

Global AIDS Response Progress Report

G E O R G I A

Country Progress Report

Reporting Period

January – December, 2014

Table of Contents

ACRONYMS	3
I. STATUS AT A GLANCE	5
II. OVERVIEW OF THE AIDS EPIDEMIC	17
III. BEST PRACTICES	23
IV. MAJOR CHALLENGES AND REMEDIAL ACTIONS	24
V. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS	25
VI. MONITORING AND EVALUATION ENVIRONMENT	28

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIDS Center	Infectious Diseases, AIDS & Clinical Immunology Research Center
ANC	Antenatal Clinics
ARV/ART	Antiretroviral drugs / Antiretroviral therapy
BSS	Behavioral Surveillance Surveys with biomarker component
CCM	Country Coordinating Mechanism
CIF	Curatio International Foundation
FSWs	Female Sex Workers
GARP	Global CountryProgress Report
GEL	Georgian Lari
GHPP	Georgian HIV Prevention Project
GIP	Global Initiative on Psychiatry
GoG	Government of Georgia
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HR	Human Resources
IDUs	Injecting Drug Users
IOM	International Organization on Migration
LSBE	Life-skills based Education
MARPs	Most-at-risk populations
MCCU	Mother and Child Care Union
M&E	Monitoring & Evaluation
MoES	Ministry of Education and Science of Georgia
MoC	Ministry of Corrections of Georgia

MoLHSA	Ministry of Labor, Health and Social Affairs of Georgia
MSM	Men who have sex with men
NCDCPH	National Center for Disease Control and Public Health
NIS	New Independent States
NSPA	National Strategic Plan of Action
NCPI	National Commitments and Policy Instrument
OIs	Opportunistic infections
OST	Opioid Substitution Therapy
PLWH	People living with HIV
PTF	STI/HIV Prevention Task Force
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programmed
UNICEF	United Nations Children’s Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. Status at a glance

a) The inclusiveness of the stakeholders in the report writing process

Based on the letter from Michel Sidibe, UNAIDS Executive Director, the Ministry of Labor, Health&Social Affairs of Georgia granted approval for the process to consult and compile the Global AIDS Response Progress Report. The National Center for disease control and Public Health (NCDCPH) led the participatory and multi-stakeholder process of compiling the Country Report.

This Country Progress Report was developed in a participatory manner, with overall coordination of the the National Center for Disease Control and Public Health (NCDCPH) and Country Coordination Mechanism (CCM). All consultations and relevant data collection endeavors have been directly facilitated by the Department of HIV/AIDS, Tuberculosis, STI&Hepatitis of the NCDCPH.

The Country Progress Report was developed through the several national consultation meetings as well as individual meetings with the key stakeholders and desk reviews. Based on UNAIDS recommendations, data for each national indicator and the draft Country Progress Report was shared, discussed and validated among the representatives of the Government of Georgia and other state and non-state actors, both national and international.

On order to report regarding the domestic and international AIDS spending by categories and financing sources and complete the National Funding Matrix the information was collected from different stakeholders.

b) The status of HIV/AIDS epidemic in Georgia

The HIV epidemic remains a significant public health concern in Georgia. Since the detection of the first case of HIV in 1989, the rate of new HIV diagnoses in the country has been increasing steadily and reached 12.7 per 100,000 in 2014.¹ The latest estimate of the number of people living with HIV (PLHIV) in Georgia is 6,800,² and 45% of these people are not aware of their status. 4,695 PLHIV were officially registered by the end of 2014. Although the infection is mainly located among the male population (69% of total reported cases), the proportion of women affected increased from 25% to 31% in 2014.

The latest available evidence indicate that the HIV epidemic in Georgia is largely concentrated among key affected populations: men having sex with men (MSM), people who inject drugs (PWID), and sex workers (SW).

(a) A growing concern is the increasing HIV prevalence among MSM, from 7% in 2010 to 13% in 2012.³ MSM have been shown to have the highest rates of recent HIV infection.⁴ Coupled with the

¹. Georgia. Country progress report, January 2012 - December 2013. Global AIDS Response Progress Report. National Centre for Disease Control and Public Health. Tbilisi; 2014

². Spectrum EPP 2014, version 5.03

³. The Integrated Bio-behavioural Surveillance Studies (IBBSS) in Tbilisi, 2012.

recent increase in HIV prevalence among MSM as well as continuing high-risk practices such as frequent change of partners of both sexes, insufficient use of condoms and involvement in group sexual practices, this calls for significant strengthening of interventions targeting this key population.⁵ High prevalence of sex with female partners among the MSM raises concerns about their bridging role in HIV transmission to the general population. 51.4% of MSM reported having female partner in the last 12 months. In 2010 it was even higher: 62.2%.³

(b) The estimated number of PWID in Georgia is 45,000.⁶The estimated HIV prevalence ranges from 0.4% to 9.1% among PWID. The percentage of drug use, as a transmission mode among newly registered HIV cases, decreased from 43.2 % in 2012 to 35% in 2013 while heterosexual transmission increased from 44.8% in 2012 to 49% in 2013. Both these trends indicate the growing spread of HIV among the sexual partners of PWID.

(c) The data on the magnitude of the HIV problem among male sex workers is limited. This group is included in MSM. HIV prevalence among FSW ranges from 0.8% to 1.3%.³

(d) A significant decrease in HIV prevalence was observed in prisons from 1.4% in 2008 to 0.35% in 2012. This is explained by the significant toughening of internal controls over high-risk behaviours in Georgian penitentiary system.

(e) HIV prevalence among pregnant women and blood donors is lower (0.04% in both sub-populations) than in general population (0.08% in 2014). On-going preventive interventions among these groups allow for avoiding spread of HIV infection and maintaining the low prevalence rate.

A late case detection and consequently treatment initiation at late stages of disease still pose significant challenges to the National HIV response in Georgia. This has detrimental effect on survival, resulting in almost 90% increased risk of short-term mortality.

c) The Policy and Programmatic Response

The Government of Georgia is strongly committed to HIV/AIDS epidemic prevention and control since 1996 when the first State HIV Prevention Program was developed. Since 2007, in response to the UNAIDS “Three Ones” principle, the Country Coordination Mechanism (CCM) was given the power of the Georgia’s sole National Coordinating Authority on HIV, TB and Malaria and started operating with full multi-sector mandate.

CCM has been actively coordinating the national response, and includes broad representation from all relevant ministries, government institutions, the UN, civil society organizations, bilateral and multilateral agencies, as well as organizations representing people living with HIV. In order to

4. Tsertsvadze T, Chkharishvili N, Dvali N, Karchava M, Chokoshvili O, Tavadze L, et al. Estimating HIV incidence in eastern European country of Georgia: 2010-2012. *Int J STD AIDS* 2014;25:913-920.

⁵. Drug use among MSM (data of 2012) is 17.9% during the last 12 months, out of those injecting drug use is reported only by 2.8%.

6. Bio Behavioral Surveillance Survey with biomarker component among HIV/AIDS risk groups, identifying the number of injective drug users (IDU), operations survey, 2012 Curatio International Foundation, Tbilisi, Georgia

enhance representation of the civil sector within the CCM, three community based organizations representing PLWH, LGBT community and drug users were selected as CCM members in 2013.

The HIV prevention task force (PTF), uniting the NGOs working on HIV, is another effective professional and civil society forum of stakeholders actively involved in HIV policy development and advocacy initiatives in Georgia.

Based on the financial gap analysis and the latest BSS data the CCM plans to conduct the midterm review of the NSPA in 2014. It will be aimed at aligning of the funding allocations to the interventions targeting the population groups at the higher risk for HIV transmission. The midterm review will allow the country to budget effectively the state HIV programs in coming years, to fill the gap and ensure sustainability of GF program funded interventions starting from 2016 when the GF's support for Georgia will be substantially lower.

In September, 2013 through transparent competitive process, the NCDCPH was selected as the principal recipient of TGF grants in Georgia in both directions: HIV and TB. The phase 2 of current Global Fund's HIV program will be implemented from April 2014 till 31st of December 2015.

