noted that there had been a significant increase in HIV infections during the past three to four years. Previously those with HIV/AIDS had been separated from other inmates, but this was no longer the case. As stated in the European Prison Rules, no segregation should be made on the basis of HIV/AIDS, unless the health of the individual so requires. Given the exceptionally high number of HIV positive inmates in the prisons, all possible measures must be taken in order to prevent the transmission of the virus among the inmates. The authorities have recognised that significant efforts must be undertaken in order to tackle the issues that are at the origins of the spread of HIV/AIDS in prisons, such a the use of drugs and violence among the inmates. It was noted that more and more prisoners who use narcotic substances are identified each year, and although the fight against drug addiction in prisons has strengthened, there are still difficulties in identifying the channels through which drugs are brought to prisons’.
While welcoming the Estonian Government HIV/AIDS Prevention action plan for 2002-2006, Commissioner Gil-Robles proposed in 2004 that such needle exchange programmes become widely available in prisons in Estonia:

‘In July 2002, the Ministry of Justice adopted an ‘HIV/AIDS prevention action plan for years 2002-2006 in the area of government of the Ministry of Justice’, with the objective to prevent the spread of HIV infection in prisons and among probationers and to secure high quality anti-virus treatment for persons with HIV-infection. I welcome the strong emphasis placed on information and awareness-raising in this Plan, and would like to propose, that as long as there continue to be drugs in prisons, exceptional measures, such as needle exchange programmes, be undertaken’.
The report submitted by the UN Special Rapporteur for the Right to Health on Romania (2005) stated:

‘65. The Special Rapporteur emphasizes that the right to health gives rise to an entitlement to health care, including mental health care, which is geographically accessible, designed to improve the health status of patients, and scientifically and medically appropriate’.
Gil-Robles (2004). Issues regarding socio-economic integration are treated as being ‘too complicated’ to be dealt with by the State Integration Programme. This approach noticeably diverges from that of the Latvian integration document ‘The Integration of Society in Latvia’ which recognises that ‘the integration of society is closely linked to social and regional problems; the course of discussions strengthened the conviction that a section on social integration should be an integral part of the programme’.
Gil-Robles (2004) observed the need for reduction in socio-economic differences as an issue of integration in Estonia:

‘Despite the positive shift in mentalities and in practice, a number of challenges still remain, however, in the practical implementation of the laws and policies, in the efforts to reduce the socio-economic differences between the different groups of the population, as well as in the protection of the minority languages and identity’.

‘Social scientists have noted that the applied side of the integration program in the years 2000-2003 has focused primarily on the cultural-linguistic aspect of the integration, while other aspects have receded relatively in the background. This approach was justified in a given period of time. In order to secure the success of political and socio-economic integration, the proficiency in Estonian language and the embedding of people in the Estonian society was of paramount importance… Alongside [language learning] more attention should be paid to objectives of political and socio-economic integration…’.
Furthermore, in 2006, Concluding Observations of the UN Committee on the Elimination of Racial Discrimination noted that:

‘While the Committee recognises the efforts made by the State party in the field of employment, including the action plans for 2004-2007 under the State integration programmes, it remains concerned by the high rate of unemployment among members of minorities, in particular Russian-speaking minorities. The Committee reiterates its previous concern that the scope of the requirement of Estonian language proficiency, including in the private sector, may have a discriminatory effect on the availability of employment to members of this community (art. 5 (e) (i)).
The new Estonia Integration Programme 2008 – 2013

recognises the priority of socio-economic integration

• **Recommendations 55.** It is essential that the authorities design and implement special programmes to tackle social marginalization and its effects that are felt particularly amongst national minorities.

• **Recommendations 160.** Authorities should pursue further their efforts to address the disproportionately high unemployment rate amongst persons belonging to national minorities in Ida-Virumaa and elsewhere by launching regional development initiatives and measures to fight direct and indirect discrimination in the labour market. This should also enhance the recruitment of qualified persons belonging to national minorities in public service.
The right to health in relation to its Russian-speaking population under the International Covenant on Economic, Social and Cultural Rights (ICESCR) (16 December 1966), acceded to by Estonia on 21 October 1991, and which entered into force for Estonia on 21 January 1992 (Art. 27, para. 2, ICESCR: “... three months after the date of the deposit of its own instrument of ratification or instrument of accession”). Through ratifying the ICESCR, Estonia has committed to providing a form of international accountability in relation to the right to health of both individuals and communities including among its Russian speaking population.
The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is given legal foundation by a range of international legal instruments, including article 25 (1) of the Universal Declaration of Human Rights (UDHR), article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), article 24 of the Convention on the Rights of the Child (CRC) and article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), as well as the right to non-discrimination as reflected in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).
The Special Rapporteur (2006) emphasizes the importance of focus on ‘disadvantaged’ individuals and communities in relation to the right to health:

‘25. in general terms a human rights-based approach requires that special attention be given to disadvantaged individuals and communities; it requires the active and informed participation of individuals and communities in policy decisions that affect them; and it requires effective, transparent and accessible monitoring and accountability mechanisms. The combined effect of these - and other features of a human rights-based approach - is to empower disadvantaged individuals and communities’.
The Special Rapporteur (2006) notes that the right to health is subject to progressive realization and this requires development of indicators and benchmarks.
Pre- Bronze Soldier (April 2007)

• Council of Europe (2004)

• UN Committee on Elimination of Racial Discrimination (2006)

• Amnesty International (December 2006)
Yet HIV, hard drug use, social marginalization of Russian speakers in North Eastern Estonia – all increasing
References

Estonian Prison System and Probation Supervision Yearbook 2007 Estonian Ministry of Justice


