Global AIDS Response Progress Report

G E O R G I A

Country Progress Report

Reporting Period

January 2010 – December 2011

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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
BSS	Behavioral Surveillance Surveys with biomarker component
CCM	Country Coordinating Mechanism
CIF	Curatio International Foundation
FSWs	Female Sex Workers
GARP	Global Country Progress 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
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
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
VRF	Vishnevskaya-Rostropovich Foundation
WHO	World Health Organization

I. Status at a glance

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

In accordance with recommendations from the Guideline on Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS, this Country Progress Report was developed over the course of several national consultation meetings (initial Global Progress Report Introductory Workshop in November 2011, midterm Country Progress Report Workshop in February, and the Report Validation Workshop in March 2012), 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 and the draft Country Progress Report were presented, discussed and validated at the broad inclusive meetings involving 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 on the part of National Center for Disease Control and Public Health (NCDCPH) and Country Coordinating Mechanism (CCM), in close collaboration with UNAIDS Country Office. The NCDCPH directly facilitated all consultations and relevant data collection endeavors.

NCPI also was developed through participatory meetings of Government and non-state actors separately. After developing a first draft of the NCPI, it was shared with the wider audience allowing all stakeholders to comment on the draft. All the comments were discussed and incorporated into the final report. NCDCPH presented the final draft document at the concluding National Consultation Meeting attended by a broad forum of stakeholders on 30 March, 2012.

b) The status of HIV/AIDS epidemic in Georgia

Georgia is a low HIV prevalence country with the prevalence of 0.05%. According to the updated estimates (Spectrum EPP) the number of people living with HIV/AIDS in the country is 4400 in 2010 and 5000 in 2011, and primarily restricted to the most-at-risk populations (MARP). The most recent Behavioral Surveillance Surveys with Biomarker Component (Bio-BSS) conducted among MSM in Tbilisi in 2010 found the prevalence of HIV among MSM at 6.4%, - the likely highest prevalence in the capital city.

However, besides the emerging epidemic among MSM, there is a risk of a further rapid spread of HIV infection in the future due to the high prevalence of injection drug use, sexually transmitted infections (STIs), and Hepatitis B and C; as well as increased migration between Georgia and neighboring countries, such as Russia and Ukraine, which are now experiencing growing HIV epidemics.

All the data on HIV related knowledge, attitudes and behavior, as well as on HIV prevalence indicators for MARPs, presented in this report were generated through Bio-BSSs carried out under the two internationally funded programs.

1. The USAID funded RTI (Research Triangle Institute) Georgia HIV Prevention Project (GHPP) (Save the Children and the Program for Appropriate Technologies in Health (PATH) as implementing partners) goal is to support HIV prevention among high-risk groups in order to avert the spread of HIV to the general population, by working with two local NGOs – Tanadgoma, and Bemoni – to develop and implement HIV prevention activities for most-at-risk populations (MARPs).

2. The GF supported HIV Project in Georgia is being implemented by the Global Projects Implementation Centre (GPIC). The Curatio International Foundation (CIF) is a main implementing partner responsible for conducting the BSSs. The National AIDS Center, NCDCPH and the local NGOs Tanadgoma, and Bemoni are also implementing partners of the Project.

Under the projects above several rounds of BSSs among IDUs, MSM, FSWs and Prisoners have been implemented in several cities of Georgia. A Respondent Driven Sampling methodology (RDS) was applied for BSS among IDUs and MSM; and Time-and-Location Sampling among FSWs. These methodologies are internationally recognized and most recommended approaches for reaching out to those hidden populations. These BSSs have used almost standardized questionnaires for each high-risk group. The use of standard methodologies and survey tools allowd collection of the data to be used in comparative analysis across cities by years. This report includes aggregated data to include information from as many survey sites as possible as well as separate indicators by survey site wherever possible.

c) The Policy and Programmatic Response

In 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. Coordinated involvement of various national and international stakeholders, including broader civil society, has been deemed essential in effective HIV response.

Since 1996 the national HIV/AIDS prevention & control programs have been coordinated by the Governmental Commission on HIV/AIDS, STIs & Other Socially Dangerous Diseases represented by line-ministries and health institutions working in the field of STI/HIV. Based on experience of the Governmental Commission, and in a response to introducing the GF assistance in Georgia, a Country Coordinating Mechanism (CCM) was established in 2002. In order to demonstrate highest political commitment to HIV response in Georgia, the CCM is led by Mrs. Sandra Elisabeth Roelofs, the First Lady of Georgia.

The CCM operates with a multi-sector mandate for 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 NGO sector within the CCM, local NGOs are

selected on a rotational basis through the STI/HIV Prevention Task Force (PTF), a professional network uniting more than 30 governmental, non-governmental, and donor organizations. The PTF is recognized as an effective professional and civil society forum of stakeholders actively involved in HIV policy development and advocacy initiatives in Georgia.

In a response to the UNAIDS "Three Ones" principle that call for the best coordination of a National AIDS Response around one agreed action framework, the CCM became the one National Coordinating Authority in May, 2007, taking a leading role in national advocacy for coordinated response, in development of national HIV strategy, policies and legislation, and in monitoring and evaluation of HIV programs nationwide. This status of the CCM was legislated in 2009 through the new Law on HIV/AIDS.

The 2nd strategic document on HIV/AIDS – the National Strategic Plan of Action (NSPA) towards achieving the Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Georgia – was developed in 2006, through the revision of the 1st NSPA for 2003-07. The NSPA 2006-10 outlined policy and programmatic priorities for the period, with four major strategic objectives: Surveillance (1); Prevention (2); Treatment, Care and Support (3); and National Commitment (4).

In 2009-10, with technical and financial support from UNAIDS, the new National Strategic Plan of Action (NSPA) 2011-16 was developed through broadly 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 final document produced through the above process was eternally reviewed by the AIDS Strategy and Action Plan (ASAP) of the World Bank. After validating the accepted recommendations, the Strategy was endorsed by the CCM in August 2010.
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 and achieving HLM 2011 commitments in Georgia.
'Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function' is one of Strategic Priorities of the NSPA 2011-16 with 5 main Strategic Areas on coordination and advocacy(1), prevention(2), treatment(3), care and support (4), and health systems strengthening(5).

The goal of the new NSP - to restrain epidemic HIV growth primarily within the most-at-risk populations and improve health outcomes for PLHIV through improved coordination and strengthened advocacy of the national response has been recently reemphasized with adoption of the new Georgia National Health Care Strategy 2011-15: (http://www.moh.gov.ge/files/2011/failebi/xarisxiani-jandacva/jandacva_Eng.pdf).

In order to effectively plan, coordinate and implement the national response, the HIV/AIDS Monitoring and Evaluation (M&E) System and Framework was developed with participation of multiple stakeholders under the auspices of the CCM and with financial and technical support from UNAIDS. The technical working group (TWG) was established, composed of independent experts from different organizations involved in implementation of the national HIV response. The experts consulted various international manuals and standardized methodologies on development of

HIV/AIDS M&E systems, conducted site visits and key-informant interviews to gain better insight of HIV/AIDS M&E needs in the country (detailed description see below, paragraph VII).
National HIV M&E System and Framework, including the Operations Manual and the Plan of Operationalization was developed through broadly participatory process of workshops and National Consultations, which allowed maximum harmonization of this new national instrument of HIV accountability with WHO/UNICEF/UNAIDS HIV reporting and UNGASS declaration monitoring tools. The new M&E system and the documents were endorsed by the CCM of Georgia in June 2011.