The NCDCPH being the PR of TGF projects in Georgia as well as the key responsible agency for disease surveillance will be able to better coordinate and consolidate state and donor funds. During transition period the NCDCPH will assist the MoLHSA to prepare the strategy ensuring the successful takeover of the TGF programs by the country in 2016.

The current GF HIV program provides substantial funding to HIV prevention, treatment, care and support, with the goal of reducing transmission of HIV among MARPs (MSM being the driving force of HIV epidemic in Georgia) and mortality among PLWHIV in Georgia.

d) Indicator Data in an overview table

Target 1. Halve sexual transmission of HIV by 2015								
Indicator #1.1	Value							Comment
	All Males	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (percentage of respondents who gave correct answer to all 5 questions)	10.22%	11.23%	9.25%	9.47%	15.65%	6.60%	14.84%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011;The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
	All			M 15-19	M 20-24	F 15-19	F 20-24	
Question 1: "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"	66.74%	66.30%	67.15%	64.27%	71.37%	62.88%	76.13%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011;The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
	All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
Answered Yes to Question 2: "Can a person reduce the risk for getting HIV by using a condom every time they have sex?"	65.46%	72.08%	59.15%	72.06%	72.14%	54.45%	69.03%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011;The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
	All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	

Answered Yes to Question 3: “Can a healthy-looking person have HIV?”	49.33%	47.44%	51.14%	46.26%	50.38%	48.47%	56.77%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011;The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
	All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
Answered Yes to Question 4: “Can a person get HIV from mosquito bites?” (Or country specific question.)	26.72%	28.35%	25.16%	26.87%	32.06%	22.70%	30.32%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011;The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
	All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
Answered Yes to Question 5: “Can a person get HIV from sharing food with someone who is infected?” (Or country specific question.)	46.78%	44.27%	49.17%	41.37%	51.53%	45.40%	57.10%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011;The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
	All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
Indicator #1.2	All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	Comment
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	11.44%	23.34%	0.10%	25.50%	17.94%	0.15%	0.00%	BSS among School Pupils and University Students in Tbilisi, Georgia, 2011; The statistical population of the BSS among youth was all students 15-24 years of age attending public (state) or private: a) secondary schools (9th to 12th grades), b) undergraduates in private or public universities; and c) students in vocational-technical training schools in Tbilisi, the capital city of Georgia. A total of 1879 respondents were chosen randomly using probability-proportional-to-size sampling. Survey data were collected through a self-administered, anonymous questionnaire. The survey was conducted only in the capital city, and therefore the findings cannot be generalized to youth nationwide. Another limitation of the BSS was that the survey was conducted only among youth who were enrolled or attending either public or private school at the time of the survey. Therefore, youth not enrolled in schools/universities were not included.
Indicator#1.3	All Females	Females	F 15-19	F 20-24	F 25-49			Comment

Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	0.52%	0.52%	0.35%	0.45%	0.58%	The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years, Data for males N/A
Indicator#1.4	All	Females	F 15-19	F 20-24	F 25-49	Comment
Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse		18.18%	0%	0%	24.00%	The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years, Data for males N/A
Indicator# 1.5	All	Females	F 15-19	F 20-24	F 25-49	Comment
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and know their results		6.45%	3.02%	10.65%	6.12%	The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years, Data for males N/A
Indicator# 1.6	All		15-19	20-24		Comment
Percentage of young people aged 15-24 who are living with HIV.	0.03%		0.00%	0.03%		HIV routine Surveillance Database
Indicator# 1.7	All FSW		<25	25+		Comment
Percentage of sex workers who replied "Yes" to both questions	64.3%		41.7%	65.3%		Source: BSS among FSWs in Tbilisi, Batumi – 2014 y. N=280 (Male Sex Workers N/A)
Percentage of sex workers who replied Yes to Question 1, "Do you know where you can go if you wish to receive an HIV test?"	80.7%		66.7%	81.3%		Source: BSS among FSWs in Tbilisi, Batumi – 2014 y. N=280 (Male Sex Workers N/A)
Percentage of sex workers who replied Yes to Question 2 "In the last 12 months, have you been given condoms?"	72.9%		50.00%	73.9%		Source: BSS among FSWs in Tbilisi, Batumi – 2014 y. N=280 (Male Sex Workers N/A)
Indicator# 1.8	All FSW		<25	25+		Comment
Percentage of female and male sex workers reporting the use of a condom with their most recent client.	95.4%		91.7%	95.5%		Source: BSS among FSWs in Tbilisi, Batumi – 2014 y. N=280 (Male Sex Workers N/A)
Indicator# 1.9	All FSW		<25	25+		Comment
Percentage of SWs who received an HIV test in the last 12 months and know their results	51.8 %		50.00%	51.9 %		Source: BSS among FSWs in Tbilisi, Batumi – 2014 y. N=280 (Male Sex Workers N/A)
Indicator# 1.10	All FSW		<25	25+		Comment
Percentage of sex workers who are living with HIV	0.7 %		0.00%	0.8%		Source: BSS among FSWs in Tbilisi, Batumi – 2014 y. N=280 (Male Sex Workers N/A)
Indicator# 1.11	All MSM		<25	25+		Comment
Percentage of men who have sex with men reached by HIV prevention programs Percentage of MSM who answered "Yes" to both questions	48.6 %		33.7 %	57.8 %		Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2012)
	All MSM		<25	25+		
Percentage of MSM who answered "Yes" to Question 1, "Do you know where you can go if you wish to receive an HIV test?"	77.5 %		69.9%	82.2%		Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2012)
	All MSM		<25	25+		
Percentage of MSM who answered "Yes" to Question 2 "In the last 12 months, have you been given condoms? "	53.7 %		41%	61.5%		Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2012)
Indicator# 1.12	All MSM		<25	25+		Comment
Percentage of MSM who reported that a condom was used the last time they had anal sex	73.2 %		76.3%	71.3 %		Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2012)

<i>Indicator# 1.13</i>	All MSM	<25	25+	Comment									
Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	33.94 %	28.92 %	37.04 %	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2012)									
<i>Indicator# 1.14</i>	All MSM	<25	25+	Comment									
Percentage of men who have sex with men who are living with HIV	12.96 %	2.99 %	29.27 %	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2012)									
<i>Indicator# 1.16</i>	All (15+)	Males(15+)	Females (15+)	Both sexes (15-19)	Males (15-19)	Females (15-19)	Both sexes (20-24)	Males (20-24)	Females (20-24)	Both sexes (25+)	Males (25+)	Females (25+)	Comment
Number of people who received HIV testing and counselling in the past 12 months and know their results	85964	35645	50319	5754	699	5055	19243	4007	15236	60967	30939	30028	HIV Routine Surveillance Database
	Females (15+)		Females (15-19)		Females (20-24)		Females (25+)						
Number of pregnant women aged 15 and older (out of the total number above) who received testing and counselling in the past 12 months and received their results	44869		4865		14640		25364		HIV Routine Surveillance Database				
<i>Indicator# 1.16EURO</i>	Injecting drug users	Sex between men	Heterosexual contact	Mother-to-child transmission	Other	Unknown	Comment						
Disaggregation by mode of transmission: HIV Testing and counselling	33%	11%	53%	1%	1%	1%	Infectious Diseases, AIDS and Clinical Immunology Research Center.						
<i>Indicator# 1.16.1</i>	%						Comment						
Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months	0						State program and Global Fund						
<i>Indicator# 1.17.1</i>	Females						Comment						
Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	87.1%						Statistics Department, National Centre for Disease Control and Public Health						
Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at any ANC visit	87.5%						Statistics Department, National Centre for Disease Control and Public Health						
<i>Indicator# 1.17.2</i>	Total	<25	25+	Comment									
Percentage of antenatal care attendees who were positive for syphilis	0.2%	N/A	N/A	Statistics Department, National Centre for Disease Control and Public Health. No data disaggregated by age groups available.									
<i>Indicator# 1.17.3</i>	%						Comment						
Percentage of antenatal care attendees positive for syphilis who received treatment	91.8%						The data is based only on STDs National Center, data from other sites countrywide is not available						
<i>Indicator# 1.17.4</i>	%						Comment						
Percentage of sex workers with active syphilis	N/A												

