HIV Programme Review in Georgia

March 2015

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Centre for Health & Infectious Disease Research

WHO Collaborating Centre on HIV and Viral Hepatitis

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Abstract

This WHO country mission conducted in March 2015 aimed to review three key components of the HIV/AIDS programme in Georgia: HIV treatment and care along the cascade of services; HIV services for key populations; and service delivery models for populations affected by the HIV epidemic from the perspective of the health system as well as review the draft new National Strategic Plan. This technical assistance was provided ahead of the submission of the Global Fund concept note, due on 20 April 2015. It follows a June 2014 WHO country mission carried out to assess the achievements, strengths and shortcomings in the implementation of the Georgian National HIV/AIDS Strategic Plan.

Georgia has a concentrated HIV epidemic but is facing serious challenges in controlling it. In 2013, of the newly diagnosed HIV infections with information about transmission mode, 37% were transmitted through heterosexual contact, 29% through injecting drug use and 14% through sex between men. At the end of 2014, the number of people living with HIV in Georgia was estimated to be 6,800, and some 45% of these people were not aware of their status.

The recommendations from the mission are presented as four priority areas: HIV testing, treatment, leadership and governance, services for key populations as well as suggestions for the revision of the National Strategic Plan.

Keywords

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Table of Contents

Abbreviations

Executive Summary 1

1. **Introduction** 5

1.1 Country epidemic 5

1.2 Continuum of care 6

1.3 The health system and its financing 6

1.4 The previous WHO mission, June 2014 7

2. **Purpose and Objectives** 7

2.1 Methods 9

3. **Findings** 9

3.1 Strengths and achievements 9

3.2. Weaknesses and challenges 12

Priority Area 1: Optimizing HIV testing 12

Priority Area 2: Optimize HIV Treatment 13

Priority area 3. Ensure leadership and governance at the highest level 14

Priority area 4. Ensure services for key populations 15

4. **Cross-cutting issues** 16

Human rights and legislation 16

5. **National Strategic Plan feedback** 17

6. **Recommendations** 18

Priority Area 1: Optimizing HIV Testing 18

Priority Area 2: Optimize HIV Treatment 19

Priority Area 3: Ensure leadership and governance at the highest level 20

Priority Area 4: Ensure services for key populations 21

7. **References** 22

8. **Annex: Mission Agenda** 23

Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CD4	T–lymphocyte cell bearing CD4 receptor
HBV	Hepatitis B virus
HCV	Hepatitis C virus
GHRN	Georgian Harm Reduction Network
MoLHSA	Ministry of Labour, Health and Social Affairs
NAC	National AIDS Centre
NTP	National Tuberculosis Programme
NCDC	National Center for Disease Control
NCTLD	National Centre for Tuberculosis and Lung Diseases
MSM	men who have sex with men
NSP	National Strategic Plan
OST	opioid substitution therapy
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PWID	people who inject drugs
TB	tuberculosis
WHO	World Health Organization
STI	sexually transmitted infections
SW	sex workers

Executive Summary

This WHO country mission conducted in March 2015 aimed to review three key components of the HIV/AIDS programme in Georgia: HIV treatment and care along the cascade of services; HIV services for key populations; and service delivery models for populations affected by the HIV epidemic from the perspective of the health system as well as review the draft new National Strategic Plan. This technical assistance was provided ahead of the submission of the Global Fund concept note, due on 20 April 2015. It follows a June 2014 WHO country mission carried out to assess the achievements, strengths and shortcomings in the implementation of the Georgian National HIV/AIDS Strategic Plan.

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The recommendations from the mission are presented as four priority areas: HIV testing, treatment, leadership and governance, services for key populations as well as suggestions for the revision of the National Strategic Plan, at the end of this report.

Recommendations

Priority Area 1: Optimizing HIV testing

Main recommendation: Increase HIV diagnosis and enrolment into care of key populations

Specific recommendations:

- Develop more effective strategies for identifying the undiagnosed population (estimated at 50% of those living with HIV) and decreasing the proportion of late testers. This includes strengthening data collection on reasons for testing and risk factors in order to evaluate the coverage of key populations, including people who inject drugs (PWID), men who have sex with men (MSM) and male and female sex workers (SW), and changes over time. Further, care pathways should be carefully organized to ensure linkage to care for these populations when tested in community settings.
- Ensure that all patients presenting with tuberculosis (TB) at TB clinics and all patients of STI clinics are offered an HIV test. Make it a universal offer, never obligatory. People with clinical or lab markers of viral hepatitis should be routinely offered an HIV test.
- Continue and increase targeted testing – with clear targets set in the new National Strategic Plan of at least 50% of key populations by 2017 (cumulative) – through community testing using friendly non-judging mobile teams and peer outreach workers; introduce even more rapid tests and develop targets for their use in the NSP.