The new M&E system reflected considerable progress which has been made since 2007 in terms of the development of the HIV/AIDS surveillance system, with the GF technical and financial support, that incorporates three main components: Routine surveillance, Sentinel surveillance and Bio-behavioral surveillance studies among high-risk groups.

The NCDCPH has been identified as a key national agency responsible for coordinating HIV/AIDS surveillance; The role is harmonized with the agency's leading role in operationalising and functioning of the new M&E system as a whole.

The national surveillance plan, featuring standard data collection forms and a methodological manual for data analysis, has been elaborated. This new system was successfully launched with the Ministerial order #217/o on July 23 2010, to support institutionalization of the development.

In order to strengthen HIV/AIDS surveillance in Georgia, evidence supporting a national HIV/AIDS program was collected. This project was funded by the Global Fund and implemented by the Curatio International Foundation (CIF) in partnership with Georgian Infectious diseases, AIDS and Clinical Immunology Research Center, Public Union "Bemoni," and association "Tanadgoma." The project took place from February, 2008 to December 2010.The aim of the project was to reform HIV/AIDS surveillance system in the country, and it encompassed 3 basic components, each of them embracing series of activities.

d) Indicator Data in an overview table

Target 1. Halve sexual transmission of HIV by 2015										
Indicator		Value							Comment
2011	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	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.
		10.22%	11.23%	9.25%	9.47%	15.65%	6.60%	14.85%	
		All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
2011	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%	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.
		All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	

2011	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%	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.
		All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
2011	Answered Yes to question 3 "Can a healthy-looking person have HIV"?	49.33%	47.44%	48.47%	46.26%	50.38%	48.47%	56.77%	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.
		All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
2011	Answered Yes to question 4 "Can a person get HIV from mosquito bites ?" (or country specific question)	26.72%	28.35%	25.16%	26.87%	32.06%	22.70%	30.32%	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.
		All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	
2011	Answered Yes to question 5 "Can a person get HIV from sharing food with someone who is infected ?" (or country specific question)	46.78%	44.27%	49.17%	41.37%	51.53%	45.40%	57.10%	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.
Indicator #1.2		All	Males	Females	M 15-19	M 20-24	F 15-19	F 20-24	Comment
2011	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%	The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.

Indicator#1.3		All	Females	F 15-19	F 20-24	F 25-49	Comment
2010	Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	0.52%	0.52%	0.35%	0.45%	0.58%	The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years, Data for males N/A
Indicator#1.4		All	Females	F 15-19	F 20-24	F 25-49	Comment
2010	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	F 15-19	F 20-24	F 25-49	Comment
2010	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
2011	Percentage of young women aged 15-24 who are HIV-infected.	0.002%	N/A	N/A	Georgia is categorized as having a low-prevalence HIV epidemic. No data disaggregated by following age groups available. Number of antenatal clinic attendees (15-24) tested whose HIV test results are positive is 5. 15-19: 1 20-24: 4
Indicator# 1.7		All FSW	<25	25+	Comment
2008	Percentage of sex workers who answered "Yes" to both questions	66.88%	9.09%	69.80%	Source: BSS among female SWs in Tbilisi – 2008 y. N=160 (Male CSWs N/A)

2008	Answered Yes to question 1, "Do you know where you can go if you wish to receive an HIV test?"	81.25%	50.00%	88.73%	Source: BSS among female SWs in Tbilisi – 2008 y. N=160 (Male CSWs N/A)
2008	Answered Yes to question 2 "In the last 12 months, have you been given condoms?"	58.75%	N/A	N/A	Source: BSS among female SWs in Tbilisi – 2008 y. N=160 (Male CSWs N/A)
Indicator# 1.8		All FSW	<25	25+	Comment
2008	Percentage of female and male sex workers reporting the use of a condom with their most recent client.	98.75%	100%	98.66%	Source: BSS among female SWs in Tbilisi – 2008 y. N=160 (Male CSWs N/A)
Indicator# 1.9		All FSW	<25	25+	Comment
2008	Percentage of CSWs who received an HIV test in the last 12 months and who knows their results	27.50%	0%	29.53%	Source: BSS among female SWs in Tbilisi – 2008 y. N=160 (Male CSWs N/A)
Indicator# 1.10		All CSW	<25	25+	Comment
2008	Percentage of sex workers who are living with HIV	1.95%	0.00%	2.10%	Source: BSS among female SWs in Tbilisi – 2008 y. N=160 (Male CSWs N/A)
Indicator# 1.11		All MSM	<25	25+	Comment
2010	Percentage of men who have sex with men reached with HIV prevention programmes Percentage of MSM who answered "Yes" to both questions	20.86%	20.99%	20.81%	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)
		All MSM	<25	25+	
2010	Percentage of MSM who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	58.63%	N/A	N/A	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)
		All MSM	<25	25+	
2010	Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	36.33%	N/A	N/A	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)
Indicator# 1.12		All MSM	<25	25+	Comment
2010	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	67.29%	75.29%	63.59%	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)
Indicator# 1.13		All MSM	<25	25+	Comment
2010	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	25.90%	27.91%	25.00%	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)
Indicator# 1.14		All MSM	<25	25+	Comment
2010	Percentage of men who have sex with men who are living with HIV	7.01%	3.61%	8.51%	Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)
Indicator# 1.15		All	Public	Private	Unknown	Comment

2011	Health facilities that provide HIV testing and counseling services	35.02%	N/A	N/A	N/A	No data disaggregated by health facility type is available.
	Indicator# 1.17					Comment
2011	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	88.09%				Statistics Department, National Centre for Disease Control and Public Health
		Total	15-19	20-24		
2011	Percentage of antenatal care attendees who were positive for syphilis	0.03%	N/A	N/A		Statistics Department, National Centre for Disease Control and Public Health. No data disaggregated by age groups available.
2011	Percentage of antenatal care attendees positive for syphilis who received treatment	N/A				No data available
	Percentage of sex workers (SWs) with active syphilis	No Data Available				No Data Available
	Percentage men who have sex with men (MSM) with active syphilis	No Data Available				No Data Available
	Indicator# 1.21	All	Male	Female		Comment
2011	Percentage of prisoners who are living with HIV	0.25%	0.26%	0%		BSS study among prisoners. 2424 prisoners were tested on HIV. Among them 2302 were males and 122 – females. 6 new HIV cases were revealed.
	Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015					
	Indicator# 2.1	N:				Comment
2011	Number of syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	22				The data are aggregated according to databases that each ten center products and delivers to program director.
	Indicator# 2.2	All	Males	Females	<25	25+	Comment
2009	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	22.42%	N/A	N/A	N/A	N/A	BSS study N=1127. The IDUs were studied in five different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi and Batumi during 2008-2009. (According to BSS questionnaire in the denominator we can count only number of people who injects drug and having had sexual intercourse in the last YEAR, not month)
	Indicator# 2.3	All	Males	Females	<25	25+	Comment
2009	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	48.09%	N/A	N/A	42.96%	48.83%	BSS study N=1127. The IDUs were studied in five different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi and Batumi during 2008-2009 Disaggregation by sex is not available.
	Indicator# 2.4	All	Males	Females	<25	25+	Comment