<i>Indicator# 1.17.5</i>	%					Comment
Percentage of men who have sex with men with active syphilis	N/A					
<i>Indicator# 1.17.6</i>	Total	Females	Males	Female (primary/secondary)	Male (primary/secondary)	Comment
Number of adult reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	1403	696	707	101	125	Statistics Department, National Centre for Disease Control and Public Health.
<i>Indicator# 1.17.7</i>	#					Comment
Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	12					Statistics Department, National Centre for Disease Control and Public Health.
<i>Indicator# 1.17.8</i>	Total					Comment
Number of men reported with gonorrhoea in the past 12 months	528					Statistics Department, National Centre for Disease Control and Public Health.
<i>Indicator# 1.17.9</i>	#					Comment
Number of men reported with urethral discharge in the past 12 months	N/A					
<i>Indicator# 1.17.10</i>	#					Comment
Number of adults reported with genital ulcer disease in the past 12 months	N/A					
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015						
<i>Indicator# 2.1</i>	Total					Comment
Number of needles and syringes distributed per person who injects drugs per year by Needle and Syringe Programs	79.41					The data are aggregated according to databases from each center.
<i>Indicator# 2.2</i>	All	Males	Females	<25	25+	Comment
Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	34.46%	34.48%	33.33%	50.29%	32.59%	BSS study N=1791. The PWIDs were studied in six different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi, Kutaisi and Batumi in 2012.
<i>Indicator# 2.3</i>	All	Males	Females	<25	25+	Comment
Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	83.47 %	83.38%	90.91%	87.71%	83.00%	BSS study N=1791. The PWIDs were studied in six different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi, Kutaisi and Batumi in 2012.
<i>Indicator# 2.4</i>	All	Males	Females	<25	25+	Comment
Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	14.68%	14.36%	40.91%	6.70 %	15.57 %	BSS study N=1791. The PWIDs were studied in six different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi, Kutaisi and Batumi in 2012.
<i>Indicator# 2.5</i>	All	Males	Females	<25	25+	Comment
Percentage of people who inject drugs who are living with HIV	3.04 %	3.08 %	0.00 %	1.13 %	0.31 %	BSS study N=1791. The PWIDs were studied in six different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi, Kutaisi and Batumi in 2012.
<i>Indicator# 2.6a</i>	#					Comment
Estimated number of opiate users (injectors and non-injectors)	N/A					
<i>Indicator# 2.6b</i>	N:					Comment

Number of people on opioid substitution therapy (OST)	4947	cumulative number of the patients on OST treatment during 2014.
<i>Indicator# 2.7a</i>	N:	Comment
Number of needle and syringe program (NSP) sites	14	Within GF project in September 2013 here was added 4 service sites - 2 in the capital and 2 in regions, totally 14 harm reduction sites are operating from this period. All service centers provide data in database which is unified for all facilities/NGOs working with MARPs.
<i>Indicator# 2.7b</i>	N:	Comment
Number of substitution therapy (OST) sites	21	From existing 21 OST sites 2 are in prisons.
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		
<i>Indicator# 3.1</i>	%	Comment
Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	100 %	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.
<i>Indicator# 3.1a</i>	#	Comment
Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	N/A	
<i>Indicator# 3.2</i>		Comment
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	70 %	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.
<i>Indicator# 3.3</i>	Total	Comment
Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	6%	Spectrum EPP
<i>Indicator# 3.4</i>	Total	Comment
Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labor and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	86%	86% - this figure is just the percentage of pregnant women who were tested for HIV and received their results during the pregnancy at the Antenatal clinics (ANC). (source NCNCPH Department of Statistics)
<i>Indicator# 3.5</i>	Total	Comment
Percentage of pregnant women attending antenatal care whole male partner was tested for HIV in the last 12 months	N/A	
<i>Indicator# 3.6</i>	Total	Comment
Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	100%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.
<i>Indicator# 3.7</i>	Total	Comment
Percentage of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks	70%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.
<i>Indicator# 3.9</i>	Total	Comment
Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	70%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.

<i>Indicator# 3.10</i>	Total	Comment
Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DPT3 visit	N/A	
<i>Indicator 3.11</i>	N	Comment:
Number of pregnant women attending ANC at least once during the reporting period	62108	
<i>Indicator# 3.11.1</i>	Total	Comment:
Percentage of HIV-positive women who had their pregnancy terminated	3.2%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and
<i>Indicator# 3.11.2</i>	Total	Comment:
Percentage of HIV-positive pregnant women who delivered during the reporting year	51.61%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and
<i>Indicator# 3.13.1</i>	Total	Comment:
Percentage of HIV-positive pregnant women who were injecting drug users	0%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and
<i>Indicator# 3.13.2</i>	Total	Comment:
Percentage of HIV-positive pregnant PWID women who received OST during pregnancy	0%	reports from OST facilities.
<i>Indicator# 3.13.3</i>	Total	Comment:
Percentage of HIV-positive pregnant PWID women who received ARVs to reduce the of mother-to-child transmission during pregnancy	0%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015

<i>Indicator# 4.1</i>	All	Male	Females	Comment								
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	38.6%	32.4%	63.4 %	Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV/AIDS Clinical care.								
	<15	15+	<1	1-4	5-9	10-14	15-19	20-24	15-49	50+	Age unknown	Comment
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	68.6%	38.3%										Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV/AIDS Clinical care.
<i>Indicator# 4.2a</i>	All	Males	Females	<15	15+	Comment						
Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	87%	84.4 %	91.8%	77.8%	87.1%							
<i>Indicator 4.2b</i>	All	Males	Females	<15	15+	Pregnancy status at start of therapy	Breastfeeding status at start of therapy	Comment				
Percentage of adults and children with HIV still alive and known to be on antiretroviral therapy 24 months after initiating treatment among patients initiating antiretroviral therapy during 2011	79.1%	76.7%	84.5%	80%	79.1%			Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV/AIDS.				
<i>Indicator# 4.2c</i>	All	Males	Females	<15	15+	Pregnancy status at start of therapy	Breastfeeding status at start of therapy	Comment				
Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiating antiretroviral therapy (from 2008)	69.9%	61.6%	93.2%	100%	69.5%							

<i>Indicator# 4.2.1a</i>	All	15+	<15					Comment	
Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	83.3%	83.3%						Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
<i>Indicator# 4.2.1b</i>	All						Comment		
Percentage of injecting drug users with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy		73.8%						Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
<i>Indicator# 4.2.1c</i>	All						Comment		
Percentage of injecting drug users with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy		59.2%						Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
<i>Indicator# 4.3a</i>	N						Comment		
Total number of fealth facilities that offer antiretroviral therapy (ART)		5						Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System.	
<i>Indicator# 4.3b</i>	N						Comment		
Health facilities that offer paediatric antiretroviral therapy (ART)		5						Source: Infectious Diseases, AIDS and Clinical Immunology Research Center.	
<i>Indicator# 4.4</i>	Total						Comment		
Percentage of health facilities dispensing ARVs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months.		0%						Source: Infectious Diseases, AIDS and Clinical Immunology Research Center.	
<i>Indicator# 4.6</i>	All	Males	Females	Sex un	<15	15+	Age un	Comment	
4.6.a Total number of adults and children enrolled in HIV care at the end of the reporting period	2732	1873	859	0	53	2679	0	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
4.6.b Number of adults and children newly enrolled in HIV care during the reporting period	514	370	144	0	6	508	0		
<i>Indicator# 4.7a</i>	All	Males	Females	Sex un	<15	15+	Age un	Comment	
Percentage of people on ART tested for viral load (VL) who were virally suppressed in the reporting period	81.4 %	80.5%	83.5 %		79.5 %	81.5 %		Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
<i>Indicator# 4.7b</i>	All	Males	Females	Sex un	<15	15+	Age un	Comment	
Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy	82.5%	81.5%	84.5%		75	82.6%		Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015									
<i>Indicator# 5.1</i>	All	Males	females	<15	15+				Comment
Number of people with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment, within the reporting year	56	48	8	1	55				Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program and Tuberculosis patient registries and WHO TB/HIV estimation
<i>Indicator# 5.2</i>	All	Males	Females	Sex un	<15	15+	Age un	Comment	
Percentage of adult and children living with HIV newly enrolled in care who are detected having active TB disease	7.2%	8.4%	4.2%		0	7.3%		Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
<i>Indicator# 5.3</i>	%						Comment		
Percentage of adult and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)					20.6 %			Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
<i>Indicator# 5.4</i>	Total						Comment		
percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit					100%			Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.	
Target 7. Critical enablers and synergies with development sectors									