- Develop a strategy and costed implementation plan in 2015 on how the coming scale up of HCV testing can benefit HIV testing - so-called tandem testing – particularly for key populations and rural populations. The National AIDS Centre should remain in its key role as the technical normative and clinical referral point for HIV and AIDS, e.g. with regards to all confirmatory HIV testing in the country.
- Additionally, the National AIDS Centre (NAC) should have a key role in the implementation of the new National Strategic Plan with regards to training health care staff including family doctors and TB screeners to provide HIV testing, including counselling and linkage to HIV care.

Priority Area 2: Optimize HIV treatment

Main recommendation: Employ a public health approach in delivering ART and HIV care, ensuring support for key populations

Specific recommendations:

- Continue and establish firmly the recently adopted cost-effective public health approach (with detailed switch targets up to 31 December 2018) to the use of ART both in the first-line and in the second/third-line of therapy. Ensure that this ART approach developed by the NAC is included in the new NSP.
- Decrease the mean number of clinical visits to the National AIDS Centre, from every second-third month to every sixth month when clinically feasible, in line with the current progress in this area.
- Develop by the end of 2015 a comprehensive plan for ensuring health care capacity and ARV drugs for the people living with HIV (PLHIV) that remain undiagnosed, with special attention paid to key populations and maintaining the ART levels for those diagnosed, in line with the new NSP.
- Ensure the clinical management of TB/HIV coinfected patients, particularly outside of the capital, where it was reported to be less efficient and less coordinated, in part due to stigma and discrimination of these infections and key populations. Both the National Tuberculosis Programme (NTP) and NAC should be involved in this process.
- Reduce stigma related to HIV and key populations in all health care settings through targeted campaigns and education.
- Ensure the health capacity and competence for the clinical management and treatment of HCV/HIV coinfected patients, who are expected to increase substantially in number as a result of the national HCV elimination plan, which should go into effect in 2015. Educational campaigns for all relevant health care providers should be put into place and nationwide information campaigns launched once the plan goes into effect.
- Ensure that retention in care is continuously developed and take into consideration the specific patient group of PWIDs and any specific needs for share care models as more PWID are tested and enter the care system.

Priority Area 3: Ensure leadership and governance at the highest level

Main recommendation: Restore the health system leadership and governance of the Ministry of Labour, Health and Social Affairs (MoLHSA) and strengthen the role of the National Center for Disease Control (NCDC)

Specific recommendations:

- Leadership and Governance
  - In order to restore the leadership and governance role of the MoLHSA, a jointly developed MoLHSA and NCDC HIV/Health System Action Plan in the context of the National Strategic Plan (NSP) and for the Global Fund concept note is needed. This Joint Action Plan should include a clear role of the State and the private sector in counselling, diagnostics and treatment, and require STI providers to service PLHIV. This type of action in these same terms is already included in the NSP 2011-2016, but should be evaluated and fully implemented.

- Financing
  - Ensure adequacy of state budget allocations for HIV prevention, testing, linkage to care treatment and retention in care to sustain and scale-up the national response, including during and after the end of any Global Fund support.
  - Include HIV in the State Universal Health Care Programme for financial protection in access and coverage of services; increase budget allocations to the National AIDS Centre to maintain the level of services and include performance payments for PHC level counselling, testing and linkage to care. This is in line with Ordinance 724, December 2014, which states, "*The necessity to ensure future financial sustainability of the state expenditure for medical services supported financially by international donor organizations (incl. Global Fund, Global Alliance of Vaccines and Immunization, USAID) is an important challenge for the health care system of the country).*

- Monitoring and Evaluation
  - Develop and implement a national M&E framework in the context of the NSP and the Global Fund concept note to improve forecasting for HIV prevention, treatment and care on a rolling basis. Consider the likely increase in new cases as the HCV elimination plan is put into effect.

- Inter-institutional coordination
  - Reinforce inter-institutional coordination. Under leadership of the MLHSP-NCDC and National AIDS Centre strengthen the formal mechanisms of coordination with:
    - Ministry of Finance (regarding budget allocations)
    - Social Health Insurance (regarding HIV and TB in package of services and financial protection)
    - Ministry of Education (regarding sex education in schools and universities)
    - Ministry of Interior/Police/Ministry of Justice (regarding drug policy and training of law enforcement)
    - Ministry of Corrections (regarding HIV services in prisons)

Priority Area 4: Ensure services for key populations

Main recommendation: Scale up harm reduction services for PWID, including opioid substitution therapy (OST)

Specific recommendations:

- To increase OST coverage (to at least 4000 by 2018), and improve geographical access where such service is needed.
- To make OST more accessible by making its provision in line with WHO Guidelines (2009), allowing methadone “take-homes”, taking into account the general and individual needs of patients.
- To offer both options of OST (maintenance and reduction) for inmates in penitentiary institutions.
- To develop and adopt legal acts on the HIV prevention services among PWID, which will define minimal standards of services (service package, requirements for staff, reporting, etc.) and to ensure that this is included in the NSP.
- To involve governmental medical institutions (HIV or substance disorders treatment centres) in needle and syringe programme implementation (e.g. stationery services).
- Increase PWID’s access to HIV testing and counselling at NSPs, outreach sites and through community-based services with the expanded use of rapid tests and active linkage to care for further HIV care.
- To develop a clear mechanism in the existing legal framework which will allow for the purchase with government funds of HIV prevention services among PWID, provided by NGOs.
- To interact with the Ministry of Justice, Ministry of Interior, General Prosecutor Office and other relevant parties in shaping a consistent national drug policy for the NSP for 2016-2018 implementation.