2009	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	5.68%	N/A	N/A	4.93%	5.79%	BSS study N=1127. The IDUs were studied in five different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi and Batumi during 2008-2009 Disaggregation by sex is not available.
Indicator# 2.5		All IDUs	Males	Females	<25	25+	Comment
2011	Percentage of people who inject drugs who are living with HIV	3.91%	3.95%	2.08%	0.32%	4.44%	Source: National HIV surveillance database
Indicator# 2.6		N:					Comment
2010	Number of people on opioid substitution therapy (OST)	1632					State Program and Global Fund
2011	Estimated number of opiate users (injectors and non-injectors)	10000					Experts opinion
Indicator# 2.7		N:					Comment
2011	Number of needle and syringe programme (NSP) sites	10					Among of this 10 sites, 1 center „Tanadgoma" is working in conflict region Abkhazia, mainly in Sokhumi.
2011	Number of substitution therapy (OST) sites	16					10 State Program, 6 Global Fund
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths							
Indicator# 3.1							Comment
2011	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	112.50%					National Clinical Database; Spectrum EPP.
Indicator# 3.2							Comment
2011	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	96.5%					One newborn out of 26 left the country before PCR test for HIV was performed.
Indicator# 3.3							Comment
2011	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	12.50%					Spectrum EPP.
Indicator# 3.4							Comment
2011	Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	82%					We used real registered number of pregnant women, not estimated number for denominator (source NCNCPH Department of Statistics)
Indicator# 3.7							Comment
2011	Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission (PMTCT)	87.5%					Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System.
Indicator# 3.10							Comment

2011	Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DPT3 visit	100% replacement breastfeeding	All newborn born from HIV positive mothers are provided replacement breastfeeding by Global Fund for 6 month.

Indicator# 3.13		Comment:
2011	Pregnant Women Who Inject Drugs	N/A	No IDU Pregnant Women has been registered in Georgia in 2011

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

Indicator# 4.1b		All	Male	Females	<15	15+	MSM	IDUs	Migrants	Prison	Comment
2011	Percentage of people diagnosed with HIV infection who need antiretroviral therapy and who receive it	97.6%	97.76%	97.1%	100%	97%	100%	98%	100%	100%	Denominator A is calculated for CD4 <200, which was eligibility criteria in 2011 in Georgia.

Indicator# 4.2		All	Males	Females	<25	25+	Comment
2011	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	78.81%	76.33%	85.07%	70%	79.20%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System.

Indicator# 4.2a		All	Males	Females	<25	25+	Comment
2011	Percentage of IDU with HIV known to be on treatment 12 months after initiating antiretroviral therapy	75.19%	75.59%	50.00%	0%	75.19%	HIV/AIDS National Surveillance Data

Indicator# 4.2c			Comment
2011	Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiating antiretroviral therapy (from 2006)	63%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.

Indicator# 4.2d			Comment
2011	Percentage of IDU with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (from 2006)	57%	HIV/AIDS National Surveillance Data

Indicator# 4.4			Comment
2011	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, AIDS Health Information System.

Indicator# 4.5	All	Males	females	<25	25+	MSM	IDUs	Migr.	CSW	Pris.

2011	Percentage of people with HIV infection who already need antiretroviral therapy at the time of diagnosis	45.52%	47.00%	41.94%	50%	45.45%	24.00%	49.21%	50.00%	0.00%	56.25%

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
2011	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	113%	N/A	N/A	N/A	N/A	2011 Antiretroviral Patient Registers from and Estimates from WHO Stop TB database 2010 (Estimated denominator disaggregated by sex and age is not available in Stop TB database)

	Indicator# 5.3	Number	%	Comment
2011	Number and percentage of adults and children newly enrolled in HIV care who start on treatment for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period	64	15.76%	Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System

	Indicator# 5.4	Number	%	Comment
2011	Number and percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care in the reporting period	387	100%	Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System

Target 7. Critical enablers and synergies with development sectors

	Indicator# 7.2	Females All	F 15-19	F 20-24	F 25-49	Comments:
2011	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)

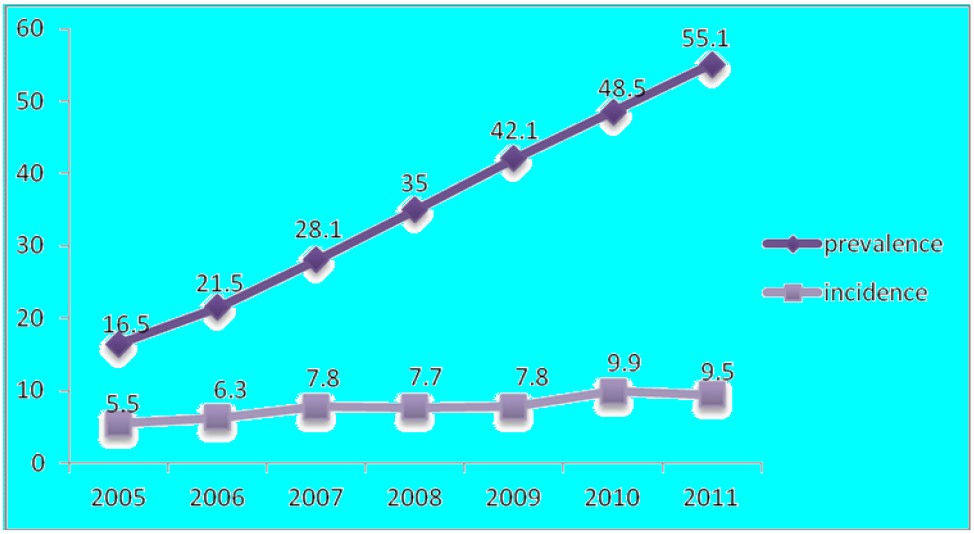
	Indicator# 7.6	Number:	Comment
2011	Number of adults and children with HIV enrolled in HIV care	1852	HIV/AIDS National Surveillance Data

	Indicator# 7.7		Comment
2011	Percentage of adults and children enrolled in HIV care who were screened for hepatitis C	100%	Based on national guidelines all cases enrolled in HIV care were tested on hepatitis

II. Overview of the AIDS epidemic

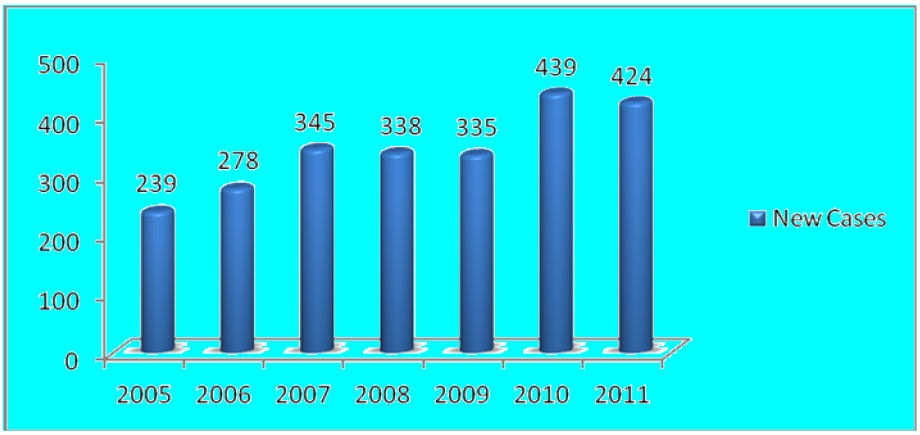
Despite low HIV prevalence (see Figure 1.), Georgia is considered to be at high risk for an expanding epidemic due to widespread injecting drug use and population movement between Georgia and neighboring high-prevalence countries such as Ukraine and Russian Federation.