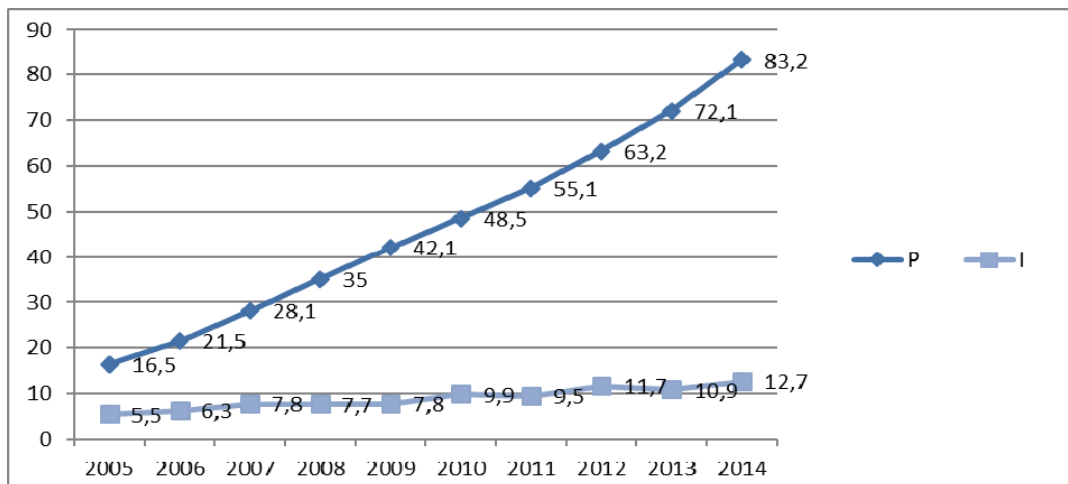
<i>Indicator# 7.1</i>	Females All	HIV + Females	HIV- Females	Females (15-19)	HIV+ Females (15-19)	HIV- Females (15-19)	Females (20-24)	HIV+ Females (20-24)	HIV- Females (20-24)	Females (25-49)	HIV+ Females (25-49)	HIV- Females (25-49)	Comments:
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	1.87%			5.38%			2.19%			1.69%			The data has been taken from the Georgian Reproductive Health survey (RHS)
<i>Indicator# 8.1</i>	%											Comment	
Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	N/A												
<i>Indicator# 10.1</i>	%											Comment	
Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age)	N/A												
<i>Indicator# 10.2</i>	%											Comment	
Proportion of the poorest households who received external economic support in the last 3 months	N/A												

II. Overview of the AIDS epidemic

The first case of HIV in Georgia was detected in 1989. There after the number of annually detected cases has been relatively small. Georgia is one of those very few countries in the world and in the region where the HIV incidence has been increasing steadily during the last decade.

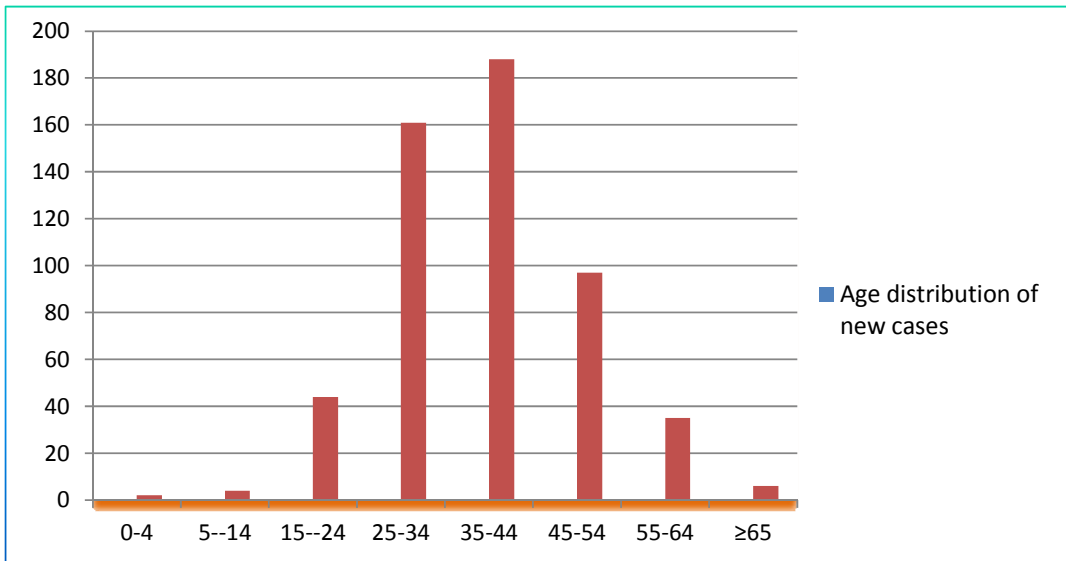
Despite a relatively low prevalence rate, the HIV/AIDS epidemic remains a significant public health concern in Georgia. HIV estimated prevalence ranges from 0,4 to 9,1% among IDUs, and 0,8%-1,3% among FSWs depending on locality. HIV prevalence increase has shown steady and alarming trend among MSM in Tbilisi, from 7% in 2010 to 13% in 2012.

Figure 1: HIV/AIDS prevalence and incidence rates 2005-2014 (per 100 000)



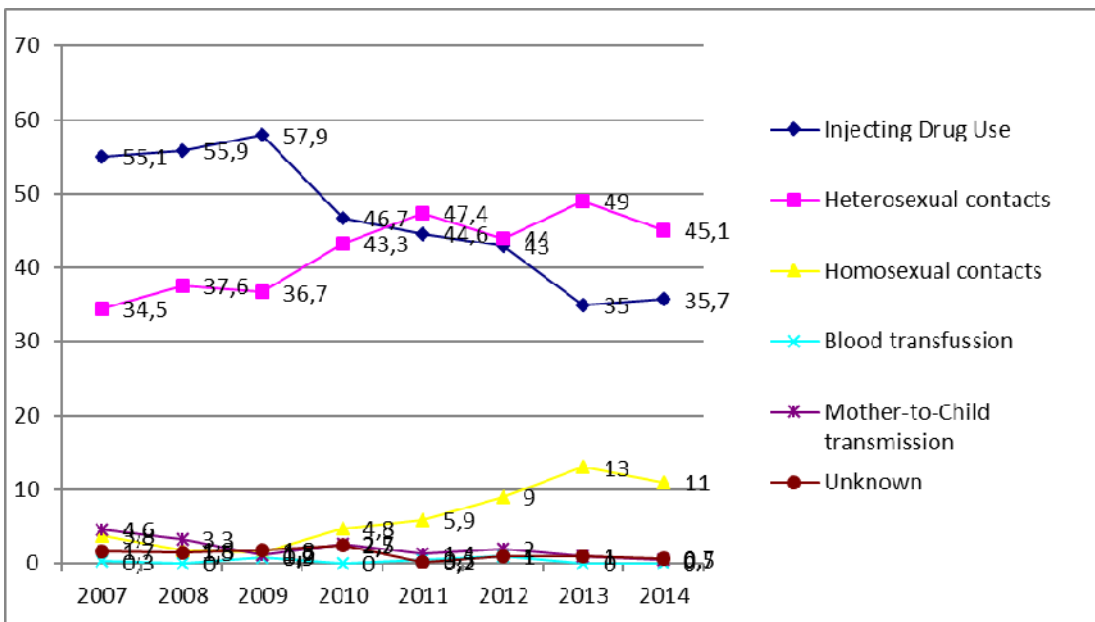
The epidemiological distribution of the disease by gender and age indicates more cases among the 25-40 age groups. The biggest difference between the number of infected men and women was also detected in this age group (25+), while the gender difference is minimal among the 15-24 year olds. In previous years, the proportions of male and female HIV+ cases were 75% and 25% respectively. In 2011, the proportion was changed, with males accounting for 70% of cases and females for 30%. This shift would be explained by the spread of HIV among sexual partners of IDUs. The trend is still maintained in last three years.

