NATIONAL CENTER FOR DESEASE CONTROL AND PUBLIC HEALTH

GLOBAL AIDS RESPONSE PROGRESS REPORT

GEORGIA
Country Progress Report

CCM GEORGIA

UNAIDS

January 2012 – December 2013

Global AIDS Response Progress Report

G E O R G I A

Country Progress Report

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIDS Center	Infectious Diseases, AIDS & Clinical Immunology Research Center
ANC	Antenatal Clinics
ARV/ART	Antiretroviral drugs / Antiretroviral therapy
Bio-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	**N**ational 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

As per recommendations from the UNAIDS Executive Director, Mr. Michel Sidibe, the Ministry of Labor, Health&Social Affairs of Georgia granted approval for the process to compile the Global AIDS Response Progress Report to meet the submission deadline of the 31 March 2014.The National Center for Disease Control and Public Health (NCDCPH) led the participatory and multi-stakeholder process of compiling the Country Report.

In accordance with recommendations from the *Guideline on Construction of Core Indicators for Monitoring* the 2011 Political Declaration on HIV/AIDS, the Country Progress Report was developed through several national consultation meetings as well as individual meetings with the key stakeholders and desk reviews. Data for specific indicators were reviewed by experts from governmental, non-governmental, and international organizations. Based on UNAIDS recommendations, data for each national indicator as well as the draft Country Progress Report were shared, discussed and validated among the representatives of the Government of Georgia and other state and non-state actors, both national and international.

This **Country Progress Report** was developed in a participatory manner, with overall coordination from the NCDCPH and Country Coordinating 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.

National Commitments and Policy Instrument (NCPI) was also developed through participatory meetings of Government and non-state actors separately. After developing a first draft of the NCPI, it was circulated with the wider audience allowing all stakeholders to comment on the draft. All the comments were discussed and incorporated into the final report.

A letter from the CCM's Chairperson was circulated among the different stakeholders in order to collect information regarding domestic and international AIDS spending, by categories and financing sources, to complete the National Funding Matrix.

The 2014 Dublin Declaration Questionnaire, elaborated by the European center for Disease Control (ECDC) was also completed by representatives from government agencies who have a solid understanding of the country's HIV response (Part A), and by representatives from civil society who are actively engaged in that response (Part B).

b) The status of HIV/AIDS epidemic in Georgia

Georgia is among low HIV prevalence (0.07%) countries being at high risk for an expanding epidemic due to widespread injecting drug use and the population movement between Georgia and neighboring high HIV prevalence countries such as Ukraine and Russia. The number of People Living With HIV (PLWH) in country was estimated to be 6640 (Spectrum EPP), although 3641 PLWH were officially registered by the end of 2012 and 4131 PLWH - by the end of 2013. The first case of HIV infection was detected in 1989. From 1989 to 1996 only few cases of HIV infection were registered in the country. Since 1997 the number of newly registered cases started to increase steadily and reached 526 in 2012 and 490 in 2013.

In the early years of the HIV epidemic in Georgia, as in most Eastern European countries, injecting drug use was the major transmission mode. Since 2010, transmission has shifted toward the heterosexual mode, which became dominant by 2011. The percentage of drug use, as a transmission mode among newly registered HIV cases has decreased from 43.2 % in 2012 to 35% in 2013 while heterosexual transmission has increased from 44.8% in 2012 to 49% in 2013 (see Figure 2).

The HIV epidemic is primarily restricted to the most-at-risk populations (MARP) – People Who Inject Drugs (PWID), , Men who have sex with Men (MSM), Female Sex Workers (FSWs) and prisoners. The results from the most recent Bio-Behavioral Surveillance (Bio and BSS studies?) 2012 among MSM demonstrated 13% HIV prevalence in Tbilisi. The epidemic among PWID, FSWs and prisoners is of lower magnitude. According to the Bio-BSS studies conducted in 2012 the HIV prevalence among PWID was 3.0% and 1.1% among FSWs in 2012. The HIV prevalence among prisoners has decreased from 1.4% in 2008 to 0.3% in 2012.

All the data on HIV-related knowledge, attitudes and behavior, as well as HIV prevalence indicators for MARPs – presented in the Bio-BSS reports of 2012, point to the high risk for HIV epidemic expansion among the key populations and from them to the general public.

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 CCM was given the power of Georgia's sole National Coordinating Authority on HIV, TB and Malaria and started operating with full multi-sector mandate.

The 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 enhance representation of the civil sector within the CCM, three community based organizations representing PLWH, LGBT (lesbian, gay, bisexual, transgender) 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.

In 2009-10, with technical and financial support from UNAIDS, the new National Strategic Plan of Action (NSPA) 2011-16 was developed through intensive participatory, inclusive and interactive process. Over 50 key national experts, policy makers, civil society and international stakeholders were directly involved in the series of National Consultations and have greatly contributed to the process. The NSPA 2011-16 is aligned to the UNAIDS Outcome Framework (Priority Areas 1, 3, 5, 7 and 9, selected on National Consultations in October 2009) and provides ample space for realizing The Three Zeros eliminating HIV/AIDS and achieving HLM 2011 commitments in Georgia.

In 2013, with support of UNAIDS, the NSPA financial gap analysis was completed. The funding allocations from the national, and bi and multilateral donor organizations were analyzed for 2011 and 2012. The analysis has revealed substantial gaps in NSPA funding and high reliance on the external financial assistance, mainly from GF and USAID.

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 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.

With the technical support from the UNAIDS country office, the NCDCPH of Georgia has organized a Team of Local Experts (TLE) that worked on the stocktaking exercise and put considerable efforts to make sure that the report is based on the comprehensive review of the evidence from all potential sources. The TLE also provided objective judgment regarding the country's progress towards achieving the Ten Targets of the Political Declaration. The results of the stocktaking were critically analyzed with

participation of all main stakeholders in order to draw sound recommendations providing the GoG, NCDCPH and other interested parties with solid basis for future informed decisions.

The draft summary report of findings and recommendations was elaborated for the identified priority targets and was circulated among the key partners and the working group members during a week and was officially presented at the National Stakeholders Consultation meeting on May 29, 2013. The final report was endorsed on May 31, 2013.

In September, 2013 through transparent competitive process, the NCDCPH was selected as the principal recipient of The Global unds 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 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**		
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)	All	Males	Females	**M 15-19**	**M 20-24**	**F 15-19**	**F 20-24**	**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.**
	10.22%	11.23%	9.25%	9.47%	15.65%	6.60%	14.84%	
	All	Males	Females	**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	
Correct answer 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	
Correct answer 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.**
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	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%	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	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 who know their results	6.45%	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%	0.03%	0.03%	HIV routine Surveillance Database		
Indicator#1.7	All FSW FSW	<25	25+	Comment		
Percentage of sex workers who replied "Yes" to both questions	65.00%	32.00%	68.24%	Source: BSS among FSWs in Tbilisi, Batumi – 2012 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?"	81.43%	56.00%	83.92%	Source: BSS among FSWs in Tbilisi, Batumi – 2012 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?"	72.14%	48.00%	74.51%	Source: BSS among FSWs in Tbilisi, Batumi – 2012 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.	91.07%	100%	90.20%	Source: BSS among FSWs in Tbilisi, Batumi – 2012 y. N=280 (Male Sex Workers N/A)		
Indicator#1.9	All FSW Females	<25	25+	Comment		
Percentage of CSWs who received an HIV test in the last 12 months and who knows their results	42.14 %	44.00%	41.96 %	Source: BSS among FSWs in Tbilisi, Batumi – 2012 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	1.09 %	0.00%	1.19%	Source: BSS among FSWs in Tbilisi, Batumi – 2012 y. N=280 (Male Sex Workers N/A)		
Indicator#1.11	All MSM	<25	25+	Comment		
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)**
Indicator# 1.13	**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)**
Indicator# 1.14	**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)**