Figure 1. HIV/AIDS prevalence and incidence rates 2005-2011 (per 100 000)



As of December 31, 2011, there were 3033 cases of HIV infection registered in the country. The first case of HIV was detected in 1989. Thereafter the number of annually detected cases has been small. Annual number of detected cases grew from around hundred during 2000-2003 to over 250 since 2006. (Figure 2.)

Figure 2. New HIV/AIDS Cases by Years



The epidemiological distribution of disease by gender and age indicates more cases among 25-40 years of age. 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 years group. 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 at 30%. This shift would be explained by the spread of HIV among sexual partners of IDUs.

Available evidence (National Surveillance Database) reveals that those older than 25 years show the highest prevalence of HIV infection (See Figure 3, 4), having almost three times the prevalence of females among males. Notably, among those under 25, there is almost no gender difference reflected.

By the end of 2011, the number of officially registered HIV infected children under 15 reached 73, with 12 new cases registered in 2010 and 6 diagnosed in 2011.

Figure 3. Rate of newly identified cases of HIV infection by gender and age groups 2010 (per 100, 000 population)

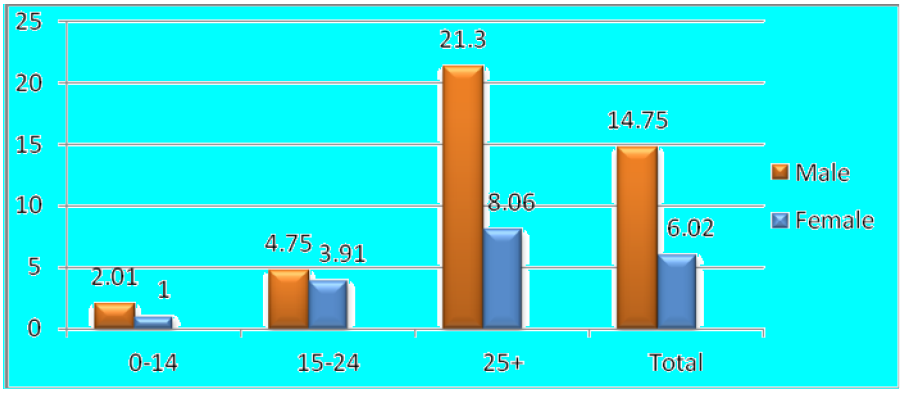
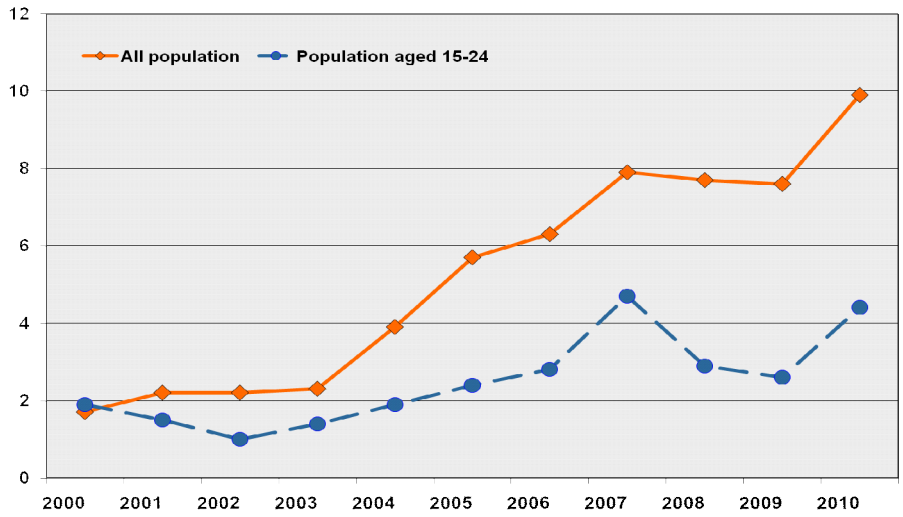


Figure 4. Incidence of HIV/AIDS per 100000 populations, Georgia



Geographically, HIV cases are spread unevenly across regions of Georgia. Over a third of people living with HIV reside in the capital (Tbilisi) with another 31% in the Black Sea Coastal regions of Adjara and Samegrelo. The highest prevalence rates in 2010 were found in Tbilisi, Samegrelo, and Adjara, respectively having 14.14, 13.50 and 9.05 cases per 100,000 populations.[1]

It is acknowledged that women attending antenatal clinics (ANC) generally provide the best available estimates of HIV prevalence in the general population as a proxy-indicator. This number is ascertained

[1] NCDCPH Statistics Yearbook

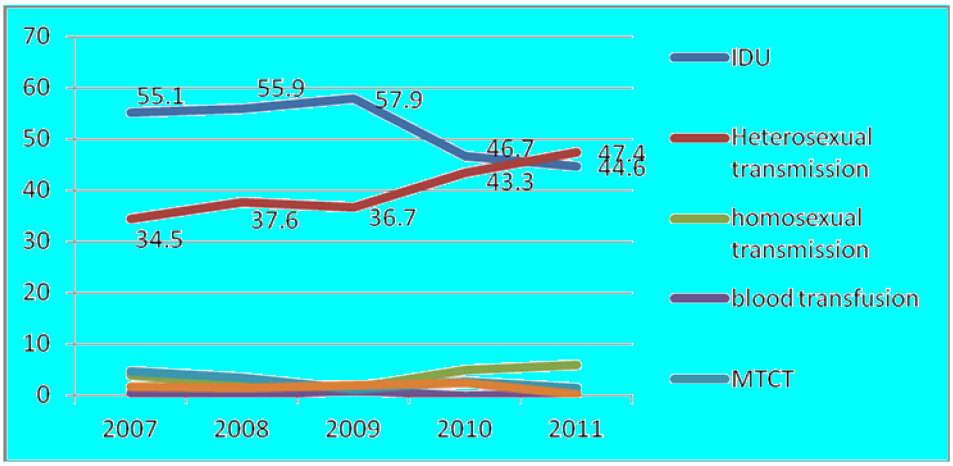
from routine surveillance. According to the surveillance data (NCDCPH, 2010) the vast majority of pregnant women attending ANCs were tested for HIV under the PMTCT program.

In 2010, 45 246 pregnant women underwent HIV testing, and among them 17 HIV+ cases were found. 6 were <25 years of age and 11 were ≥ 25. Further in 2011, 45 819 pregnant women underwent HIV testing and 15 incident cases were found with a respective distribution of 5 and 10 cases.

In 2010, HIV testing coverage among pregnant women was 82.1% and the prevalence of infection was 0.04%. In 2011, coverage was 82.3% and the prevalence at 0.03%. The validity of the magnitude of coverage in 2010 has been independently substantiated by the results from the 2010 The Women's Reproductive Health Survey. The survey also reported a high rate of antenatal care coverage approximating at 98%. [2]

In early years of the HIV epidemic in Georgia, as in most Eastern European countries, injected drug use was the major transmission mode. Since 2009, transmission has shifted toward heterosexual mode (See Figure 5) becoming dominant by 2011. In 2010, injected drug use represented 46.7% of transmission, while heterosexual activity represented 43.3%. By 2011, injected drug use represented only 44.6 %, while heterosexual activity accounted for 47.4%. It should be noticed, in the recent report, the above mentioned tendency (shown on Fig.5) is based just on distribution of new cases.