Figure.2.Age distribution of new cases , 2014



Georgia is facing critical challenges such as drug abuse and related health and social consequences. Similar to the most Eastern European countries, injecting drug use was the major transmission mode in the early years of the HIV epidemic in Georgia. Since 2009, transmission has shifted toward the heterosexual mode (Figure 2.) which became dominant by 2011 and the trend escalated in 2013.

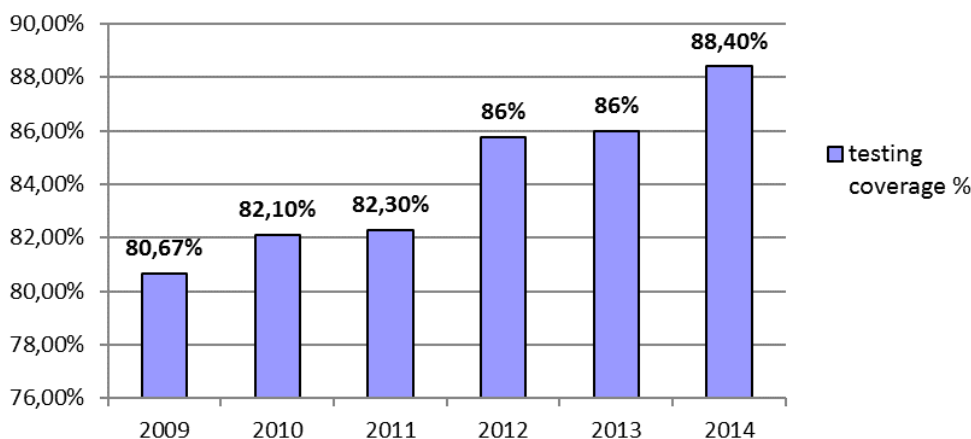
Figure 3: Percentage mode of HIV transmission by year



In Georgia routine surveillance of pregnant women serves two purposes: 1) to improve early detection of HIV infection among pregnant women and hence prevent mother-to-child transmission risk 2) It is acknowledged that HIV prevalence among pregnant women generally is the best available estimate of HIV prevalence in the general population as a proxy-indicator;

Since 2005 Georgia continues to provide universal access to PMTCT services, including universal screening of pregnant women for HIV, use of antiretrovirals (ARVs) among HIV positive mothers and their newborns. In 2013, 51,180 pregnant women underwent HIV testing, and among them 22 HIV+ cases were found. 4 pregnant women were <24 years of age and 18 were ≥24. In 2013, HIV testing coverage among pregnant women was 86%. According to the data of last years, coverage of pregnant women by HIV testing is increasing (fig.3).

Figure.4. HIV-testing coverage in pregnant women by years



National Response to the AIDS Epidemic

The national response to HIV epidemic prioritizes the development of an effective prevention to care continuum. Priority directions include the further scale up of the outreach and basic prevention services targeting key affected populations, radical increase in the uptake of VCT leading to more effective and earlier detection of HIV cases, comprehensive measures to ensure expedient progression to care and treatment for HIV positive people, as well as improved adherence and retention in quality care leading to suppression of viral load. Improved accessibility and quality of essential services, optimized treatment regimens, strengthened surveillance and monitoring, removal of legislative and regulatory obstacles to effective service delivery, protection of human rights, and implementation of stigma reduction measures support the realization of these priorities.

Heavy reliance on donor support for funding preventive interventions is a challenge that Georgia aims to address. The state will gradually take over the responsibility for funding preventive interventions currently financed by the GF including but not limited to OST, harm reduction services, VCT etc. In 2014, NCDCPH has

become Principle Recipient of the GFATM grant to Georgia. This provides opportunity to line up state and donor-supported programs in order to achieve better results in the coming years.

Achievements: HIV Prevention and Detection

Since 2006, significant increase has been observed in coverage with preventive services of PWID. The scope of services has been expanded and geographic reach improved through establishing new sites for delivering harm reduction (including 4 sites delivering women-friendly services) and VCT services as well as more active outreach. Preventive efforts among PWID resulted in positive behavior change with 78.4% (Batumi) and 89% (Tbilisi) of PWID using sterile injecting equipment.

Opioid substitution services (OST) have become more accessible both in civil sector (20 sites) and in penitentiary system (2 sites). By the end of 2014 there were about 2,600 patients receiving OST.

2014 was marked by the first ever size estimation surveys among sex workers and MSM. The estimated sizes are: MSM – 17200 and sex workers – 6525.

HIV testing services have become increasingly available for MSM. HIV testing has been provided both indoors by three specialized clinics (*Healthy Cabinets*) in Tbilisi, Kutaisi and Batumi and outdoors during outreach with the mobile laboratories. MSM coverage by preventive interventions has been increasing since 2010 and reached 48.6% in 2012.

In 2014 HIV prevention interventions targeting sex workers (SWs) have achieved considerable progress with regard to condom use with commercial clients (85-98%), as well as increased HIV testing rates during the last 12 months (40.6% in Tbilisi and 66.7% in Batumi). In addition to street-based outreach, five specialized clinics (*Healthy Cabinets*) in Tbilisi, Kutaisi, Batumi, Zugdidi and Telavi provide HIV and STI diagnostic and STI treatment services to SWs. Based on 2014 IBBSS data coverage of SWs with prevention interventions is 64.3%. HIV voluntary counseling and testing services have been available at all penitentiary facilities in Georgia.⁷ Despite universal availability of HIV voluntary counseling and testing services in all penitentiary facilities of Georgia, only 18.3% of prisoners were reached by preventive program. Obvious gaps in prevention among prisoners are: low coverage by preventive programs and low rates of providing test results to the prisoners. 31.2% of the prisoners were tested for HIV during the last year while in prison and 21.3% had been tested for HIV and informed about their test results.

Intensive preventive efforts aimed at ensuring safety of donor blood, preventing mother to child transmission of the virus and post-exposure prophylaxis among health care workers allowed for controlling HIV spread in these groups.

Despite the achievements described above, the preventive interventions so far have not resulted in a significant progress in terms of avoiding infection spread in communities where HIV is most heavily concentrated including MSM, PWID and SW. The growing prevalence of HIV, poor knowledge about HIV transmission and risk behaviors among MSM⁸ and PWID call for further scale-up of coverage and improvements in quality of interventions in order to fully control the epidemic.

⁷. HIV risk and prevention behaviours among Prison Inmates in Georgia Bio-behavioural surveillance survey in 2012. Curatio International Foundation, Tanadgoma. February, 2013. <http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/124.pdf>.

⁸. HIV risk and prevention behavior among Men who have Sex with Men in Tbilisi, Georgia. Bio-behavioral surveillance survey in 2012. Curatio International Foundation, Tanadgoma. February, 2013. <http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/123.pdf>.

Achievements: HIV Care and Treatment

The provision of HIV/AIDS treatment and care services in Georgia started in the 1990s and universal access to ART has been ensured since 2004 through the state and GF supported programs.

Delivery of HIV clinical services in Georgia are led by the Infectious Diseases, AIDS and Clinical Immunology Research Center (National AIDS Center), which is country's referral institution for HIV diagnosis, treatment (including PMTCT, PRER and PEP) and care. Specific clinical services are provided by the dedicated departments of the infectious diseases centers/hospitals in the capital city of Tbilisi and regional facilities in the cities of Kutaisi, Batumi, Zugdidi and Sokhumi.

According to UNAIDS data Georgia has the highest ART coverage in the region of Eastern Europe and Central Asia (EECA).⁹The number of patients on ART has been increasing annually and exceeded targets set in 2011-2016 National HIV/AIDS Strategic Plan (NSP), largely because of implementing latest 2013 WHO guidelines recommending treatment initiation at CD4 count level of <500 cells/mm (See Figure 1 below). Latest data indicates that 95% of those diagnosed and known to be in need of treatment were on ART by the end of 2014. It should be mentioned that Georgia is switching to public health approach in terms of providing standard ART regimens in accordance with 2013 WHO guidelines, and the process is planned to be fully completed by the end of 2015.