1. Introduction

Georgia is located at the crossroad of western Asia and eastern Europe; bounded to the west by the Black Sea, to the north by the Russian Federation, to the south by Armenia and Turkey, and to the southeast by Azerbaijan. The capital city is Tbilisi. Georgia covers a territory of 69,700 kilometres and has approximately 4.49 million inhabitants.

1.1 Country epidemic

The number of people living with HIV (PLHIV) in Georgia was, at the end of 2014, estimated to be, 6800 *(1,2)*, and some 45% of these people were not aware of their status. Cumulatively, as of the end of that year, 4695 PLHIV were officially registered in Georgia.

In 2013, of the newly diagnosed HIV infections with information about transmission mode (99%), 37% were transmitted through heterosexual contact, 29% through injecting drug use and 14% through sex between men *(3)*. The same year, Georgia had a reported a cumulative total of 81 children infected through mother-to-child transmission, including 3 in 2013.

The Georgian National HIV/AIDS Strategic Plan for 2016-2018 reports that the HIV epidemic in Georgia is mainly concentrated among key populations: men having sex with men (MSM), people who inject drugs (PWID), and sex workers (SW). Although the infection is mainly among the male population (69% of the total reported cases), the proportion of women affected increased from 25% to 31% in 2014 *(3)*.

In the past ten years, the rate of newly diagnosed HIV infections increased greatly from 3.6 per 100,000 population (157 cases) in 2004 to 10.7 in 2013 (474 cases)*(4).* This 197% increase is above the average increase for the European Region (80%) and indicative of major weaknesses in HIV prevention for key populations, notably people who inject drugs and others with high risk behaviours, including their sexual partners.

Late detection remains a challenge in the country. Over half (66%) of people diagnosed with HIV in Georgia in 2013 were diagnosed at a late stage of infection (CD4 cell count <350), including 40% with advanced HIV infection (CD4 <200), which has serious consequences for AIDS incidence, the effectiveness of treatment, mortality and the onward transmission of HIV.

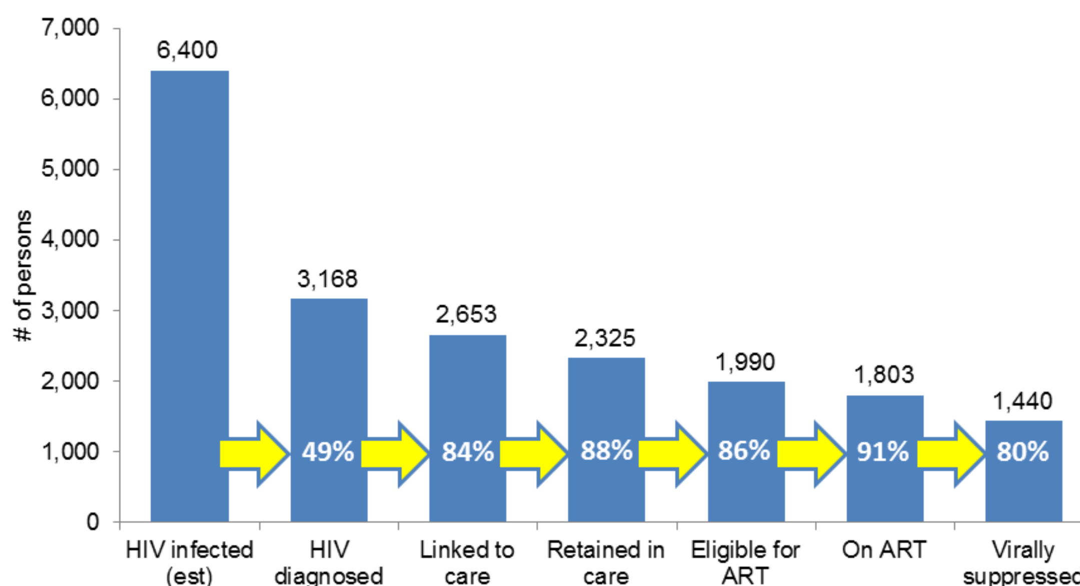
As reported to the WHO Regional Office for Europe and the European Centre for Disease Prevention and Control (ECDC), 18,091 HIV tests (4.1 per 1000 population) were performed in Georgia in 2013, a 26% decrease compared with the number of tests in 2004 (24,311 tests). Information about the number of tests by specific population group is not available. Among key populations, 15% of PWID, and 34% of MSM were reported to have been tested for HIV and received their results in 2013 *(5)*.

Of further concern is the 162% increase in the rate of newly diagnosed AIDS cases, from 2.6 per 100,000 population (112 cases) in 2004 to 6.8 per 100,000 (303 cases) in 2013, indicative of late diagnoses and insufficient ART coverage.