Figure 5. Percent Mode of HIV Transmission by Year

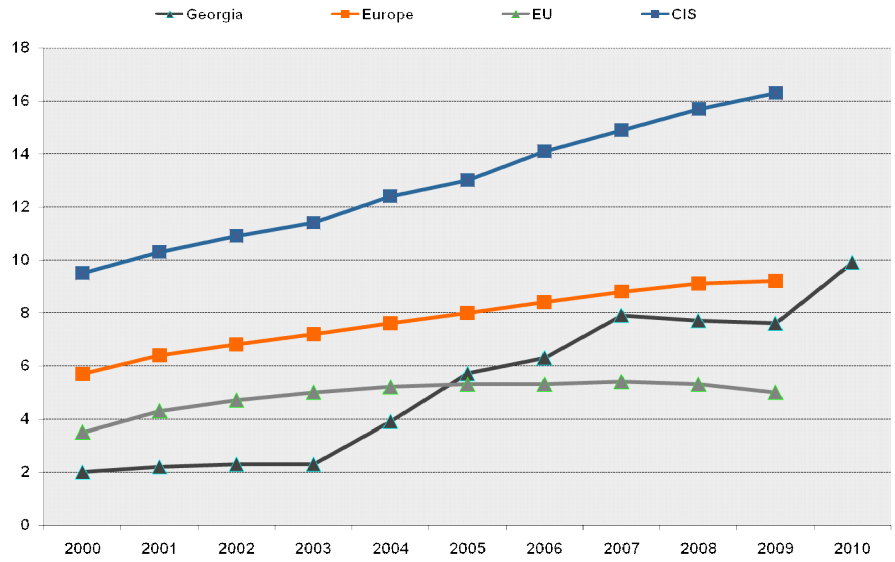


Source: National Surveillance Database, 2011

[2] NCDCPH Statistics Yearbook

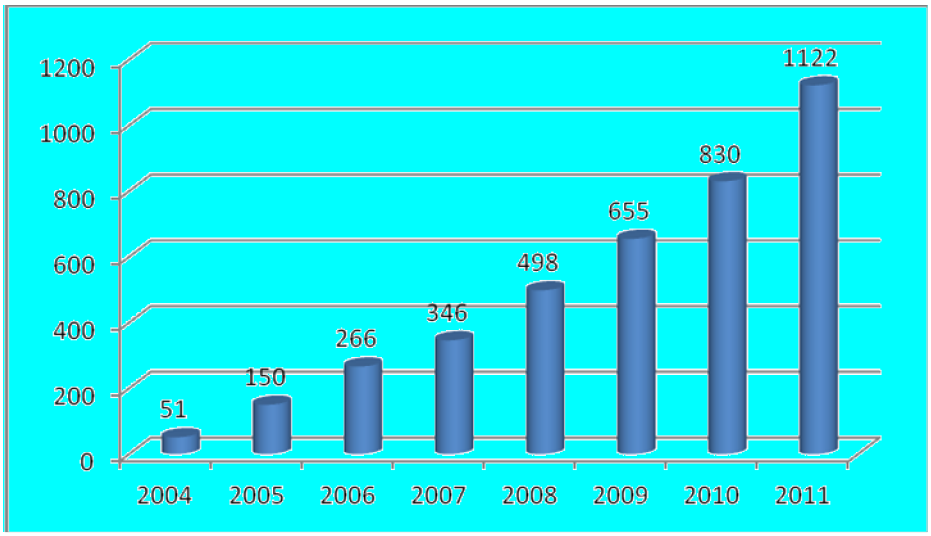
Graphical comparison of HIV incidence by year in Georgia, CIS countries and European Union are shown in Figure 6.

Figure 6. Dynamics of incidence of HIV (per 100000 populations), Georgia, the European Region, the EU, the CIS



In recent years the number of patients receiving antiretroviral therapy has grown. Between 2004-2011, the number of patients receiving antiretroviral therapy grew 22-times (see Figure 7).

Figure 7. Number of people receiving antiretroviral therapy in Georgia



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III. National Response to the AIDS Epidemic

HIV/AIDS prevention and control interventions in Georgia have been mainstreamed into several State programs: the HIV/AIDS Prevention and Treatment Program, the Safe Blood program, and the Prevention of Mother to Child Transmission (PMTCT) program.

The main purpose of the State program on HIV/AIDS prevention is early detection of HIV/AIDS new cases 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, blood donors, pregnant women, MSM, and FSWs.

State program on HIV/AIDS treatment covers outpatient and inpatient services, and 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.

The new HIV/AIDS surveillance system was introduced countrywide in January 2010.Within the framework of the GF project, CIF developed an HIV surveillance electronic database. The newly designed routine surveillance system now collects electronic case-based data on every tested individual by epidemiologic group. The data supports and the software program automatically produces different types of analytical reports.

VCT centers in prisons have also been established under the GF supported project. Sixteen VCT service centers have become operational in Georgia, with approximately 5600 receiving HIV counseling and testing in prisons.

The HIV/AIDS monitoring and evaluation framework for Georgia aims to guide informed decision making on HIV interventions by providing reliable information on progress towards achieving predefined targets and objectives, and in determining what interventions yield desired outcomes. It enables the tracking of progress in the national response to HIV/AIDS and enhances informed and sound decision making and policy for multi-sector and decentralized HIV/ AIDS interventions.

Palliative care has been recognized as an essential component of a comprehensive package of care for PLWHIV. Since 2008 palliative care services continue to operate 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 spiritual problems.

IV. Best Practices

International experts regard the Georgian model of HIV/AIDS treatment and care 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. HIV/AIDS treatment and care program is implemented by the Infectious Diseases, AIDS and Clinical Immunology Research Center (National AIDS Center), which along with three affiliated regional facilities provides free medical services through national program and the GF supported projects. Remarkably, TGF support was critical in scaling-up ART in the country and since 2004 Georgia remains the only former Soviet Union (FSU) country to achieve almost universal access to ART.

Based on guiding principles of accessibility, quality of care and equity of access, the National AIDS Center, back in 2004, developed comprehensive approach for provision of treatment and care services that determined the success of the program. Effective selection algorithm, which includes 4-monthly clinical and laboratory monitoring of all registered patients, ensures that all patients in need of treatment are timely started on ART. The algorithm has been a key for maintaining universal access over the last 7 years with 98% of eligible patients receiving lifesaving therapy in 2011. As per the Georgian National guidelines, the standard of ART monitoring relies upon laboratory monitoring of CD4 count, HIV-1 viral load, and development of resistance based on a resistance-genotype detection when indicated.

Special attention is paid to adherence as an important determinant of treatment success. A program to promote and maintain antiretroviral adherence has been developed that includes patient education, adherence monitoring and counseling. Since 2008 home-based adherence support and monitoring program started countrywide through operation of mobile units.

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.

Strong collaboration and alignment exist between HIV and tuberculosis (TB) services. Development of a national strategy on HIV/TB in 2007 resulted in a scaling-up collaborative activities, including the establishment of a HIV/TB working group, screening for TB and HIV, and provision of free medical services. In recent years additional important steps have been made for intensifying TB case finding among people living with HIV, including implementation of modern laboratory methods for detecting active and latent forms of TB. Currently all patients with dual HIV/TB infection receive free care, including treatment for both diseases.