Universal access to ART has led to significant reduction in mortality among people living with HIV in Georgia. 12-month survival significantly increased from 79% in 2011 to 86% in 2012 ($p=0.01$) and remained stable through 2014. 2013 target for 24-month survival of 80% was achieved in that year with 82% of patients remaining on ART, however the indicator slightly reduced to 79% in 2014. The indicator measuring 36-month survival varied substantially over time, with rates reaching 76% in 2012, then dropping to 69% in 2013 and again increasing to 77% in 2014. Comparison of data with EECA region shows that Georgia has better 12-month survival/retention compared to regional average. Data on 24-month survival in the region is available for 4 countries only with an average rate of 67% (range: 60%-79%). The recent ART program data further confirm that persons with history of IDU are at higher risk of attrition both at 12 and 24 months after starting ART. Also IDUs have been shown to be at higher risk of disengagement for the entire HIV care. These data underscore the need for directing additional efforts towards HIV positive persons with history of IDU.

The National HIV Program pays particular attention to adherence as an important determinant of treatment success. Special approach to promote medication adherence is in place and includes both clinic-based and out of clinic services delivered by mobile units. The best evidence of effectiveness of available adherence services is the significant improvement of levels of viral load suppression. Evaluation of trends in the engagement in HIV care continuum from 2008 shows that among those on treatment the proportion of virally suppressed patients increased from 68% in 2008 to 80% in 2013 ($p<0.0001$), significant improvements in viral suppression has been noticed among total diagnosed population with rates increasing from 23% in 2008 to 45% in 2013 ($p<0.0001$).¹⁰

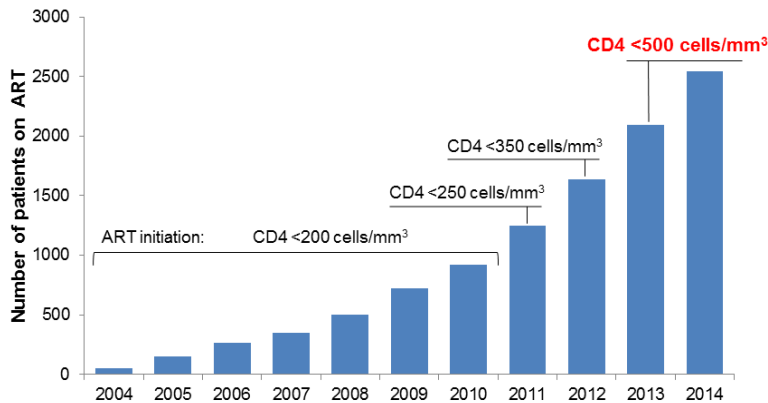
Provision of care and support services remains essential component of comprehensive package of care for people living with HIV (PLHIV). Community-based HIV self-support centers operate in Georgia since 2004 that provide psychosocial support through peer groups as well as through trained psychologist and hot-line services. In 2014 the network provided more than 5000 combined hotline, online and face-to-face consultations to PLHIV. The palliative care service provision for PLHIV in Georgia has been established in 2008

9. The Joint United Nations Programme on HIV/AIDS. The Gap Report. Geneva: UNAIDS; 2014.

10. Chkhartishvili N, Chokoshvili O, Sharvadze L, DeHovitz JA, del Rio C, Tsertsvadze T. Trends in Cascade of Care in the Eastern European Country of Georgia: 2008-2012. [Paper #997]. Paper presented at: Conference on Retroviruses and Opportunistic Infections (CROI 2014), 2014; Boston.

and since then has been led by the Georgian National Association of Palliative Care. The program delivers home-based services through operation of palliative care mobile units in Tbilisi, Kutaisi, Batumi and Zugdidi. Services provided include medical, psychological, social and spiritual support for chronically ill patients, and are implemented by health workers and non-health caregivers, including PLHIV. Over the last 3 years the program has been providing care to up to 40 patients on a monthly basis. The number of visits ranged from 1,461 to 1,689 per year.

Figure 1. Evolving ART Initiation Recommendations and Number of Patients on ART



Achievements: Leadership and Policy Development

Georgia has attained all three targets within the Joint United Nations Program on HIV/AIDS (UNAIDS) “Three Ones” Principle. All HIV stakeholders act within the frames of endorsed national HIV strategies that are regularly revised and updated. The Country Coordinating Mechanism (CCM) functions as a main platform for country dialogue and participatory decision-making on HIV related issues. The CCM umbrella unites representation from all relevant ministries, government institutions, civil society organisations, bilateral and multilateral agencies, as well as organisations representing people living with HIV and key affected populations. National Monitoring and Evaluation framework endorsed by CCM in 2012 serves as the main source for evidence-based decision-making.

Greater involvement of Civil Society Institutions has been achieved through effective collaboration of the state institution with the HIV prevention task force (PTF), which is composed of NGOs and professionals working on HIV. Since 2013 PTF elects 4 instead of 2 members to represent PTF at the CCM board. Three out of these 4 members represent communities affected by HIV/AIDS – drug users, LGBT and PLHA.

Georgia HIV law adopted in 2009 has improved the overall legal environment for national response, but it has not addressed regulatory barriers for drug users and prisoners stemming from criminal code of the country. Strict Drug Law environment represents a severe obstacle for the effective work of the NSP program.

A critical factor limiting the effectiveness of the national response to HIV is the widespread stigma towards PLHIV and KAPs among the general public as well as relevant professionals including health care workers.

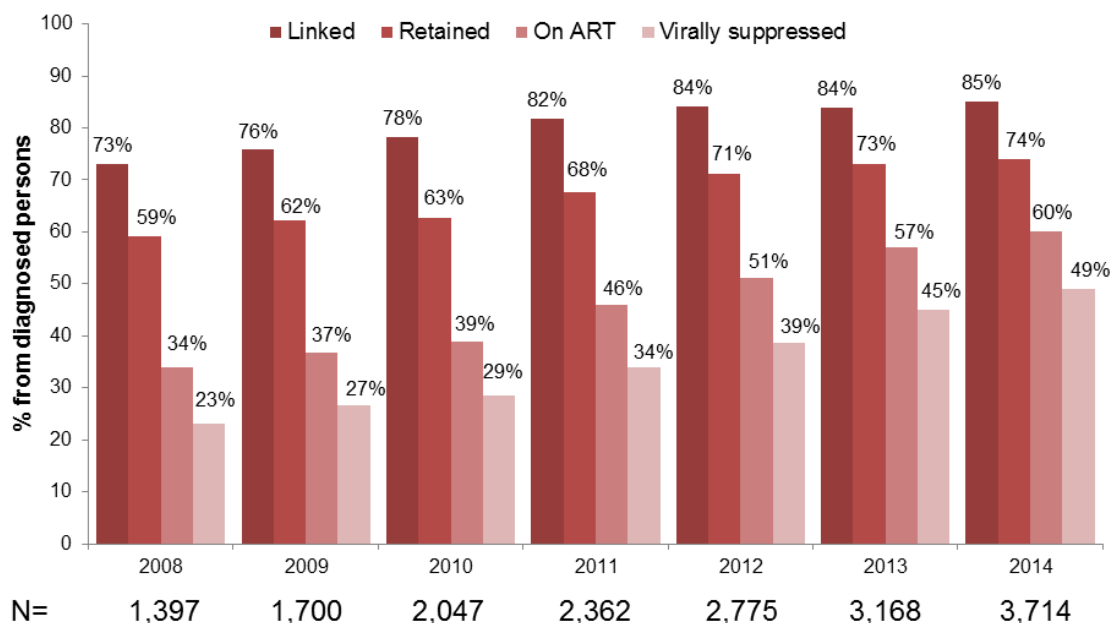
III. Best Practices

Georgia’s achievements in HIV treatment and care represent best practice on a Global scale. International experts describe the Georgian model of HIV treatment and care delivery as exemplary and regard it as the best among countries of former Soviet Union (FSU) and one of the best, if not the best, among low and middle income countries worldwide. The National AIDS Treatment Program has started to operate in 1995 and has been substantially strengthened since 2004 through the resource allocation from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). GFATM support proved to be critical for scaling-up treatment and care in the country.