1.2 Continuum of care

The most recent continuum of care figures (2014) illustrates some of the challenges for HIV and AIDS testing, treatment and care in Georgia (see Fig 1).

Figure 1. Engagement in the HIV Continuum of Care in Georgia *(2)*



The continuum of care is founded on the estimation that more than half of the people living with HIV are undiagnosed. This gap is related to low HIV testing coverage of key populations at risk of contracting HIV and missed opportunities to test for HIV in the health sector *(2, 6)*. The large number of undiagnosed HIV cases has serious implications both from individual and public health standpoints, and viral suppression is currently achieved in only 22.5% of all PLHIV in Georgia. As stated in the column for viral suppression, the viral suppression rate among those on ART is 80%, but represents only 22% of the estimated number of PLHIV.

Compared to treatment cascade figures for 2012 *(3,4,7)*, the estimated number of undiagnosed people has increased (from 2355 people to 3232 people in 2014). The numbers on the "right side" of the treatment cascade have increased proportionally – which needs to be acknowledged. Nevertheless, the growing number of undiagnosed HIV cases remains a major challenge for achieving the individual and public health benefits of ART.

1.3 The health system and its financing

In 2007, the Georgian government in a radical change of policy declared that the entire health care system would be privatized. Under the ideology of allowing free markets to energize health care delivery, there were very few people who had any experience with managing private health care institutions. Hospitals were suddenly faced with the need to enter into a complex system of reimbursement, but the infrastructure did not exist. Likewise, few people had any experience with creating and running health insurance companies. The concept of insurance as a protective mechanism was beginning to become established in 2007, but health insurance was practically non-existent. The institutional infrastructure, both the insurance

industry and health care providers, was not fully in place or equipped to handle a new environment devoid of government support *(8)*.

Skilled physicians, nurses, hospital administrators, and managers who could administer in a privatized setting were and remain another gap in the health care environment. The privatization reforms sent shock waves through a country where much of the population still lives in poverty and cannot pay even small insurance premiums *(9)*. The privatization wave affected all sectors of the economy. Today, the Georgian health care sector is 95% private. Even the National AIDS Centre, for example, is on privatized land and faces the constant uncertainty of being evicted.

This situation is compounded by the announced reduction in financing from the Global Fund, which is expected to gradually take place in the short term. At the same, there are indications of increased budgetary commitment by the Georgian government to the health sector and to sustain HIV gains specifically. This is included in the draft NSP 2011-2016, which indicates that "in the context of reducing investment from external sources one of the biggest challenges facing the national response to HIV is the need to significantly increase the allocation of state funding. The increase envisaged by the present NSP will be coordinated with the current and planned allocation from external funding mechanisms, most notably the Global Fund." *(10)*

1.4 The previous WHO mission, June 2014

In June 2014, a WHO country mission was carried out to assess the achievements, strengths and shortcomings in the implementation of the Georgian National HIV/AIDS Strategic Plan *(3)*.

The country mission in June made as series of recommendations, which form the basis of the objectives set out in Section 2, i.e. to further investigate priority areas including beyond treatment issues.

2. Purpose and Objectives

Georgia is eligible for a Global Fund grant to support its national programme on HIV/AIDS. Through the Global Fund-WHO Regional Office for Europe collaborative agreement, Georgia requested the WHO Regional Office for Europe to provide technical assistance to conduct an HIV programme review and to review its draft National Strategic Plan. Technical assistance is organised through two WHO Collaborating Centres: on HIV and Viral Hepatitis and on Harm Reduction. This assessment follows up on the implementation of the WHO mission recommendations developed during the country mission there in June 2014 *(3)* and included four components:

1. *Review of HIV treatment and care along cascade of services*
    - HIV testing: for general population and key populations, including community-based testing and linkage to HIV treatment and care services
    - Early HIV infant diagnosis, MTCT and paediatric ART
    - Enrolment and retention in HIV care, including general HIV care, management of coinfections and co-morbidities, integration of HIV/Viral hepatitis, HIV/TB, HIV/OST services

- ART: estimated need and coverage, criteria for ART initiation, adherence ART regimens (first line, second line and third line).
- Monitoring of ART response and diagnosis of treatment failure: VL, ARV toxicity, HIVDR
- Patient tracking system
- ART outcome: viral suppression
- People lost to follow up at every cascade step and reasons

2. *HIV services for key populations*
    - Needle and syringe programme
    - Drug dependency treatment
    - ART access
    - Prison settings
    - Community outreach (HIV testing and linkage to HIV treatment and care services, ARV dispense, case management/social accompanying)

3. *Analysis of service delivery models for populations affected by the HIV epidemic from the perspective of the health system*
    - Capacity of the national health system to provide effective human, financial and infrastructural resources to address health needs of affected by HIV epidemic populations, including key populations which require a proactive approach in service delivery with strong social support and case management
    - Health systems barriers and interventions needed to optimize and monitor HIV services along continuum of care and ensure high coverage with HIV testing, enrolment to HIV treatment and care, adherence to ART, integration and linkage of services