Indicator# 1.16	**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	12749	9762	2987	456	346	110	1480	1156	324	10813	8260	2553	**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	22	1	3	18	**HIV Routine Surveillance Database**

Indicator# 1.16EURO	**Injecting drug users**	**Sex between men**	**Heterosexual contact**	**Mother-to-child transmission**	**Other**	**Unknown**	**Comment**
Disaggregation by mode of transmission: HIV Testing and counselling	35%	13%	49%	1%	1%	1%	**HIV Routine Surveillance Database**

Indicator# 1.16.1	%	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

Indicator# 1.17.1	Females	Comment
Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	85.5%	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	85.5 %	Statistics Department, National Centre for Disease Control and Public Health

Indicator# 1.17.2	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.

Indicator# 1.17.3	%	Comment
Percentage of antenatal care attendees positive for syphilis who received treatment	N/A	

Indicator# 1.17.4	%	Comment
Percentage of sex workers with active syphilis	N/A	

Indicator# 1.17.5	%	Comment
Percentage of men who have sex with men with active syphilis	N/A	

Indicator# 1.17.6	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	1089	554	535	81	119	Statistics Department, National Centre for Disease Control and Public Health.

Indicator# 1.17.7	#	Comment
Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	N/A	

Indicator# 1.17.8	Total	Comment
Number of men reported with gonorrhea in the past 12 months	527	Statistics Department, National Centre for Disease Control and Public Health.

Indicator# 1.17.9	#	Comment
Number of men reported with urethral discharge in the past 12 months	N/A	

Indicator# 1.17.10	#	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						
Indicator# 2.1	**Total**					**Comment**
Number of needles and syringes distributed per person who injects drugs per year by Needle and Syringe Programs	45.3					**The data are aggregated according to databases from each center.**
Indicator# 2.2	**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.**
Indicator# 2.3	**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.**
Indicator# 2.4	**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.**
Indicator# 2.5	**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.**

Indicator# 2.6a	**#**	**Comment**
Estimated number of opiate users (injectors and non-injectors)	N/A	**State program and Global Fund**
Indicator# 2.6b	**N:**	**Comment**
Number of people on opioid substitution therapy (OST)	4613	**cumulative number of the patients on OST treatment during 2013.**
Indicator# 2.7a	**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.**
Indicator# 2.7b	**N:**	**Comment**
Number of substitution therapy (OST) sites	20	**In September 2013 (Within GF project) 4 service sites were add.**

Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		
Indicator# 3.1	**%**	**Comment**
Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	76.36 %	**Denominator represents estimate derived from Spectrum. We believe that 55 is an overestimate of actual number given that country ensures universal screening of pregnant women and their linkage to HIV services.** **In 2013 42 HIV positive women were identified countrywide and all of them received PMTCT services.** **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Numerator: Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery	42	
Denominator: Estimated number of HIV-positive pregnant women who delivered within the past 12 months	55	
Indicator# 3.1a	**#**	**Comment**
Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	N/A	
Indicator# 3.2		**Comment**
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	45.45 %	**Denominator represents estimate derived from Spectrum. We believe that 55 is an overestimate of actual number given that country ensures universal screening of pregnant women and their linkage to HIV services.** **In 2013 25 infants were born to HIV positive women and all of them received virologic test.** **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Numerator: Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once	25	
Denominator: Number of HIV-positive pregnant women giving birth in the last 12 months	55	
Indicator# 3.3		**Comment**
Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	10.9%	**Spectrum EPP.**
Indicator# 3.4		**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)**
Indicator# 3.5		**Comment**
Percentage of pregnant women attending antenatal care whole male partner was tested for HIV in the last 12 months	N/A	
Indicator# 3.6		**Comment**
Percentage of HIV-infected pregnant women assessed for ART eligibity through either clinical staging or CD4 testing	68%	**Denominator represents estimate derived from Spectrum. We believe that 62 is an overestimate of actual number given that country ensures universal screening of pregnant women and their linkage to HIV services.** **In 2013 42 HIV positive women were identified countryode and all of them were assessed for ART eligibility, onlcuding CD4 testing** **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Numerator: Number of HIV-infected pregnant women assessed for ART eligibility	42	
Denominator: Estimated number of HIV-infected pregnant women	62	

Indicator# 3.7		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	40.3 %	**Denominator represents estimate derived from Spectrum. We believe that 62 is an overestimate of actual number given that country ensures universal screening of pregnant women and their linkage to HIV services.** **In 2013 25 infants were born to HIV positive women and all of them received prophilcatic ART** **Numerrator is derived from the national AIDS Health Information System operated by the Infectious Diseases, AIDS and Clinical Immunology Research Center.**
Numerator: Number of infants born to HIV-infected women who received antiretroviral prophylaxis to reduce early mother-to-child transmission (early postpartum, in the first 6 weeks)	25	
Denominator: Estimated number of HIV-infected pregnant women giving birth	62	
Indicator# 3.9		Comment
Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	**40.3%**	**Denominator represents estimate derived from Spectrum. We believe that 62 is an overestimate of actual number given that country ensures universal screening of pregnant women and their linkage to HIV services.**
Numerator:	25	**In 2013 25 infants were born to HIV positive women and all of them received CTX prophilcatxis**
Denominator:	62	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Indicator# 3.10		Comment
Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DPT3 visit	N/A	
Indicator# 3.11		Comment
Number of pregnant women attending ANC at least once during the reporting period	88024	
Indicator# 3.11.1		Comment
Percentage of HIV-positive women who had their pregnancy terminated	8.3%	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Indicator# 3.11.2		Comment
Percentage of HIV-positive pregnant women who delivered during the reporting year	69%	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Indicator# 3.13.1		Comment
Percentage of HIV-positive pregnant women who were injecting drug users	0%	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Indicator# 3.13.2		Comment
Percentage of HIV-positive pregnant PWID women who received OST during pregnancy	0%	**reports from OST facilities.**
Indicator# 3.13.3		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 AIDS Health Information System**

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

Indicator# 4.1	All	Male	Females	Comment
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	31.5 %	27.8 %	43.2 %	**Denominator represents estimate of total number people living with HIV derived from Spectrum, that is why indicator is below 50%.** **When indicator is clacluated using Spectrum derived estimated number of HIV patients eligible for ART, than indicator value is 80% (2092/2620).** **When indicator is calculated using number eligible HIV patients among those already diagnosed, the indicator value is greater than 90%of persons (2092/2295)** **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**
Numerator: Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period.	2092	1405	687	
Denominator: Estimated number of adults and children living with HIV	6640	5050	1590	

	<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	63.4%	31.2%										

Indicator# 4.2a	All	Males	Females	<15	15+	Comment
Percentage of adults and children with HIV known to be on treatment 12 months after initiation treatment among patients initiating antiretroviral therapy	85.5 %	83.1 %	90.6 %	100%	85.3 %	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**

Indicator# 4.2b	All	Males	Females	<15	15+	Pregnancy status at start of therapy	Breastfeeding ststus 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	82.1%	82.1%	82.1%	85.7%	80.9%			**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**

Indicator# 4.2c	All	Males	Females	<15	15+	Pregnancy status at start of therapy	Breastfeeding ststus 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)	71.3%	66.2%	87.2%	81.8				**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**

Indicator# 4.2c	All	25+	<25	Comment
Percentage of injecting drug users with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	80.1%	80.2%	79.5%	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System**

Indicator# 4.2.1b	All	Comment
Percentage of injecting drug users with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy	79.1%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System
Indicator# 4.2.1c	All	Comment
Percentage of injecting drug users with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy	59.4%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System
Indicator# 4.3a	N	Comment
Total number of health facilities that offer antiretroviral therapy (ART)	5	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center
Indicator# 4.3b	N	Comment
Health facilities that offer paediatric antiretroviral therapy (ART)	5	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center.
Indicator# 4.4	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.