Built on the guiding principles of accessibility, quality and equity of access, the national HIV/AIDS treatment and care program developed multifaceted approach for service delivery. This approach includes: comprehensive HIV-related medical care, close linkages with related medical fields such as tuberculosis and substance abuse, and patient support services, including home-based adherence support. This approach ensure high patient engagement in HIV care

Recent analysis of persons diagnosed showed that engagement in HIV care continuum in Georgia has been improving over time. The improvement has been seen in all stages of care: linkage increased from 73% in 2008 to 85% in 2014, this translated into significant improvement in retention. As a result of evolving treatment guidelines the proportion of people on ART increased from 34% to 60% in 2014. The proportion of persons with viral suppression more than doubled from 2008 reaching 49% of total diagnosed population in 2014.

Cascade of HIV Care in Georgia: 2008-2014



This high engagement ensures sustainability of universal ART access, which has already translated into significant survival benefit. Mortality analysis over 1989-2012 period showed significant decline, with more than 3-fold reduction in AIDS-related mortality compared to 2004.¹¹

One of the important recent achievements of Georgian treatment and care services is the establishment of free hepatitis C treatment program for all eligible HIV/HCV co-infected patients. Since 2011, through the GFATM support, the program provides free treatment with the combination of Peginterferon and Ribavirin, as well as comprehensive laboratory and clinical monitoring. This was the first instance in the country when specific population sub-group gained access to free treatment. Over 400 HIV/HCV co-infected patients were started on treatment since the initiation of this program. Preliminary analysis of outcomes show promising results suggesting that program will decrease liver related morbidity and mortality among people living with HIV in Georgia.

IV. Major Challenges and Remedial Actions

Despite the accomplishments in various areas of national HIV response, the epidemic continues to grow. One of the key drivers of the epidemic in Georgia is undiagnosed HIV. It has been documented that HIV positive persons unaware of their status are primary sources of new infections, therefore identification of those infected not yet diagnosed is considered as critical component of combination HIV prevention.

Data indicates that in Georgia significant gap exists between the estimated number of HIV infected individuals and those who are already diagnosed. HIV incidence estimation using recent infection testing algorithm (RITA) indicated that over 2010-2012 period number of new infections in Georgia exceeded the number of new diagnoses by at least 60%.¹² Obviously this difference contributes to further expansion of the gap between infected and diagnosed. Spectrum estimation exercise shows that around the half of HIV infected persons are not yet diagnosed.

This has serious implications both from both individual and public health perspectives. As mentioned above HIV positive individuals not aware of their status unknowingly transmit the virus and contribute to majority of new infections. In addition to fueling transmission, this gap leads to late HIV diagnosis, which is the leading cause of death among HIV patients in Georgia.

The major reason for this problem is the low HIV testing coverage of key populations at risk and missed opportunities to diagnose HIV in healthcare settings. Reducing the number of undiagnosed cases of HIV infection will be critical to achieve the impact on the epidemic in terms of saving lives and preventing new transmission. Increased efforts are needed to expand HIV testing and counseling services as it serves as gateway for linking vulnerable populations to prevention and care services.

Stigma and discrimination of HIV + groups continues to be a major barrier to HIV prevention and service utilization. Negative social attitudes and low public awareness also remain obstacles, especially for MSM population.

¹¹Chkhartishvili et al. Mortality and causes of death among HIV infected individuals in the country of Georgia: 1989 - 2012. *AIDS Res Hum Retroviruses*. 2014 Jun;30(6):560-6.

¹²Tsertsvadze et al. Estimating HIV Incidence in Eastern European Country of Georgia: 2010-2012. *Int J STD AIDS*. 2014 Nov;25(13):913-20.

Beyond societal attitudes, state criminal laws, regulations, and policies relevant to drug use and preventive work among IDUs and prisoners are among limiting factors. The laws on drug addiction prevention and control are not supportive to implementing effective interventions in public and penal sectors. Therefore, issue-focused and targeted advocacy efforts aimed at improving legal environment is essential for the future success of Georgian HIV policy and response.

V. Support from the Country's Development Partners

The Global Fund to Fight AIDS, Malaria and Tuberculosis

The Global Fund continues to be the major player in scaling up the National Response to HIV/AIDS in Georgia. The current funding for the grant-program "Sustaining and scaling up the existing national responses for implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care intervention in Georgia" is available till the 31st of December 2015. In 2014 the Principal Recipient of the grant has been changed. On 11th of September, 2013 the Country Coordination Mechanism has elected the National Center for Disease Control and Public Health as the principal recipient. The new PR is responsible for TGF's HIV program implementation from April 2014 till 31st of December 2015 with total budget about 17.5 million EUR. Total allocation of the funds for 2014 was 5.78 Million USD. With the new role the NCDCPH's involvement in HIV surveillance and prevention has been considerably increased as it started acting as the PR for the GF programme and also implementing the national HIV surveillance program. The Center now is in the position to consolidate state and donor finances and prepare an effective strategy for successful transition from the GF's to the domestic funding of the HIV programmes after 2018.

The current GF HIV program provides substantial support to HIV prevention, treatment, case and support, with the goal of reducing transmission of HIV among MARPs (MSMs being the driving force of HIV epidemic in Georgia) and mortality among PLWHIV in Georgia.

Currently the following service delivery areas are covered by the GF program:

Prevention through

- HIV prevention interventions targeting MARPs (IDUs, FSWs, MSMs and prisoners)

The interventions include community outreach, behavioral Change Communication, Counseling and testing, needle, condom and lubricant distribution, Methadone Substitution Treatment in public and penitentiary systems, STI diagnosis and treatment, TB prevention, testing on hepatitis B and C.

- PMTCT;

Treatment

- Antiretroviral treatment (ARV) and monitoring;
- Hepatitis C treatment and monitoring among co-infected individuals;

Care and Support

- Care and support for the chronically ill through home based palliative treatment and support provided through the Self-support Centers of PLHIV.

In order to ensure the sustainability of the GF HIV Program, the CCM of Georgia has already submitted the Concept Note for GFATM New Funding Model to secure the Fund's support for the period of 2016-2018. Within the NFM the country request the GF to provide 13.6 million USD support for filling the gap in the NSP funding for next 3 years.

United Nations Population Fund (UNFPA)

Within the framework of the UNFPA second 2011-2015 Country Programme youth SRH&R is one of the special priorities for UNFPA covering the issues of access to SRH (sexual reproductive health) services including HIV/AIDS prevention, awareness raising and promotion of healthy life-style.

- National Youth Policy developed by the Ministry of Sport and Youth Affairs (MoYS) of Georgia with support of UNFPA and UNICEF with involvement of all concerned duty bearers and right holders, followed by drafting the National Action Plan to support the implementation of the Youth Policy in 2013. Special section is dedicated to youth SRH&R including STI/HIV prevention.
- Survey on analysis of youth situation in Georgia 2013 around the priority areas of national youth policy focusing on SRH and HIV issues has generated evidence and data to inform the Youth Policy and Action Plan development. Survey conducted with support of UNFPA and UNICEF
- In 2013 UNFPA/Georgia advocated integration of SRH&R issues including HIV/AIDS in the secondary school curriculum within the frames of National Youth Policy and Action Plan. The advocacy efforts have been based on the National Concept on Healthy and Harmonious Education incorporating SRH&R, HIV prevention developed through an extensively participatory process with UNFPA-EU support and the Recommendations to the National Educational Plan elaborated based on this concept.
- UNFPA supported Ministry of Labor, Health and Social Affairs (MoLHSA) to produce comprehensive Recommendations on Revealing, Referring, and Documenting the Cases of Physical, Sexual and Psychological Violence against Women and Children, where the SRH and HIV issues are integrated.
- The nation-wide Reproductive Health Survey-2010 has been undertaken in collaboration with UNICEF and USAID allowing objective monitoring of dynamics in the reproductive health status of population and evaluating the effectiveness of the strategies and investments in the field. The survey with a separate set of questions regarding HIV/AIDS, including those related to UNGASS indicators.
- UNFPA introduced the concept of Youth friendly RH services with integrated HIV prevention in 2007 and since then continues support to Youth Friendly SRH services including through supply of FP modern methods, STI and HIV tests, IEC materials and training of professionals.
- UNFPA remains one of the main providers of free of charge contraceptives to the country and ensures continuous provision of the supply of modern contraceptives including condoms.
- UNFPA is a leader in piloting and dissemination of a Youth Peer Education concept in the country creating a highly effective and sustainable and standardized model that is being widely utilized to bring information and education messages across to the youth community via the informal education. Large-scale

awareness-raising campaigns, including public education through trainings, peer education fully integrate SRH, HIV/AIDS, GE, and DV. Young people including those representing the vulnerable groups, such as IDPs, minorities have been covered with information education sessions on SRH&R issues including HIV/AIDS prevention