Georgia is advancing towards eliminating vertical transmission of HIV by ensuring universal access to services for the prevention of mother-to-child transmission (PMTCT) of HIV. These services include HIV testing and prophylactic ART for HIV positive mothers and their newborns. Since 2005 there have been no cases of vertical transmission among women enrolled in PMTCT program.

During the reporting period special attention was paid to ART adherence as it is an important determinant of treatment success and outcomes. Assessment of adherence has been specifically addressed in the National HIV/AIDS Treatment and Care Guidelines.

Sustaining universal access to ART continues to be the major success of the country. Georgia's success in realizing the principle of equity of access is especially commendable. While reluctance to prescribe ART to IDUs because of concerns about compliance is still common practice in many parts of the world, Georgia's HIV/AIDS treatment and care program has been able to fully engage IDUs in medical services, who are majority among those receiving ART in Georgia. ART program analysis has demonstrated equally effective treatment regardless of history of drug abuse, and challenges the prevalent misconception that IDUs are less likely to benefit from therapy.

In 2010-2011 important steps were made towards implementing a new ART initiation criteria according to 2010 WHO recommendation. Under the leadership of CCM, and joint efforts of Principal Recipient (PR) for TGF grants and National AIDS Center, existing TGF projects were reprogrammed to accommodate additional treatment need. New treatment eligibility criteria will be fully implemented in 2012.

Two important initiatives were started in 2011. The first initiative, directly linked to the ART program, is the implementation of a HIV drug resistance (HIVDR) strategy. The strategy aims to support ART program in terms of preventing emergence and transmission of HIVDR. The second initiative addresses the burden of HIV/HCV co-infection. A study conducted by the National AIDS Center identified high prevalence of HCV infection and resulting morbidity and morbidity among people living with HIV in Georgia. The study served as basis for an application to TGF which succeeded in securing funds for treating hepatitis C among dually infected patients. This program started enrolling patients in 2011.

2011 also marked the launch of a web-based AIDS health information system (AHIS). Developed by the National AIDS Center, AHIS networks all HIV/AIDS clinical facilities countrywide and has been regarded as exemplary for other fields of healthcare. AHIS captures epidemiological, clinical and laboratory data on all patients registered since the start of the epidemic. Its implementation represents an important advancement for individual patient management, as well as program monitoring and planning, and importantly, AHIS generates important data for national HIV M&E system.

V. Major Challenges and Remedial Actions

An important challenge that treatment and care services currently face is the early loss of patients due to late HIV diagnosis. A five year assessment of ART program outcomes showed that advanced immunodeficiency at the time of HIV diagnosis was the major cause of death (Tserstavdze et al., AIDS Res Treat. 2011). As shown in this report, a significant proportion of newly diagnosed HIV patients enter healthcare late in the course of their chronic HIV infection, and this situation has remained stationary over the last several years. The two major reasons underlying this problem are the low HIV testing uptake among key populations, and missed opportunities to diagnose HIV earlier in healthcare setting as identified by operational research conducted by the National AIDS Center. Consequently two strategic approaches were outlined to improve earlier diagnosis:

- To increase coverage with HIV testing and counseling among MARPs, especially among IDUs
- To implement HIV indicator disease guided testing and counseling in healthcare system particularly focusing on primary healthcare

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. 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 compatible with 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.

UN Joint Team is actively engaged and closely working with the CCM of Georgia and broader community of the national and internationals stakeholders of HIV response to achieve **enabling legal environment** in the country. In 2009 the new progressive legislation on HIV ad AIDS was developed in close collaboration between the GF supported HIV Programme and the UN Theme Group on HIV and AIDS and endorsed by the Parliament. The new progressive drug legislation projects have been developed in close collaboration with UN agencies and more specifically EU supported UNDP SCAD (South Caucasus Anti Drug) programme, by 2009, and submitted to and discussed within the Parliament of Georgia. Though, despite International Agencies' bold advocacy for improving narcotic drugs policy and laws in Georgia, regrettably, adequate steps to decriminalize drug use and enable effective HIV prevention among people who inject narcotic drugs yet to be made.

Reducing legal and regulatory barriers for drug users and prisoners through supporting multisectoral work on legal and regulatory issues and elaborating policies aimed at eliminating legal barriers to effective HIV/AIDS interventions among IDUs and prisoners' is one of the objectives articulated through the NSPA (National HIV Strategic Plan of Action) 2011-16.

In 2011, GHPP assisted the Parliamentary Committee on Health and Social Affairs to assess the national drug policy and existing legal framework within the context of international drug policy and UN conventions. GHPP developed a report, Mapping the Future: Options for the Drug Policy in Georgia, which reviews the national drug policy and provides a set of policy recommendations, including a roadmap for implementing drug policy reforms in Georgia.

Notably, recent statistics by the Georgian Government are suggesting that significant achievements in fighting crime including drug trafficking have been demonstrated. In this light, establishing the new Interagency Drug Council (The President of Georgia decision by Nov 2011) could be reflecting a will for creating adequate momentum and environment towards future improvements, in close collaboration with the CCM of Georgia.

VI. Support from the Country's Development Partners

U.S. Agency for International Development (USAID)

U.S. Agency for International Development (USAID) has been making significant contributions in the effort to control HIV/AIDS in Georgia. In February 2010, USAID initiated a new 5-year project titled the "Georgia HIV Prevention Project" (GHPP). The goal of the project is to support HIV prevention among high-risk groups in order to avert the spread of HIV to the general population.
GHPP awarded RTI International and its subcontracting partners, Save the Children, and Program for Appropriate Technologies in Health (PATH), to work with a number of local nongovernmental organizations (NGOs) to develop and implement HIV prevention activities for most-at-risk populations (MARPs). GHPP develops and implements HIV prevention activities for most-at-risk populations, specifically injecting drug users and their partners, men who have sex with men, female sex workers, and at-risk youth. The project works at the individual, community, societal, and policy levels to reduce HIV-related stigma and discrimination in Georgia. Activities in 2010-2011 were implemented in six major cities of Georgia.

For all risk groups, GHPP works through local NGOs to increase prevention and voluntary counseling

and testing (VCT) efforts offered through drop-in centers and mobile labs. The introduction of the hepatitis B and C rapid testing into prevention outreach has resulted in an increase in the uptake of HIV counseling and testing. In 2010-2011, more than 4,000 representatives of MARPs have been tested for HIV and received their results.

In collaboration with BPU, GHPP developed and piloted a community-level intervention (CLI) to target injecting drug users and engage their social network and community members to support sustained behavior changes. Based on the results of the 2010-2011 CLI pilot intervention in Telavi, the CLI model is now being scaled up in other GHPP supported sites to increase the coverage of prevention interventions for injecting drug users.

As a part of its youth-focused component, 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. Currently steps have been taken to institutionalize the use of the HLC in all secondary schools nationwide.

In March-June, 2011, GHPP conducted the first Behavioral Surveillance Survey in Georgia among school and university students in Tbilisi. The survey has generated reliable data about the HIV/AIDS related knowledge, attitudes and behaviors of youth (15-24 year olds) in the capital city. Survey findings will inform national policy development.