Indicator# 4.6	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	2369	1629	740	0	51	2318	0	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System
4.6.b Number of adults and children newly enrolled in HIV care during the reporting period	439	321	111	0	3	436	0	
Indicator# 4.7a	All	Males	Females	Sex un	<15	15+	Age un	Comment
Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	81.2%	82.3%	78.9%		73.8%	81.4%		Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System
Indicator# 4.7b	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	84.3%	85.6%	81.6%		100	84.2%		Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, National AIDS Health Information System

Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015						
Indicator# 5.1	**All**	**Males**	**Females**	**<15**	**15+**	**Comment**
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	88 %					**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**

Indicator# 5.2	**All**	**Males**	**Females**	**Sex un**	**<15**	**15+**	**Age unknown**	**Comment**
Percentage of adult and children living with HIV newly enrolled in care who are detected hiving active TB disease	7.5%	9.5%	1.8%		0	7.6%	0	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center**

Indicator# 5.3	**%**	**Comment**
Percentage of adult and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	21 %	**Source: Infectious Diseases, AIDS and Clinical Immunology Research Center.**
Indicator# 5.4	**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**

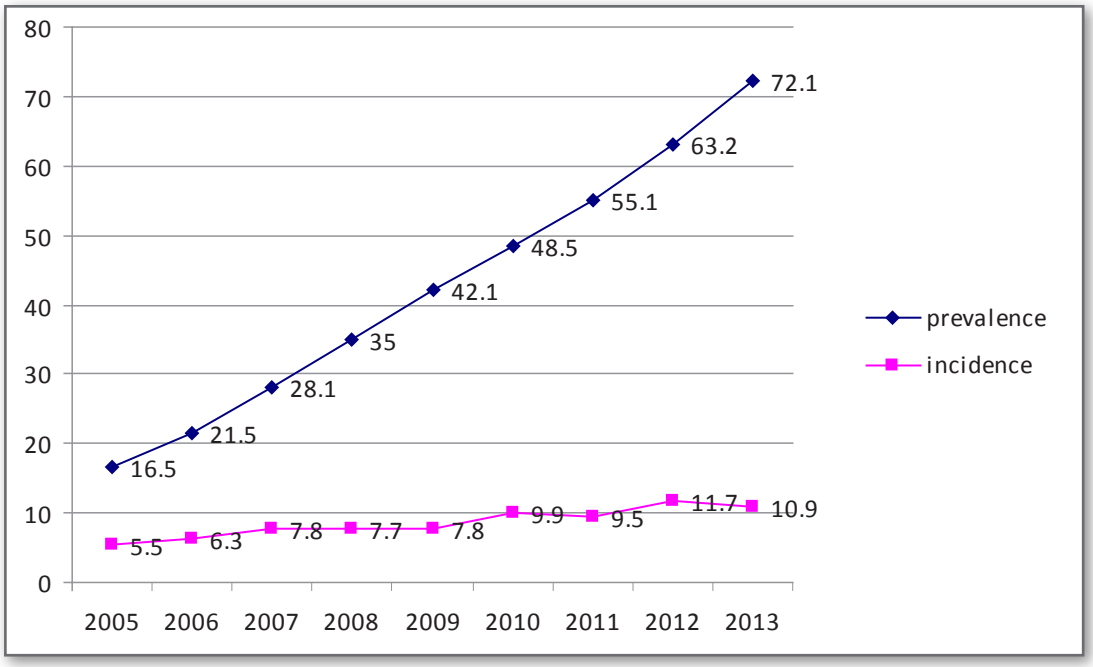
Target 7. Critical enablers and synergies with development sectors													
Indicator# 7.1	**Females All**	**HIV + Females**	**HIV- Females**	**Females (15-19)**	**HIV+ Females (15-19)**	**HIV- Females (15-19)**	**Females (20-24)**	**HIV+ Females (20-24)**	**HIV- Females (20-24)**	**Females (25-49)**	**HIV+ Females (25-49)**	**HIV- Females (25-49)**	**Comment**
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)**

Indicator# 8.1	**%**	**Comment**
Percenage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	N/A	
Indicator# 10.1	**%**	**Comment**
Current scool attence among orphans and non-orphans (10-14 years old, primary school age, secondary school age)	N/A	
Indicator# 10.2	**%**	**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. Thereafter 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.

Figure 1: HIV/AIDS prevalence and incidence rates 2005-2013 (per 100 000)



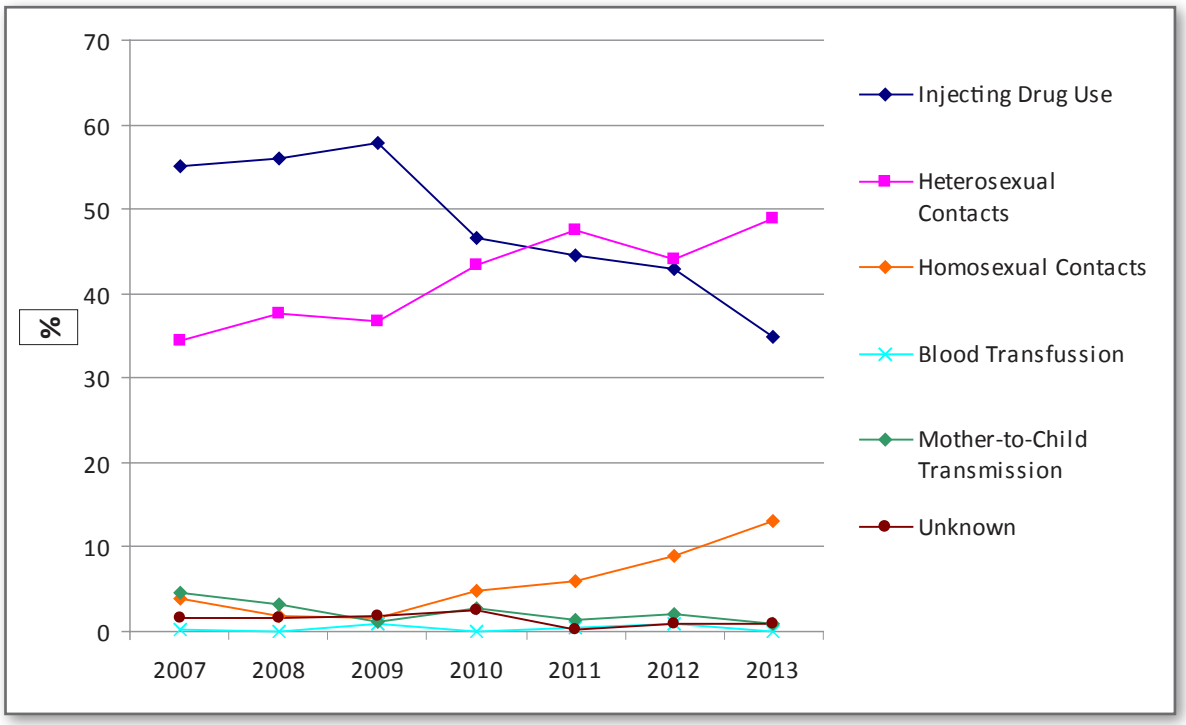
Despite a relatively low prevalence rate, the HIV/AIDS epidemic remains a significant public health concern in Georgia. There were 4131 HIV/AIDS registered cases in the country by the end of 2013. The HIV epidemic is largely concentrated among males and high-risk groups such as IDUs, MSM and FSW. HIV 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 (the capital city), from 7% in 2010 to 13% in 2012.