- UNFPA in partnership with local NGOs continues to reach out youth and key population by targeting sex workers, MSMs, transgender by condom social marketing, direct condom supply and behavioral change communication (BCC) activities.

USAID funded Georgia HIV Prevention Project

The goal of the U.S. Agency for International Development (USAID)–funded Georgia HIV Prevention Project (GHPP) is to support HIV prevention among high-risk groups in order to avert the spread of HIV to the general population.

GHPP, funded at around 5 million USD, was a five year initiative (2010-2014) implemented by RTI International and its subcontracting partner, Save the Children International, and local nongovernmental organizations (NGOs) – Bemoni Public Union, and Center for Information and Counseling on Reproductive Health - Tanadgoma. GHPP developed and implemented HIV prevention activities for key populations, specifically injecting drug users and their partners, men who have sex with men, female sex workers, and at-risk youth. Project was operational in major cities of Georgia -Tbilisi, Kutaisi, Batumi and Rustavi (2010-2014), as well as Telavi and Zugdidi (2010-2011). Within the framework of the project, NGO partners provided voluntary counseling and testing services to key population on HIV, hepatitis B and C at service centers and through two mobile laboratories, risk counseling consultation, training on peer education, etc.

GHPP in partnership with the Ministry of Education and Science (MoES) of Georgia, has successfully pilot-tested a consolidated Healthy Lifestyles Curriculum (HLC) in Tbilisi and Telavi. In 2012, the use of HLC was institutionalized in all secondary schools nationwide. In 2013 GHPP provided technical assistance to develop the capacity of the MoES to conduct rigorous monitoring and evaluation of the program and to assess the HLC implementation process, with a focus on quality of educational materials and teaching process.

GHPP collaborated with the Ministry of Corrections (MoC) to conduct a qualitative study among most-at-risk male adolescents detained or on probation. Informed by the findings, in partnership with local NGO, GHPP developed and implemented a psychosocial educational pilot intervention based on elements of Cognitive Behavioral Therapy (CBT) for incarcerated youth, youth on probation, and at-risk youth outside of the penitentiary system. The MoC and MoES plan to institutionalize the program to make it part of routine practice in Georgia.

Through a participatory process, GHPP designed and printed a national BCC strategy targeting most-at-risk populations (MARPs) in Georgia and developed a Guide to Strategic Planning of Behavior Change Communication Strategy for key affected populations.

In 2012-2013, GHPP worked closely with the staff of the NCDCPH and revised a National HIV M&E Framework to strengthen HIV surveillance in the country. GHPP has produced several technical products: (a) guides to the provision of a core package of HIV prevention services, (b) unit costs for HIV preventive interventions, (c) a national database for registration of HIV services delivered and outputs/outcomes, and (d) a toolkit and manual for monitoring of HIV prevention service delivery to key populations.

With increased focus on protecting the rights of prisoners, the Ministry of Corrections of Georgia, in partnership with the USAID/GHPP developed a national policy on HIV Counseling and Testing in the penitentiary system.

GHPP works at the individual, community, societal, and policy levels to reduce HIV-related stigma and discrimination in Georgia. GHPP in partnership with media universities in Tbilisi elaborated a manual for faculty members of schools of journalism on the coverage of HIV and drug addiction issues. GHPP provides training sessions for medical personnel to reduce HIV-associated stigma and discrimination within health care settings.

GHPP has placed special emphasis on strengthening technical capacity of local government and nongovernmental organizations to design, manage, implement and monitor HIV/drug prevention interventions in the country. In 2012, GHPP conducted training needs assessment among key government and non-governmental institutions. Based on the findings and identified training needs, GHPP has provided numerous training sessions to staff members of local institutions and civil society organizations. GHPP, within its small grant programs and through merit-based competitions, has awarded more than 15 small grants to various local NGOs.

GHPP established a youth-targeted website www.geoyouth.ge to provide youth and their parents with accurate and reliable information about high-risk behaviors in a non-threatening and private manner.

HIV prevention and stigma reduction messages are most effective and compelling when they are personalized, visually memorable, and carefully tailored for the intended target group. In 2013, GHPP produced its second educational movie entitled *Restarted Game* with the aim of challenging stereotypes surrounding HIV, and reducing stigma and discrimination. GHPP produced six educational video-clips that are frequently aired on national TV channels. GHPP produced educational, visual materials on HIV prevention and stigma reduction have been posted on popular websites www.myvideo.ge and www.youtube.com.

European Union

The European Union has been supporting for several years the HIV/AIDS prevention, advocacy and awareness raising projects for different target groups of Georgia. These projects have been and are implemented by the non-state actors on regional and national level using the EU programmes like Investing in People, Non-State Actors and Local Authorities, European Instrument for Democracy and Human Rights.

WHO

In the frame of WHO support in providing policy and strategy guidance to the countries to expand and strengthen universal access for prevention treatment and care, particularly for target groups, as well as support in Viral Hepatitis prevention and control the following activities have been carried out in 2014:

- WHO Mission on Evaluation of the HIV/AIDS Treatment and Care in Georgia was carried out by experts from WHO Collaborating Center on HIV and Viral Hepatitis, Copenhagen, Denmark, in June, 2014. The mission purposed to assess the achievements, strengths and shortcomings in implementation of the Georgian National HIV/AIDS Strategic Plan across the cascade of care, and to generate strategic recommendations for improving key outcomes and impacts.

The mission had specific focus on providing recommendations on standardizing treatment regimens, how to reduce the number of different ARV regimens, and how to optimize the HIV/AIDS investment from a public health perspective.

- Strengthening capacity of human resources Georgian specialists in directions of HIV/AIDS surveillance and Viral Hepatitis (participation of Georgian specialists in WHO/ECDC Meeting of the European Network for HIV/AIDS Surveillance, Dubrovnik, Croatia, May, 2014, and in Global Hepatitis Program Partners' Meeting, March, 2015, Geneva, Switzerland).

VI. Monitoring and Evaluation Environment

The M&E system in the country is crucial for the Government of Georgia to estimate the magnitude of the problem based on more accurate data, identify contributing factors, and generate realistic estimates of resources required. Adequate data collection and reporting mechanisms ensure transparency in the implementation of national response and encourage participation of multiple local and international partners and civil society.

The Georgia National HIV/AIDS Monitoring and Evaluation Framework was adopted in 2011. Several consultative meetings were conducted to agree on a core set of indicators and institutions were aligned to improve coordination of the M&E system. In order to ensure effective functioning of the national HIV M&E system, the NCDCPH is assigned to serve as a technical arm for the CCM. The NCDCPH, in close collaboration with the CCM technical secretariat is responsible for the overall coordination on the various data flows and the availability and easy access to data. A core function of NCDCPH is to coordinate the national HIV/AIDS surveillance system. In order to improve the M&E system implementation the Working Group on M&E issues, comprised by the experts from governmental and nongovernmental organizations have been established. The M&E Working Group is responsible to conduct the critical assessment of the system, will identify the data flow gaps and develop the recommendations for the system improvement.