UNAIDS

Since 1999, the United Nations (UN) Theme Group on HIV/AIDS has played a crucial role in providing financial and technical assistance to expand the national response to AIDS in Georgia. Over the last two years, the UNAIDS's contribution has became very visible and well acknowledged. With a support from the Joint United Nations Program on HIV/AIDS (UNAIDS), a new National Strategic Plan of Action - NSPA 2011-16 was developed through broadly inclusive and interactive process and approved by the CCM in August 2010. The NSPA 2011-16 is aligned with and based on UNAIDS Outcome Framework (2009-11). It provides ample space for realizing the new global strategy of "Getting to Zero" and achieving 2011 HLM on HIV targets, as well as new political declaration commitments in Georgia by 2015. It has the following 5 main Strategic Areas 1) coordination and advocacy, (2) prevention (3) treatment (4) care and support and (5) health systems strengthening. Remarkably, the new National Health Care Strategy 2011-2015 supported the main goal of the HIV NSPA.
In 2010-11 the one National HIV M&E System and Framework was developed through UNAIDS supported participatory national process and endorsed by the CCM of Georgia in June 2011. This allowed maximum harmonization of the new national instrument of accountability with well-practiced international HIV monitoring and reporting tools.

The Global Fund to Fight AIDS, Malaria and Tuberculosis

Since 2004, funds mobilized through The Global Fund (TGF) have been critical for scaling up the National Response to HIV/AIDS in Georgia. The country consolidated 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 interventions in Georgia" started on January 1, 2010. This project ensures sustainability and expands where feasible, effective HIV/AIDS prevention, treatment, care and support interventions initiated through Round 2 and Round 6 projects in Georgia, as well as newly submitted Round 9 projects aiming at treatment of opportunistic infections and implementation of HIV drug resistance strategy in Georgia. Consolidated proposals led to allocation of 24 million EUR (EUR 24,209,417.00, Board approved amount), from the TGF for Phase 1 (Jan 2010 – 31 Dec 2012).

The Global Fund provides substantial support to all major strategic priorities and places the main emphasis on:

- Establishment of supportive environment for the implementation of HIV/AIDS Prevention, treatment, care and support interventions;
- Further increase of coverage and quality of preventive interventions targeted at MARPs – IDUs;
- Improving coverage with agonist treatment (MST) and psycho-social support for IDUs in civil sector and prisons;
- Sustaining and scaling up HIV/AIDS and STI Prevention Programs for MARPs – FSWs, MSM and prisoners;
- Development of quality management system for Safe Blood Service;
- Improving Survival Rates and quality of life of PLHIV, including sustainability of HIV treatment and Prevention of Mother to Child HIV transmission;
- Care and Support of PLHIV, including palliative care;
- Development and implementation of national strategy on HIV drug resistance (HIVDR) prevention and assessment;
- Improving management of opportunistic infections and co-infections;
- Generate evidence base on progress in behavior modification among MARPs and effectiveness of preventive interventions, to inform policies and practice;
- Minimize the impact of stigma and discrimination on the access to HIV interventions for IDUs in healthcare settings.

Curatio International Foundation

Curatio International Foundation (CIF) is a Georgian non-governmental, not-for-profit organization, established in 1994 with mandate to support health and social system reforms in countries with transition economies. Since establishment CIF has implemented more than 120 programs and research projects in 18 countries. CIF works in HIV/AIDS since 2004.

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

The first component implied the following activities: a) Assessment of current HIV/AIDS Surveillance

system, b) Development of the National HIV/AIDS Surveillance Plan b) Development of HIV/AIDS Surveillance guidelines/protocols (including standard case definition, registration, notification, reporting, and investigation forms), c) Trainings of the personnel working in institutions/ facilities involved in HIV/AIDS surveillance d) development of software application for processing and analysis of case-based data for HIV/AIDS at the regional and central level.

The second component of the project foresaw elaboration of the sentinel HIV/AIDS Surveillance guidelines including registration, notification, reporting forms and standard operation procedures. Collection of data through sentinel surveillance provides evidence-grounded HIV/AIDS statistics to strengthen HIV/AIDS surveillance in Georgia.

The third component focused on the development of standardized guidelines for second generation surveillance, including standardized methodology, tools, and carrying out Behavior Surveillance Survey with biomarker components among the IDUs, CSWs, and Prisoners. Under this component during 2008-2010 ten BSSs were implemented with partner organizations in different geographical locations.

World Health Organisation

A significant contribution was made by the World Health Organization Country Office in Georgia in regards to capacity building. With support of WHO, the following activities have been carried out in 2009-2011:

- Annual national workshops on HIV/AIDS clinical management facilitated by leading European experts;
- Out-of-country trainings of Georgian specialists;
- Updated National guidelines contributing to the provision of quality treatment and care.
- Research on late detection if HIV

World Vision Georgia

It is well known that immigration and mobility of populations is an important factor in the transmission of HIV in Southern Caucasus Countries (Georgia, Armenia and Azerbaijan). There have been joint-efforts between WV across sub-regions to respond to this humanitarian crisis. In 2007-2011 World Vision Georgia Armenia and Azerbaijan implemented the project ‘’Mobility Exacerbated HIV Prevention and Impact Mitigation” The project was aimed at raising awareness about HIV and AIDS and reducing the risk of transmission of HIV and other STIs among mobile populations by 1) increasing knowledge about the transmission of HIV/AIDS and STIs; and 2) increasing the use of preventive measures through partnership with Civil Society Actors.

Based on subsequent evaluation and lessons learned from the results of the project, WV Georgia started a new 3 years Project –“Cross Border Join Advocacy for HIV Prevention Project”. The new

project aims to decrease vulnerability of migrants to HIV/STIs and strengthen human rights. The project fosters advocacy for victims of gender and family violation through joint Civil Society Actors/Governmental Organizations advocacy efforts. The project intends to reduce migrants' socio-cultural vulnerability, increase access to improved and sustainable prevention, care and support services in home and destination country.

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

Centre for Information and Counselling on Reproductive Health – Tanadgoma

The main goal of association is to improve the physical and mental health of Georgian population. At the moment Tanadgoma has branches - information/counselling centres in three regions- in Batumi, Zugdidi and Kutaisi.

Since 2009 Tanadgoma was involved in service provision to key populations - FSWs, MSM, IDUs, prison inmates in 4 cities of Georgia -Individual counseling through hotlines and face to face visits, outreach, Voluntary Counselling and Testing on HIV at the Tanadgoma's centers as well as through mobile laboratories, STI testing and treatment at the "Healthy Cabinets" operating under the GFATM-funded program, Peer Education and condom and materials provision.

Since 2009, a BioBSS among MSM has been conducted in Tbilisi, involving 278 representatives of this population. Besides, in combination with BioBSS, a size estimation of this group was carried out.

The main donors in the field of HIV/AIDS for Tanadgoma are USAID/RTI, GFATM, to some extent (not services but advocacy-related) - amfAR (2011), RFSU/SIDA (sexuality education), UNFPA (training on HIV to all UN staff).

Maternal and Child Care Union

Non-Governmental organization ''Maternal and Child Care Union'' (MCCU) is functioning since 2000. The activities of MCCU are related with prevention, counseling and education of different infectious diseases, including HIV/infection. The main target groups are women of childbearing age and their partners, children and youth.
MCCU has performed different projects in the field of HIV/AIDS:

- "Prevention of mother-to-child HIV transmission in Georgia", funded by Elizabeth Glaser Pediatric AIDS Foundation. The goal of the project was development and implementation of HIV voluntary counseling and testing services for pregnant women and prevention of mother-to-child HIV transmission. About 400 healthcare workers (obstetricians/gynecologists and pediatricians) were

trained on HIV infection. For training purpose the manual “HIV/AIDS” was written and published by MCCU. Voluntary HIV counseling and testing services were implemented in all prenatal care centers in Tbilisi, capital of Georgia. More than 30,000 pregnant women were counseled and tested on HIV infection and prophylactic antiretroviral treatment was administered to HIV positive mothers and their infants.