HIV prevalence among pregnant women and blood donors is lower (0.04% in both sub-populations) than in general population (0.07% in 2013).

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 two years.

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 2: Percentage mode of HIV transmission by year



Over the past few years, Georgian government, together with international donor organizations, has been strengthening HIV surveillance and preventive efforts among high-risk groups. Second-generation surveillance among MARPs was initiated in 2002. Since then, several rounds of Bio-BSS Surveys have been conducted to measure prevalence of HIV among IDUs and provide measurements of key HIV risk behaviors. According to the last BSS conducted in 2012 among IDUs, in six major cities of Georgia (Tbilisi, Gori, Telavi, Zugdidi, Batumi and Kutiasi) prevalence rates from Batumi and Zugdidi show that the HIV epidemic has reached a concentrated epidemic level. HIV prevalence ranges from the lowest 0.4% in Telavi to the highest 9.1% in Zugdidi.

According to the national HIV surveillance system 9.3% in 2012 and 13% in 2013 of all new HIV cases were attributed to the homosexual route of transmission.

The findings of the last Bio-BSS conducted in 2012 among MSM in Tbilisi showed the substantial increase in HIV prevalence within the last two years. The most alarming finding of this study is increase in HIV prevalence from 7% in 2010 to 13% in 2012 proving that HIV epidemic is concentrated among this group of population. High risk practices have not changed over the last two years. There is high sexual activity among MSMs, with risky sexual practices such as frequent change of partners of both sexes, insufficient use of condoms and involvement in group sexual practices. This raises concerns about the bridging role of MSMs in HIV transmission to general population.

As for rates of HIV infection among FSW, these have remained low during the last ten years. According to the recent Bio-BSS among FSWs conducted in 2012 in two cities of Georgia (Tbilisi and Batumi) safe sexual practices are widespread among FSWs. However, condom use rates have slightly decreased with different kinds of partners since 2008, when the previous BSS was conducted. Worsened behavior trend among FSWs (decrease in consistent condom use with the clients in Batumi), indicates the need of continuous provision of prevention information and condoms (especially to the newcomers to Batumi sex business).

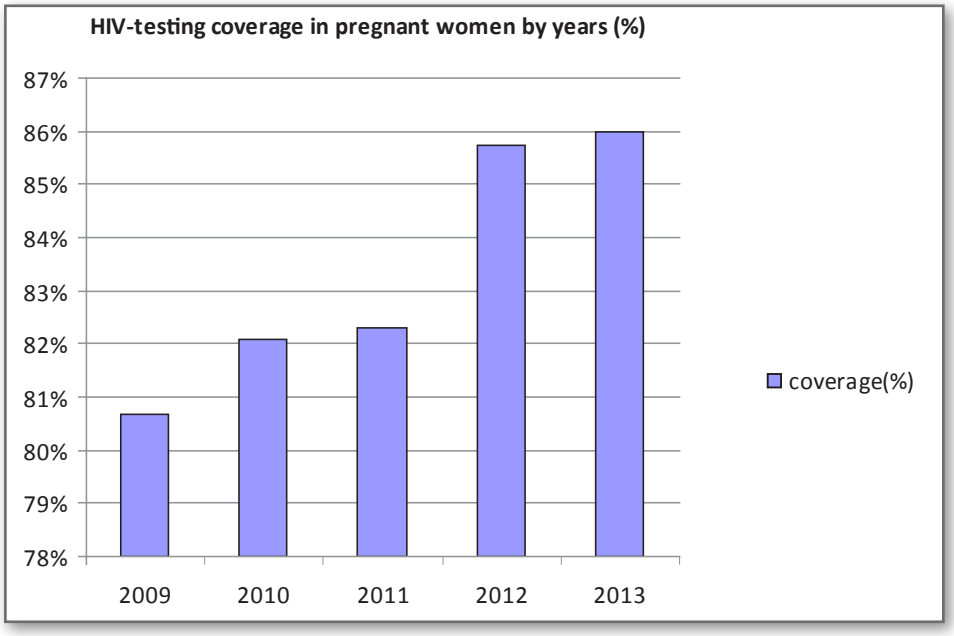
Prisons are considered as endemic areas for diseases such as tuberculosis, HIV infection, hepatitis B and C. According to various data, risk behaviors such as sharing syringes, needles and other injecting equipment are widespread in prisons. HIV prevalence in prisons in Georgia is 0.35% based on the

results of Bio-BSS among prisoners conducted in 2012. Explanation of such low prevalence of HIV among prisoners could be found in practical elimination of all HIV-related risk behaviors during the last 3-4 years inside the penitentiary system of Georgia. The increased control of the environment prevented drug and alcohol use, sexual intercourses, and other risky practices, such as tattooing. This is very positive achievement of the system.

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) as a proxy-indicator of HIV prevalence in the general population as HIV prevalence among pregnant women generally is the best available estimate of this. ;

Since 2005 Georgia continues to provide universal access to prevention of mother-to-child transmission (PMTCT) of HIV 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.3. HIV-testing coverage in pregnant women by years



In 2013, a total 42 HIV positive pregnant women were in need of ARVs for PMTCT and all of them received the prophylactic treatment.

The successful collaboration of HIV and TB services continue as evidenced by the indicator on co-management of tuberculosis and HIV treatment, with 86% of estimated number of co-infected patients receiving both, TB and HIV treatment. HIV prevalence among TB-patients has slightly increased last years and ranges 3-4%.

Since 2004, through support from the GFATM country has ensured universal access to antiretroviral therapy (ART for all patients in need. It should be mentioned that Georgia remains the only country in the Eastern European region that achieved and maintained universal access to this lifesaving therapy. Georgia is keeping pace with evolving international guidance on ART. At the end of 2013 the country adopted new treatment initiation criteria of CD4 count ≤500 cells/mm3 recommended by 2013 WHO guidelines. Earlier treatment initiation is expected to further improve survival in the country and also to contribute towards prevention of HIV transmission.

At the end of 2013 a total 2092 persons living with HIV were on ART, representing >90% coverage among those who are diagnosed and eligible for treatment.