4. *A review of the National Strategic Plan, focusing on*:
    - NSP defines and determines priorities and strategic directions over a period of time (e.g.: five years and is aligned with the national health plan)
    - NSP provides a clear framework that specifies the appropriate strategic interventions to reach the country's HIV/AIDS care and control goal(s), objectives and targets
    - It guides decision making on allocating resources and on taking action to pursue strategies and set priorities
    - Interventions and objectives are adequately and coherently linked. Moreover, activities and sub-activities inherent to each intervention are clearly specified, highlighting clear target(s) for each intervention and identifying where and when each activity or sub-activity should be implemented and who will implement it
    - NSP specifies the budget needed to implement interventions and activities
    - It also clearly describes how the interventions and activities will be operationalized as well as how the implementation will be monitored and their effect will be evaluated
    - It provides information on the technical assistance needed to make this operationalization effective

2.1 Methods

The mission took place in 2−6 March 2015. During the country mission, the four WHO experts undertook interviews and visited sites in the capital, Tbilisi. In addition to field visits and data collection, the review included a desk review and analysis of available documents (guidelines, national policy/strategy/plans, clinical guidelines, publications, reports, etc.), key informant interviews, focus group discussions and field observations.

3. Findings

3.1 Strengths and achievements

HIV testing and linkage to care
A recent major achievement in Georgia is the re-introduction of anonymous HIV testing in 2015. During the first two months of 2015, an increased number of HIV-positive patients were diagnosed *(11)*. The HIV testing of MSM and PWID was scaled up during 2014 with a substantial increase in the total number of HIV tests of PWID performed (>20,000 tests).

HIV testing is offered once during pregnancy and almost all women accept the offer to test. In 2014, 54 pregnant women were diagnosed with HIV and no child was born with HIV, due to the effective prevention of mother-to-child transmission (PMTCT). The testing of patients with tuberculosis (TB) is mandatory and carried out on all patients who are treated for TB at the National Centre for Tuberculosis and Lung diseases (NCTLD).

Testing is also carried out by NGOs, who are specialized in reaching hard to reach groups like MSM and PWID. In Tbilisi, for example, Tanadgoma has an MSM-friendly testing at its office and carries out outreach activities at cruising areas and in night clubs. They help beneficiaries obtain treatment for e.g. STIs in other clinics in five cities.

Outreach programmes have tested PWID with rapid tests. The number of people tested for HIV increased from 8228 in 2013 to 20,543 (or 46% of the estimated number of PWID) in 2014. A significant increase in HIV testing coverage was possible due to the re-introduction of anonymous HIV testing. Of 20,543 PWID tested in 2014, 87 people were found HIV positive, or 0.4%. Of 87, who tested HIV positive, 53 were confirmed through laboratory testing as new HIV-positive cases; 16 were already registered; and 10 refused to provide their identification. The Georgian Harm Reduction Network (GHRN) is the only implementer of HIV testing through harm reduction services.

HIV clinical care and treatment
In general, among those who were diagnosed with HIV and enrolled in HIV care, there is a high retention rate (88%) and 91% of those eligible are given antiretroviral therapy (ART). The cumulative proportion of PWID among HIV diagnosed subjects in Georgia is 49.3% and 37.0% among newly diagnosed in 2014. According to an analysis of 2012 data among the total number of diagnosed persons, compared to non-injecting drug users, PWID were less likely to initiate care (88% vs. 80%, $p<0.0001$), and to remain in care (79% vs. 67%, $p<0.0001$) *(2,6,7)*. As a result, the patient population includes a high proportion of "difficult-to-treat" PWID, yet the rate of undetectable viral load (80%) is reasonable. The clinical care and treatment programme is staffed with a professional team at the NAC consisting of personnel with complementary competences who have a good understanding of the issues and

challenges. The care component is highly prioritized to the benefit of the patients, which results in higher retention rates also among PWID than in many other countries in Eastern Europe. The emphasis on adherence support is high.

The data system that oversees persons in care is well functioning and is critically important. The system is used not only for collecting national statistics on the HIV epidemic, clinical care and treatment, but also to support the clinical decisions made by the physicians and for identifying and tracing patients who have not been adherent to planned visits. The tracing is performed by means such as telephone calls, SMS and e-mail, as well as personal visits to the clients, and is based on the well-structured health care and high competence as well as engagement of the health care personnel. Relevant guidelines are in place.

Since the third quarter of 2014, there has been an ongoing gradual switch from a more individualized approach to a public health approach concerning the use of ART, in line with the recommendations of the consolidated 2013 WHO guidelines *(12)* and the 2014 WHO mission report *(3)*. In all first-line therapy patients, these guidelines and recommendations have been followed since late 2014. For second and third-line therapy patients, the switch is ongoing and gradually as part of the routine clinical care visits of the patients. The high quality of care and high efficacy of ART have been sustained during this implementation process. A limited number of patients have developed adverse events in connection with a therapeutic switch, which has made it necessary to switch back to the original therapy regimen. However, this situation has been handled professionally with sustained quality of care. The reported plan for the continuation of the implementation of the public health approach to ART is relevant and follows the consolidated 2013 WHO guidelines and the 2014 WHO mission recommendations to Georgia.