- “HIV information for expecting and breastfeeding mothers” in partnership with World Vision. The objective of the project was to increase HIV awareness among socially disadvantaged young women. Through the project social workers and health care workers of maternity hospitals were trained on HIV infection and on HIV pretest and posttest counseling. Two HIV manuals (for social workers and for health care workers) and different educational materials for young women were developed, printed and distributed. Trained social workers were conducting HIV counseling for young mothers and evaluation of counseling effectiveness using pre- and post counseling surveys.
- “Prevalence and awareness of blood borne infections among Georgian Health Care Workers”, funded by Fogarty International Center (NIH) and NATO Science for Peace and Security program. Within the project 1480 HCWs were surveyed (KAP survey) on HIV and hepatitis and blood tests were done to estimate the prevalence of blood borne infections.

In 2011 MCCU carried out the project “Peer education on healthy lifestyle issues, including HIV/AIDS” among youth at universities, vocational training centers, secondary schools and among juveniles in conflict with law. The project was performed in a partnership with Research Triangle Institute International (RTI) which is implementing USAID funded Georgia HIV Prevention Program. Within the project more than 1000 persons were educated on HIV/AIDS in Tbilisi and different regions of Georgia.

Since 2007 till present MCCU is conducting the project "The public health impact of couple oriented HIV prenatal counseling and testing in low HIV prevalence countries" funded by ANRS (French National Agency on AIDS Research) in partnership with University of Bordeaux. The objective of the project is to provide couple oriented HIV prenatal counseling to young pregnant women and evaluate the changes of attitudes and behavior related to HIV/AIDS, sexual and reproductive health. This is a multi-center multi-country intervention trial within four urban areas where HIV prevalence is below 10% and where PMTCT services are available: Yaounde (Cameroon), Prune (India), Santo Domingo (Dominican Republic) and Tbilisi (Georgia). Within this intervention trial women attending antenatal care clinics are individually randomized to receive either standard post-test HIV is counseling or couple-oriented post-test HIV counseling. The impact of the couple-oriented posttest HIV counseling session on the incidence of partner HIV counseling and testing, couple HIV counseling and on attitudes and behaviors related to HIV/AIDS and the prevention of sexual transmission of HIV is assessed.

There are many other international organizations and donors that must receive acknowledgment for their valuable contribution to the development and implementation of wide-range HIV prevention, treatment and research activities in the country. The list includes the European Union, European Commission, Vishnevskaya-Rostropovich Foundation (VRF),Open Society Georgia Foundation (OSGF), etc.

VII. Monitoring and Evaluation Environment

In 2010, UNAIDS established the National Experts Group to work on elaboration of National Monitoring and Evaluation System in the country. Significant progress has been made since the last UNGASS reporting period in terms of development of a National HIV/AIDS Monitoring and Evaluation System.

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 M&E framework document incorporated stakeholder feedback and was submitted to the CCM for endorsement in March 2011.

The following reasons justify the necessity of having one agreed National HIV/AIDS M&E Framework:

1. It provides opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV/AIDS;
2. It assists in responding to the international commitments and reporting requirements;
3. It 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 document outlines an HIV/AIDS monitoring and evaluation (M&E) system for Georgia. It 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).

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.

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.

Overall such information is useful to understand the scale and outcome of implementation and can be used to secure continued funding for the expansion of HIV/AIDS programs.

The role of NCDCPH in monitoring and evaluating HIV national response is twofold:

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 will 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 will fulfill 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 will serve as a common platform at the country level for storage of M&E documents and publications.

Quality Control Functions:

- Control quality of the information flow and provide digitalization of data
- Identify needs for modifying data collection forms and any changes in data flows, and prepare recommendations for improvement
- Oversight timeliness and quality of data obtained from entities participating in HIV/AIDS surveillance
- Identify shortcomings of the surveillance system and submit recommendations for improvement
- Prepare terms of reference and procure necessary services for updating HIV surveillance methodology as required.

In order to implement the system, initial steps have been taken regarding the establishment of the M&E unit at the NCDCPH. The newly assigned M&E Coordinator has started to fulfill the roles and responsibilities according to the National M&E work plan. Decisions regarding the creation of the Working Group on M&E issues, comprised by the experts from governmental and nongovernmental organizations has been made.

Despite great progress, we all need to challenge ourselves to do better,
to do more, to be creative and innovative in reaching the ambitious targets set forth!

Annex 1.

Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 declaration of Commitments on HIV/AIDS

In accordance with recommendations from the Guideline on Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS, this Country Progress Report was developed over the course of several national consultation meetings (initial Global Progress Report Introductory Workshop in November 2011, midterm Country Progress Report Workshop in February, and the Report Validation Workshop in March 2012), 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 and the draft Country Progress Report were presented, discussed and validated at the broad inclusive meetings involving 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 on the part of National Center for Disease Control and Public Health (NCDCPH) and Country Coordinating Mechanism (CCM), in close collaboration with UNAIDS Country Office. The NCDCPH directly facilitated all consultations and relevant data collection endeavors.

NCPI also was developed through participatory meetings of Government and non-state actors separately. After developing a first draft of the NCPI, it was shared with the wider audience allowing all stakeholders to comment on the draft. All the comments were discussed and incorporated into the final report. NCDCPH presented the final draft document at the concluding National Consultation Meeting attended by a broad forum of stakeholders on 30 March, 2012.

Annex 2.

National Commitments and Policy Instrument (NCPI) 2012

Data for the **N**ational Commitments and Policy Instrument (NCPI) have been collected by administering NCPI questionnaire in accordance with recommendations from the Guideline on Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS. The questionnaires have been translated into Georgian and distributed among all key stakeholders. The Part (A) of the questionnaire has been completed by the Government officials, and Part (B) by the Civil Society Organizations, Bilateral Donors and UN Agencies.

Technical coordinators for each part have reviewed completed questionnaires and consolidated the data. The preliminary results were discussed at the National consultation meeting organized by the NCDCPH on March 27, 2012.

Two separate meetings have been held for Government officials and Civil Society Organizations, Bilateral Donors and UN Agencies.

The following organizations participated in the NCPI :

I. Government (Part A)

1. Country Coordinating Mechanism
2. The Ministry of Labor, Health and Social Affairs
3. Penitentiary System
4. Ministry of Justice
5. Ministry of Education and Science
6. National Center for Disease Control and Public Health
7. Infectious Diseases, AIDS and Clinical Immunology Research Center
8. Research Institute on Drug Addiction
9. National Center for TB and Lung Diseases

II. NGOs, donors and international organizations: (NCPI Part B)

1. Association " Tanadgoma"
2. Curatio International Foundation
3. World Vision Georgia
4. Unicef
5. UNAIDS
6. UNFPA
7. Public Union "Bemoni"
8. World Bank
9. USAID
10. The Global Fund
11. Harm Reduction Network

12. USAID Georgia HIV prevention project
13. WHO Country Office

In order to obtain the necessary information, the key people were interviewed about the specific topics.

Based on completed questionnaires, interviews and consensus reached during the consultation meetings, the NCPI responses were finalized and presented at the final workshop held on March 30, 2012 for validation and approval.

The final NCPI data were submitted using the dedicated software provided on the Global AIDS Progress reporting website (www.unaids.org/AIDSReporting) and attached the Global Country Progress Report.