III. National Response to the AIDS Epidemic

Due to the recognition of the increased health burden associated with HIV/AIDS, the Government of Georgia has utilized various mechanisms and resources to mitigate the impact of the epidemic.

NCDCPH, as a leading organization in the Country responsible for disease control and prevention is implementing several State programs: the HIV/AIDS Prevention and Treatment Program, the Safe Blood program, and the PMTCT program.

The main purpose of the State program on HIV/AIDS prevention is early detection of HIV/AIDS new cases in order to reduce the spread of HIV/AIDS and provide access to treatment for HIV/AIDS patients. This program covers voluntary counseling and testing for high risk groups, including IDUs, TB patients, STI patients, prisoners, patients with hepatitis B and C, patients with clinical signs of HIV/AIDS, persons having contact with HIV infected people, blood donors, pregnant women, MSMs and FSWs.

State program on HIV/AIDS treatment covers outpatient and inpatient services, while ART is fully funded by the Global Fund. The State program on Safe Blood envisages mandatory testing of all blood donors on HIV, hepatitis B and C infections and Syphilis.

There are 18 Opioid Substitution Therapy (OST) sites in civil sector and 2 sites in penitentiary system over the country. The cumulative number of the patients on OST treatment during 2013 is 4613. Among them 4261 have received OST service in civil sector programs, while 352 persons have been treated in penitentiary system.

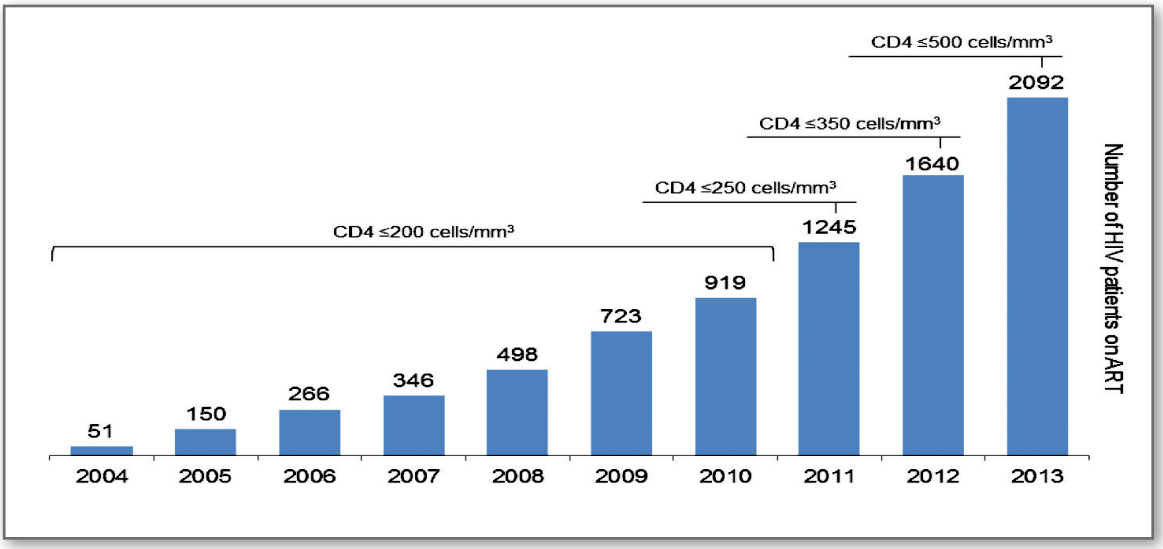
HIV voluntary counseling and testing services are available and accessible to all prisoners in all penitentiary facilities in Georgia. By the end of 2012, eighteen VCT service centers were operating in Georgia, with approximately 5600 prisoners receiving HIV counseling and testing annually. Shortly, after the Parliamentary elections in October, 2012, as a result of massive amnesty wave, the number of prisoners decreased drastically. In addition, some prisons were closed permanently due to unacceptable conditions and few became temporarily nonfunctional due to the renovation. By the end of 2013, only 12 facilities were operational in the penitentiary system with around 9,000 prisoners (vs. 24,000 in 2011). HIV counseling and testing services supported by TGF are available in all prisons, and the number of inmates tested on HIV was around 2,000 in 2013. OST (only detoxification) short course is available for drug addicts in only two (#2 and #8) prisons within the frames of the Global Fund HIV grant.

In 2013, as a result of rigorous advocacy initiatives carried out by the Ministry of Corrections in close partnership with civil society organizations and human rights advocates, the Government of Georgia initiated hepatitis B vaccination and hepatitis C testing and treatment program in penitentiary system. The program ensures that all incarcerated persons infected with hepatitis have equal access to hepatitis treatment. Initiation of the program can be considered as one of the most remarkable achievements focused on improving prisoners' access to health care in closed settings. Palliative care has been recognized as an essential component of a comprehensive package of care for PLWHIV. Since 2008 palliative care services have been operational in Georgia with the aim of improving the quality of life of patients and their families, through the prevention, assessment, and treatment of physical, psychosocial and psychological problems.

Since 2005, Georgia has continued 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, a total 42 HIV positive pregnant women were in need of ARVs for PMTCT and all of them received the prophylactic treatment. However, estimates from Spectrum suggest that 62 HIV positive pregnant women were in need of ARVs. Plausible, the Spectrum estimate is an overestimate of actual need. As mentioned above there is universal HIV screening of pregnant women, also there is well established system that ensures rapid linkage to HIV care and comprehensive follow-up of HIV positive women. It seems impossible that system missed 20 HIV positive cases. We are confident that PMTCT coverage in Georgia is at least >90% but not 68% as suggested by Spectrum estimation.

Georgia has made substantial progress in HIV/AIDS treatment and care service delivery. Since 2004 through support from the GF the country ensured universal access to ART for all patients in need. It should be mentioned that Georgia remains the only country in the Eastern European region that achieved and maintained universal access to this lifesaving therapy. Georgia is keeping pace with evolving international guidance on ART.At the end of 2013 the country adopted new treatment initiation criteria of CD4 count ≤500 cells/mm^3 recommended by 2013 WHO guidelines. Earlier treatment initiation is expected to further improve survival in the country and also to contribute towards prevention of HIV transmission.

Figure.4. **Evolving ART Guidelines and Number of HIV Patients on ART in Georgia**



At the end of 2013 a total 2092 persons living with HIV were on ART, representing >90% coverage among those who are diagnosed and eligible for treatment. Estimates generated by Spectrum suggests that in 2013 Georgia met 80% of treatment need, and this is the universal access threshold defined by WHO and UNAIDS (indicator 4.1).

Compared to previous years, 2012-2013 showed improvement in survival/retention among patients initiating ART. For example, 12-month retention indicator increased from 79% in 2011 to 86% and 85% in 2012 and 2013 respectively (indicator 4.2a). It should be noted that 24-month retention is 82% (indicator 4.2b) suggesting that major loss occurs within the first year of ART and is primarily attributable to death due to late HIV diagnosis. Retention rates are also high among persons with history of IDU, reaching 80% at 12 months and 79% at 24 months (indicators 4.2.1a and 4.2.1b). This data indicates that Georgia has been successful in providing ART to IDUs, challenging prevalent misconceptions that IDUs may not fully benefit from ART.