The mean number of patient visits to the clinic is high (every second-third month for most patients) but the HIV RNA viral load and CD4 cell count monitoring are used in an efficient manner. There is a strategy to transfer patients on stable ART to less frequent visits (every sixth month), which is now being implemented.

Diagnostic facilities at the NAC are well developed including access to viral load and CD4 cell count monitoring, as well as diagnostics of the various types of opportunistic infections AIDS patients suffers from. Further, the diagnostics of viral hepatitis are well-developed. Equipment for genotypic resistance testing and sub/genotyping is available. There is a high competence in diagnostic molecular virology among staff members at the NAC.

HIV/Viral hepatitis and HIV/TB services

Patients with a coinfection with hepatitis B or C have access to relevant antiviral therapy at the NAC. The new National Strategic Plan for eradication of HCV through the use of a direct-acting agent in combination with alpha-interferon and ribavirin also includes patients with HIV/HCV coinfection and is planned to be initiated during 2015. This will result in an earlier detection of not only HIV infections but also HCV infection, which may constitute a major therapeutic advantage for patients with coinfections since HCV-induced liver disease progress more rapidly in patients with HIV/HCV coinfection as compared to patients with HCV mono-infection.

HIV testing coverage of TB patients at the NCTLD is very high due to its mandatory nature. While this leads to improved case finding, mandatory testing is not recommended by WHO.

Subjects with HIV/TB coinfection are given ART adequately in an informal efficient collaborative manner between the NCTLD and NAC in Tbilisi.

Opioid substitution therapy (OST)
The estimated number of PWID in Georgia is 45,000 *(13)*. In February 2015, (GHRN carried out a survey of 357 PWID about substances they used during the last 30 days *(14)*. The survey indicated that the most prevalent substances were opioids: 52.7% of PWID used heroin, 34.7% desomorphine[1] obtained from codeine containing medications, 19.3% illegal buprenorphine, 12.6% other illegal opioids (painkillers, homemade products from poppy shells, etc.), and 7.8% illegal methadone. The second most-often prevalent substance (30%) was cannabis. The third most prevalent group of substances (23.5%) was of anxiolytic and sedative medications. The fourth (22.7%) was stimulants derived from medications containing ephedrine or related substances. There is no clear estimate of how many of the 45,000 PWID are dependent on opioids. The aforementioned survey indicated that at least 70-80% of PWID could be dependent on opioids.

OST in many parts of Georgia is well established; however, coverage still remains low. By the beginning of 2015, there were OST sites in many geographical locations including several different sites in the capital. The state-owned Centre for Mental Health and the Prevention of Addiction coordinates the development of OST in Georgia. Overall, there were around 2500 OST patients, 500 in OST sites funded by the Global Fund and the remainder in services funded by the Ministry of Health and patients themselves (GEL 110 or USD 51 per month). OST sites had established links with both HIV and TB services. OST was available in two penitentiary institutions in Tbilisi, including pre-detention facilities, allowing patients to continue therapy without interruption.

OST has a strong perspective of sustainability in Georgia due to the following factors:

- Governmental institutions under the Ministry of Health and Ministry of Justice implemented and expanded OST, and integrated it to a certain level into their regular services.
- The state budget provided financial support for OST and the mechanism of private payment increased the probability of continuation of OST, even if donor and government funding were inadequate. However, private payment limits access to OST for those PWID who cannot afford to pay.
- Legal acts on OST exists.
- OST is available in two prisons; there is continuity in OST provision between community OST sites and prisons; and
- OST has links with HIV and TB services. For example, a weekly or similar supply of methadone is transported from OST clinic and stored at the HIV centre for dispensing as prescribed by an addiction specialist.

Needle Syringe Programmes
The Georgian Harm Reduction Network (GHRN) implements the needle and syringe programmes in Georgia. GHRN unites 26 NGOs, including organizations which provide outreach and/or advocacy activities. In the past couple of years, the coverage of PWID with HIV prevention services has increased significantly. In 2014, 38,980 PWID or 87% of the estimated number of PWID received at least one of 4 HIV prevention services (provision of injecting equipment, provision of condoms, counselling or HIV testing) *(14)*. The "minimum

[1] In slang in Russia and some other countries this is referred to as "krokodil".

package" of interventions (at least two interventions of the four) was provided to 12,354 or 27% of the estimated number of PWID. The number of syringes distributed to PWID increased 79 syringes per estimated PWID in 2014.

Outreach programmes provided screening services for syphilis, viral hepatitis C and TB. In 2014, 10,149 PWID (or 23% of the estimated number of PWID) were tested for syphilis (RPR), and 490 cases were positive (5%). In 2014, overall 14,410 PWID were tested for viral hepatitis C, in 6750 or 47% of the cases, the result for HCV was positive. In 2014, of 4,075 PWID who underwent TB screening, outreach workers referred 10% to TB centres for additional screening, and 33 or 0.8% were part of the National TB Treatment Programme.