Other HIV treatment and care related indicators show accomplishment of the program in Georgia. Overall 81% of those on ART had suppressed viral load, including 84% among those remaining on therapy for 12 months (indicators 4.7a and 4.7b).

HIV and TB services continue successful collaboration as evidenced by indicator Co-management of tuberculosis and HIV treatment, with 86% of estimated number of co-infected patients receiving both TB and HIV treatment.

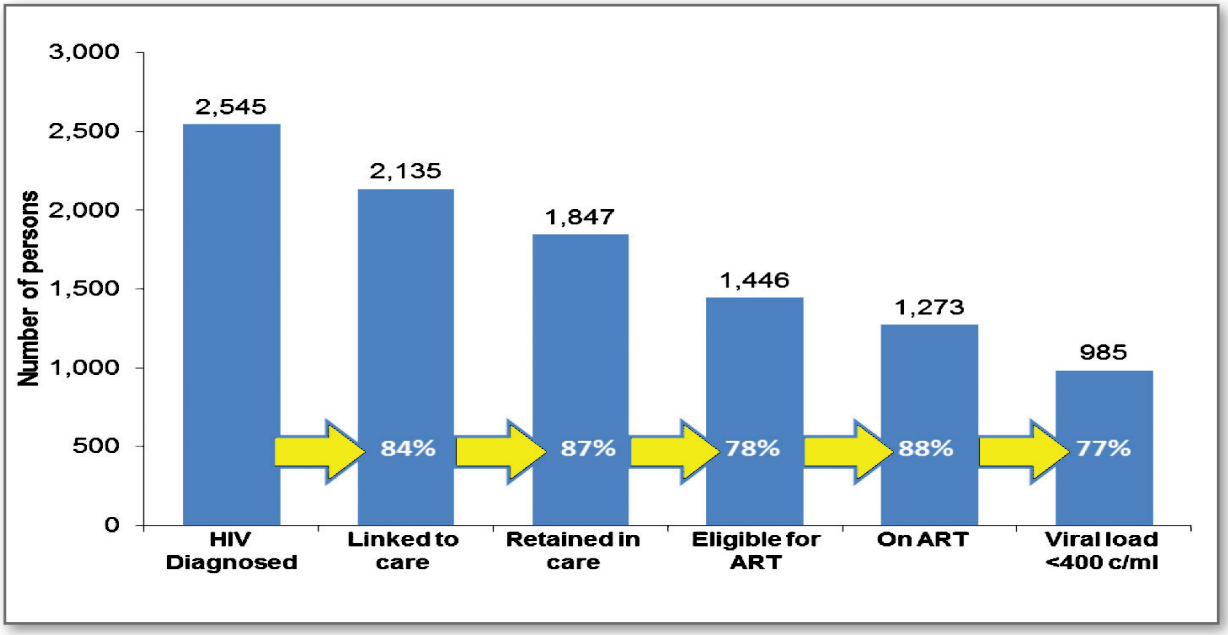
IV. Best Practices

Effective mechanisms are in place to promote engagement in care, resulting in high rates of linkage to care. In 2011 over 90% of newly diagnosed patients were linked to HIV clinical care at national or regional facilities. Trusted provider-patient relationships and availability of ancillary services for patients promote high retention, with only a 5% lost in a follow-up rate. ART program data indicates that early attrition largely results from cases of death, which in turn result from late detection of HIV cases.

Other services that contribute to improving quality of life of people living with HIV in Georgia include palliative (institutional and home-based) care, food assistance, close linkages with drug dependence and tuberculosis services and network of patient self-support centers.

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 GFATM . GFATM support proved to be critical for scaling-up treatment and care in the country. Since 2004 Georgia remains the only country in Eastern European region that achieved and maintained universal access to antiretroviral therapy. The key to this success is the effectiveness of the program that ensures high engagement of HIV patients in care services. 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.
Recent analysis of cascade of patient engagement in the continuum of HIV care in Georgia showed high rates of engagement of patients in all steps of the continuum of HIV care.

Figure.5. **Cascade of HIV Care in Georgia***



*Analysis includes patients diagnosed as of October 2012
**Percentage of patients with viral load <400 copies/ml represents total population on ART. Among those on ART for at least 12 months rate of viral suppression reach 85%.

With 84% linkage and 87% retention rates, as well as high treatment coverage, Georgia ranks among the bests worldwide. 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.[1]

In December 2013 Georgia completed adaption of 2013 WHO guidelines for earlier treatment initiation, and now ART is recommended for all patients with CD4 count <500. Implementation of new guidelines combined with sustained high patient engagement allows Georgia to aim for greater impact on the epidemic in terms of saving lives and preventing new infections. Georgia clearly bears potential of translating treatment as prevention concept into reality, if identification of HIV positive persons is substantially improved in the country.

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 300 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.

[1] Chkhartishvili et al. Mortality and causes of death among HIV infected individuals in the country of Georgia: 1989 - 2012. AIDS Res Hum Retroviruses. *In Press.* (Published online ahead of print: 2014 Feb 24)

V. 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 the number of new infections in Georgia exceeded the number of new diagnoses by at least 60%.[1] Obviously this difference contributes to further expansion of the gap between infected and diagnosed. A Spectrum estimation exercise shows that around half of the HIVinfected in Georgia persons are not yet diagnosed.

This has serious implications 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.

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.

Recent developments in Georgian drug policy include following: In November 2011, President of Georgia signed a decree *"On Approval of the Composition and Regulations of the Interagency Coordinating Council for Combating Drug Abuse"* (Decree n.751), establishing Council under the auspices of the Ministry of Justice. Interagency Coordinating Council is chaired by the Minister of Justice and includes line ministries, as well as experts in the field. Since 2012, Council started intensive work on National Anti-drug strategy and action plan (2013-2015) involving all relevant stakeholders in the process. Given the change in the government the process was prolonged but in late December 2013 final versions of the Strategy and 2014-2015 Action plan were adopted.

Attempts to make relevant changes and amendments in Georgian drug legislation date back to 2008 but none of them succeeded. In May 2012 legislative changes proposed in the amendment package submitted to the parliament in 2008 (by then vice speaker of the Parliament) were adopted. With the adopted bill, the *Law on Narcological Aid* was enhanced: the list of new psychoactive substances was added, additional norms for legal turnover of drugs as well as rules for mandatory randomized drug testing of public servants were adopted; in addition, so called "small amounts" for heroin and methadone were defined and added to the list of quantities of controlled substances.

Given the emerging trend of new psychoactive substances and the problem of abuse of over the counter drugs in Georgia, Ministry of Interior Affairs developed 2 packages of legislative amendments regarding these issues.

[1] Tsertsvadze et al. Estimating HIV Incidence in Eastern European Country of Georgia: 2010-2012. Int J STD AIDS. *In Press* (Accepted February 2 2014)

VI. Support from the Country's Development Partners

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, is a five year initiative (2010-2014) being 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 develops and implements 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. Activities in 2012-2013 were implemented in four major cities of Georgia -Tbilisi, Kutaisi, Batumi and Rustavi. GHPP provides voluntary counseling and testing services to key population on HIV, hepatitis B and C at service centers and through two mobile laboratories.

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.

The Global Fund to Fight AIDS, Malaria and Tuberculosi

The Global Fund continues to be the major player in scaling up the National Response to HIV/AIDS in Georgia. The present proposal "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" has been approved through round 10 and will be implemented until the 31st of December 2015.
During the current TGF's HIV program implementation period 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 phase 2 of the current TGF's HIV program will be implemented from April 2014 till 31st of December 2015 with total budget about 18 million EUR.

NCDCPH role 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. It will be able to consolidate state and donor finances and prepare an effective strategy for successful taking over GF programmes after 2016.

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.

The following service delivery areas are covered:
through

- HIV prevention interventions targeting MARPs (IDUs, FSWs, MSMs and prisoners)
  The intervention includes 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.
- PMTCT;

Treatment

- Antiretroviral treatment (ARV) and monitoring;
- Prophylaxis and treatment for opportunistic infections;
- Hepatitis C treatment and monitoring

Care and Support

- Care and support for the chronically ill

Curatio International Foundation

The Curatio International Foundation (CIF) is a Georgian non-governmental, not-for- profit organization, established in 1994 with a mandate to support health and social system reforms in countries with transition economics. Since its establishment CIF has implemented more than 120 programs and research projects in 23 countries. CIF has worked in HIV/AIDS prevention since 2004.

Since 2008, under the Global Fund to Fight AIDS, Tuberculosis and Malaria, CIF has been working on the establishment of an Evidence Base for the HIV/AIDS National Program by Strengthening HIV/AIDS Surveillance System. The project was implemented in partnership with the Georgian Infectious diseases, AIDS and Clinical Immunology Research Center, the Public Union "Bemoni" and the association "Tanadgoma". It covers the following components: 1) Improvement of the HIV/AIDS routine information system (HIV and AIDS case reporting); 2) Implementation of second generation HIV/AIDS surveillance-based behavioral surveys with a biomarker component and; 3) Establishment and implementation of sentinel surveillance for STI patients.

First two components have been completed by 2010. Since then CIF is implementing BSS and size estimation surveys in Georgia, providing information to monitor the project implementation. Currently CIF is implementing size estimation survey among MSM population in country. Before the end of the GFATM Round 10 project the following surveys will be implemented:

a) BSS and size estimation study among Commercial Sex Workers
b) BSS and size estimation study among MSM;
c) BSS and size estimation study among IDU population;
d) BSS among prisoners.

World Health Organization

With the support of World Health Organization Country Office in Georgia the following activities were carried out during 2012-2013:

- Annual National Workshops on HIV/AIDS clinical management, facilitated by leading European experts. Namely, 1.National Training Workshop on HIV/AIDS Clinical Management (April, 2012), facilitated by WHO external consultant from University of Copenhagen, Department of Health, Immunology and Microbiology, Prof. Jens Lundgren. Participants were able to receive information and upgrade their knowledge on clinical management of HIV/AIDS. This workshop also led to establishment of collaboration with the Copenhagen HIV Program (CHIP) of the University of Copenhagen, enabling the Infectious Diseases, AIDS & Clinical Immunology Research Center (IDACIRC) later on to be involved in two pan-European studies administered by CHIP (HIDES study and TB/HIV study); 2.National Training Workshop on Clinical Management of HIV and Hepatitis Co-infection (November, 2012), facilitated by WHO external consultant, Prof. Vincent Soriano, Infectious Disease Department, Hospital Carlos III, Madrid, Spain. The workshop was aimed at strengthening human resource capacity to provide high-quality medical care for people living with HIV and hepatitis co-infections. Overall 20 clinicians, including specialists from regional AIDS centers, participated in the workshop; 3. National Training workshop on HIV/AIDS and viral hepatitis Co-infection Clinical Management (August, 2013), facilitated by WHO external consultant, Dr. Jürgen Rockstroh, Professor of Medicine, University of Bonn and Head of an HIV outpatient clinic, Germany. Participants were able to receive information on latest advances in the field and upgrade their knowledge on clinical management of HIV/AIDS and viral hepatitis co-infections.
- Research on Estimating HIV incidence in Georgia in 2012, carried out by the Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC) .
- WHO technically and financially supported updating of national guideline on Clinical indicators for HIV testing for PHC and other physicians and developing web based training course on HIV

indicator disease guided testing and counseling. Work was done by IDACIRC.

- WHO financially supported human capacity building through participation of national specialists in WHO events abroad.

World Vision

World Vision, together with the local partner organizations, has been working to increase HIV prevention and mitigate the impact of the HIV infection in the South Caucasus region and Russian Federation. Two years initiative *„Cross-Border Cooperation For HIV/AIDS Prevention And Impact Mitigation In Southern Caucasus And Russian Federation"*supported by the European Union, covered Armenia, Azerbaijan, Georgia and Russian Federation and aimed to strengthen the joint, cross-border response to HIV among migrants.

During the years 2012-2013 following advocacy initiatives have been implemented on regional and national levels.

Desk Review Report (issued in June 2013) The document does situation analyses of migration and HIV/AIDS related processes in South Caucasus countries and Russian Federation and sets out the recommendations on policy and service delivery levels, as well as gives insight into awareness raising methods on HIV among migrant population.

In 2013 the project in Georgia started an initiative to address the missing health component into existing Migration Strategy of Georgia. The project sensitized local government and national stakeholders in addressing recommendations about HIV/AIDS prevention for migrants in Georgia. The process will be continued by the local implementing partner "Real People, Real Vision".

The project also established the bases for the Cross-border referral mechanism in terms of HIV and migration among project partners from South Caucasus and Russian Federation and helped in smooth regional networking. Cross-border referral is a mechanism of assisting migrants in need to get appropriate HIV-related services such as HIV testing, check-up, treatment, care and various psycho-social support. The key players are local NGOs from 4 countries that cooperate among each other and ensure the individual and confidential assistance for every beneficiary.

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.

The several local NGOs functioning in the Country that has been made a significant contribution towards prevention of HIV/AIDS:

Center for Information and Counseling on Reproductive Health – Tanadgoma

Mission of Tanadgoma is to improve the physical and mental health of Georgian population through implementing prevention, educational, diagnostic and rehabilitation programs, as well as advocacy of these programs. Also, Tanadgoma provides technical support and expertise to improve capacities of the relevant organizations, communities and other stakeholders.

Tanadgoma is presented in Tbilisi and four cities of Georgia: Batumi, Zugdidi, Kutaisi and Telavi.

Since 2000 Tanadgoma has been providing services to key populations – FSWs, MSMs, IDUs, prisoners and youth. It offers individual counseling through hotlines and face to face visits, outreach, peer education, condom and materials distribution, different educational workshops and training, voluntary HIV counseling and testing at Tanadgoma centers and through mobile laboratories and STI testing and treatment at the GFATM-funded "Healthy Cabinet" clinics.

Tanadgoma conducts various qualitative and quantitative researches in order to identify needs of the target populations, assess knowledge, and estimate prevalence of infections and high risk behavior. Since 2002, Tanadgoma, together with the partner organizations, regularly conducts BBS surveys among FSWs, MSM and prisoners.
Tanadgoma's main donors are GFATM, USAID/RTI, RFSU/SIDA, EU, UNFPA etc.

Health Research Union

NGO Health Research Union (HRU) (formerly Maternal and Child Care Union) has a 14-year experience in implementing different public health projects related to prevention, counseling and education of different infectious diseases including HIV/AIDS. In recent years HRU has undertaken several educational projects in the field of HIV/AIDS:

In 2011-2012 HRU implemented the project: Promotion of Healthy Behaviors among Juveniles in Conflict with Law funded by Ministry of Justice of Georgia. Throughout the project about 100 juveniles who were in conflict with law in Tbilisi, Kutaisi and Batumi received intensive informational educational sessions on healthy lifestyles including HIV prevention and stigma reduction.