GHRN intends to further increase coverage of the PWID population with HIV prevention interventions by starting to operate from mobile vehicles (altogether eight new vehicles are planned for 2015-2016). Vehicles will serve for outreach work and HIV testing in geographical areas and cities not yet reached by HIV prevention services.

3.2. Weaknesses and challenges

Priority Area 1: Optimizing HIV testing

An analysis of the HIV continuum of care in Georgia shows that the major gap occurs in the stage of HIV testing/diagnosis. Based on this analysis, around half (49.5%) of the estimated 6,400 persons living with HIV are not yet diagnosed. This gap is primarily the result of low HIV testing coverage of key populations at risk. The testing coverage is especially low among PWID, 15% (6) but also among MSM (34%). Further, HCV infection is diagnosed in around 20% of those reported as sexually infected (15) and the proportion of PWID among newly diagnosed providers are unaccountable and (16). Thus, since a substantial portion of undiagnosed people expected to become newly diagnosed will be "difficult-to-treat" PWID, a major challenge would be to sustain the linkage and retention to care.

New innovative approaches to reach these populations are necessary, including an expansion of NGO-provided services beyond the MSM-friendly testing site in the capital and outreach activities at cruising areas and in nightclubs, for example. The new National Strategic Plan, based on a six-month multistakeholder writing and revision process, and set to be approved in mid-2015, should remedy the situation. It includes inter alia provider initiated testing, as recommended by the WHO mission in 2014.

The HIV testing of patients with TB at the NCTLD is mandatory. Based on the potential negative impacts of any mandatory provider HIV testing, there is a risk that patients with TB, potentially coinfected with HIV, avoid seeking health care at the NCTLD despite the good quality of care given. Also, the general testing rate in Georgia of patients with TB is too low (62%), particularly outside of the capital, and it is most likely that a substantial number of TB patients coinfected have not been HIV diagnosed. As it was pointed out in the WHO evaluation report from 2014, private clinics in particular do not see it as their responsibility to offer HIV testing and a Ministry decree/regulation is needed in order to ensure that all clinics in the country caring for TB patients routinely offer an HIV test.

All but two STI-clinics are private and it is unknown to which extent HIV testing is performed in patients at these clinics due to a lack of centralised statistics. It must be emphasized that this is a major disadvantage in combating the HIV epidemic in Georgia. The rate of STIs, e.g. syphilis, among HIV infected patients at the NAC is high *(11)* and it is most likely that patients with HIV infection are not diagnosed at the private STI clinics due to insufficient HIV testing.

Stigma and discrimination of key populations in society at large and in some health care settings continues to impede testing in general and, most importantly, the testing of people living with HIV. Priority area 4, below, addresses this with regards to PWID.

Priority Area 2: Optimize HIV Treatment

Georgia adheres to the 2013 WHO Consolidated Guidelines on the use of Antiretroviral Drugs for Treating and Preventing HIV, and ART is thus initiated at a level of 500 CD4 cells/mm^3. Most patients have a CD4 cell count below this level already at diagnosis since late diagnosis occurs at a high rate in Georgia (65% below 350 CD4 cells/mm^3). Most of the patients thus need ART at diagnosis and the estimated country need will increase substantially up to 2018 as compared to 2014.

The targets for ART coverage suggested in the National Strategic Plan start with a baseline of 2541 people on ART. Based on Spectrum, the ART targets increase to 3800 in 2016, 4300 in 2017 and 4800 in 2018, based on estimates of newly diagnosed and in need of treatment according to the national treatment protocol. Analysis of HIV treatment and care cascade of services shows ART coverage of 28%, when it is calculated as a proportion of patients receiving ART among the total estimated number of PLHIV. If estimated number of PLHIV would have remained the same for 2016-2018, new targets would have represented 59%, 67% and 75% coverage.

The ongoing transition from an individualized ART approach to a public health approach has to date been successful at the NAC with a sustained high quality of care. A challenge is to continue this implementation and expand it further to patients who are given second or third-line of ART.

HIV/Viral hepatitis and HIV/TB services
The National Strategic Plan for eradication of HCV, based on the use of direct-acting agents in combination with alpha-interferon and ribavirin to all identified HCV-infected individuals can become highly beneficial for patients with HIV/HCV coinfections but also expose challenges. A substantial proportion of undiagnosed patients with HIV/HCV coinfection are expected to have difficulties in adherence to clinical care and to treatment, due to e.g. ongoing drug use, psycho-social reasons and/or psychiatric diseases. In addition, drug-drug interactions and adverse effects are challenges for the outcome of not only HCV-therapy but also HIV-therapy. For example, co-administration of zidoduvine and ribavirin is not advised *(17)*.

The care of HIV/TB infected patients outside Tbilisi remains, however, suboptimal. This is likely to be, at least partly, due to stigma and discrimination of PLHIV. In view of the well-functioning integration of TB and HIV care in Tbilisi, this model should be implemented at the clinics outside Tbilisi and approaches to diminish stigma and discrimination should be emphasized.