In 2012 HRU delivered educational sessions to youth within the frames of USAID funded Georgia HIV Prevention Project (GHPP) on healthy lifestyle issues including HIV prevention and HIV related stigma reduction. Around 700 schoolchildren of 9- 12th grades from different regions of Georgia were educated through this project. In addition, 26 employees of Youth Leadership Houses operated at Public Service Halls received training of trainers (ToT) on healthy lifestyles education including HIV prevention and HIV associated stigma reduction.

Another educational project related to HIV/AIDS within the frames of USAID funded GHPP was implemented in 2013 by HRU in partnership with USAID funded Applied Civic Education and Teacher Training (ACETT) Program. Training of trainers (ToT) was organized for 15 staff members of ACETT partner NGOs countrywide. Peer education (PE) sessions on healthy lifestyles including HIV prevention and HIV related stigma reduction were conducted for schoolchildren (9th-12th grades) at school-based civic clubs operated countrywide by ACETT Program involving trained staff members of ACETT partner NGOs. About 800 schoolchildren were educated through this project.

Currently HRU is conducting the project "Promotion of healthy lifestyles among youth in Georgia" funded by US Embassy Democracy Commission Small Grant Program. The project aims to organize peer education sessions on healthy lifestyle issues including HIV prevention among young people in different regions of Georgia. Overall, more than 1200 students will be included in the program.

Another ongoing project "Evaluate of dental health care workers (DHCWs) knowledge, attitude and behavior about the principles of universal safety precautions and methods for reducing occupation exposure" funded by Fogarty International Center, NIH, aims to evaluate DHCWs knowledge, attitude and behavior about blood borne infections (including HIV infection); The principles of universal safety precautions and methods for reducing occupation exposure to blood/body fluids and to develop recommendations for DHCWs to prevent transmission of blood borne disease in dental care settings and pilot testing of PCR methods to measure environmental contamination by blood borne viruses in dental clinics.

Georgian Harm Reduction Network

GHRN was established in 2006 and since 2008 is the sub recipient of GFATM. GHRN has 26 member organizations and has 14 harm reduction service sites in 11 cities across Georgia (Tbilisi – 4 sites, one in each in Gori, Telavi, Rustavi, Ozurgeti, Kutaisi, Samtredia, Zugdidi, Poti, Sukhumi and Batumi). Its main goal is to develop cooperation for implementing effective drug policy and expanding medical, social and legal services for drug users in Georgia.

GHRN is the key actor to deliver low threshold harm reduction services to PWIDs. The services accessible in service sites include but are not limited to needle/syringe, safe injection devices, safe sex devices, information material distribution among IDUs. GHRN service sites offer medical counseling and other supplementary services. GHRN reaches out to over 9 500-11 000 PWIDs per month and plays a crucial role in HIV/AIDS prevention among them.

Apart from service delivery, GHRN pursues advocacy strategies based on human rights and public health principles. It is represented in the inter-agency council on drug policy and actively promotes evidence based drug policies. GHRN is a strong advocate of community systems strengthening and community's inclusion in decision making and implementation processes at all levels.

Infectious Diseases, AIDS and Clinical Immunology Research Center

Infectious Diseases, AIDS and Clinical Immunology Research Center (National AIDS Center) is Georgia's reference institution for diagnosis, treatment and care for HIV/AIDS and other infectious diseases (except of tuberculosis). The Center is acclaimed internationally for excellence in clinical care, biomedical research and medical education. The main activities include:

- Provision of a broad range of patient services, including diagnostics, treatment and prevention of HIV/AIDS, viral hepatitis and other infectious diseases
- Implementation of research projects, including basic, clinical and applied research in the fields of HIV/AIDS, and other infectious diseases
- Education of medical students, physicians and other health-care providers

National AIDS Center has done pioneering work in the field of HIV/AIDS both in Georgia and entire region. The Center started to build strong human, clinical and laboratory capacity back in 1980s, which substantially contributed to the progress of national HIV response. Pivotal work conducted by the Center in 1990s and early 2000s served as basis for the establishment of effective AIDS control service, which allowed Georgia to avoid explosive spread of HIV in the country.

National AIDS Center coordinates the National HIV/AIDS Treatment and Care Program since its inception in 1995, which has been substantially strengthened by resource allocation from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Center developed systematic approach for treatment and care service delivery, which ensure very high patient engagement in clinical care services. This approach allowed Georgia to become the first and the only country in the Eastern Europe to achieve and maintain universal access to ART since 2004. Currently National AIDS Center is the leading institution of Georgian AIDS control service and is responsible for the treatment and care component of the national HIV response.

VII. 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. These results will be used to delineate the scope and coverage of this programmatic intervention. 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.

An appropriate and efficient M&E system is the cornerstone of a country's HIV response. The results provide data needed to make evidence-based decisions for program management and improvement, policy formulation and advocacy, and is necessary to satisfy accountability requirements.

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.

The one agreed National HIV/AIDS M&E Framework:

1. Provides opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV/AIDS;
2. Assists in responding to the international commitments and reporting requirements;
3. Provides the platform for partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating national and decentralized responses to HIV/AIDS.

The framework contains three separate sections: HIV national M&E system design; M&E operations manual (which describes how individual components of the national M&E system works), and the operationalization plan (which provides an overview of the priorities to be undertaken within the first three years of establishing the system).
More importantly, it enhances local community and health-facility-based programs. The National HIV/AIDS M&E Framework provides stakeholders with a tool for well coordinated, harmonized and functional HIV/AIDS M&E systems that allow them to efficiently assess how well HIV/AIDS interventions are contributing to achieving the national program goals.

The NCDCPH has critical role in monitoring and evaluating HIV national response:

I. 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. The NCDCPH M&E coordinator use a national HIV/AIDS database as a warehouse to store monitoring and evaluation information, to undertake periodic and/or specific analysis of available data, and make the M&E research products readily available to stakeholders as required.

II. A core function of NCDCPH is to coordinate the national HIV/AIDS surveillance system. The center through its HIV surveillance unit fulfills the following functions:

Core Functions:

- Analyze data (through appropriate IT infrastructure and software administration)
- Based on data analysis, generate reports, and conduct regular assessment and analyses of the epidemiological situation
- Prepare recommendations on revisions needed to modify variables, indicators or definitions for epidemiological analysis.

- Run the HIV National web portal to ensure that all M&E products are collected and are easily available to all stakeholders. This serves as a common platform at the country level for storage of M&E documents and publications.

In addition, the NCDCPH has the data quality control function to validate the M&E information and identify and correct the shortcomings of the surveillance system.

In 2013 in order to improve the M&E system implementation initial steps have been undertaken regarding the establishment of the M&E unit at the NCDCPH. The M&E Coordinator and M&E specialists have started to fulfill the roles and responsibilities according to the National M&E work plan. The Working Group on M&E issues, comprised by the experts from governmental and nongovernmental organizations have been established. The M&E Working Group and M&E staff will conduct the critical assessment of the system, will identify the data flow gaps and develop the recommendations for the system improvement.

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