Priority area 3. Ensure leadership and governance at the highest level

There are several effects resulting from the privatization of health care in the country described above. Firstly, the Ministry of Labour, Health and Social Affairs (MoLHSA) has been left with limited leadership and governance powers over the health care sector. The Ministry is still in charge of basic health legislation, public health, human resources development and oversight of the health care system. However, on quality and equity of health care services the action scope of the Ministry is very limited – and this is critical for HIV patients. It was reported that private primary health care providers either refuse to consult with HIV patients or treat patients without minimal dedication. The powers of the Ministry to intervene are non-existent.

Because of a limited mandate, particularly with regard to direct health care service provision, purchasing and some aspects of health care providers' regulation, the public perception is that providers are unaccountable and the Ministry unresponsive *(18)*.

Need to reconstruct the health care system and the value of health care
This situation needs to be re-assessed for the good of the health care system in general and for the health care services related to HIV patients specifically. A health care system based on principles of public good and rights has to be restored.

The options for the Ministry of Health are limited. In other circumstances ministries control or contribute to matters such as accreditation of health care facilities and the licensing of private providers, consultations, primary health care group practices, diagnostic laboratories and the like. Through these institutional mechanisms for ensuring quality of care, ministries or the accreditation agency can introduce conditions to the accreditation/re-accreditation and licensing/re-licensing. Among these conditions there should be one related to providing access and service coverage for HIV (and TB) patients. This is currently not the case in Georgia. Accreditation was suspended years ago based on the argument that "the very low quality of facilities means that priority should be given to ensuring minimum standards rather than focusing on quality measures" *(19)*. Regardless, an effort should be made to restore accreditation and licensing processes and require the aforementioned conditions.

Given the limited institutional infrastructure for health in the public sector the MoLHSA and the National Centre for Disease Control should continue to collaborate in assessing the current situation with the health care system and make proposals to restore the necessary role of the State in health leadership, governance and regulation. This strategic alliance would benefit the health care sector in general and HIV/AIDS patients in particular.

HIV financing
The particular situation of the need to have a National AIDS Centre that is stable, well-staffed and equipped and with modern and adequate facilities is a matter of concern and action is needed to avoid an interruption of services in case of eviction from the current premises.

HIV patients need financial protection. The State Universal Health Care Programme, the main source of public health care financing for access and coverage of health care services, should be encouraged to expand the implementation of the financial protection to HIV patients both for general health care services and for specific services related to their condition of HIV patients. Although nominally protected under the UHC system, these patients' rejection on the part of STI and private providers (i.e. dental care, gynaecological examinations and

psychological support) was reported. The financial protection should ensure that providers do provide the services that are part of the UHC system. A nominal health financial protection with limited access to health care services means an absence of financial protection in practice.

It is crucial to consider that access to services is secured and of good quality in the difficult context of a privatised health system and reduced Global Fund funding.

Priority area 4. Ensure services for key populations

Opioid substitution therapy
The overall coverage of OST remains low at 5.5% (2500 patients) of the estimated 45,000 PWID (low-level target up to 20%, mid-level 20-40% as set by WHO/UNODC/UNAIDS (2012) *(20)*. Geographically, OST in some Georgian cities is not at all available in spite of the documented need there.

Mission findings revealed a number of significant barriers for the PWID population to enter and benefit from OST:

- Restricted medication take-homes
- Substantial payment from patients at the fee-for-services OST centres run by the Ministry of Health
- Daily travel/opportunity costs
- OST opening hours, conflicting with regular job hours
- Lack of individually tailored and patient-needs based psychosocial support
- Confidentiality issues/legal acts or practices, which prevent patients from applying for a job in governmental institutions or to obtain a driving license
- Minimum age limit of 21 as a clinical indication for OST

Some of these barriers contradict recommendations presented in the WHO Guidelines on OST (2009) *(21)*.

In penitentiary institutions, OST aims for abstinence and patients are required to undergo mandatory decrease of their methadone dosage over a several month period. The termination of treatment is mandatory, even though the sustainable abstinence from opioids (including opioid medications) may not be a realistic therapy goal for many PWID, including those living with HIV.

Needle-syringe programmes
Currently, in Georgia, only NGOs run needle and syringe programmes. They rely fully on external funding. To date, there have been no strategies available on how government institutions could outsource HIV prevention services from the NGOs. There were no legal acts from the Ministry of Health, which would regulate prevention of HIV among PWID and ensure proper linkage to care. Therefore, needle-syringe programmes remained in the "grey" zone or "semi-legal", when legal, with their clients not always tolerated by law-enforcement officials including the police. There were reports of routine cases in which the police fined or arrested PWID while accessing HIV prevention services for possession of small quantities or use of illegal drugs. There were also reports that police arrested clients of HIV prevention services for possession of used syringes with traces of illegal drugs. Therefore, outreach workers do not collect used syringes.

Real practices and the low level of tolerance of police for HIV prevention services for PWID differ from one location to another. However, generally, there was solid evidence that to a significant extent the current drug policy undermines the country's efforts to reverse the HIV epidemic. There is no governmental needle and syringe programme operated by a governmental institution (by a HIV or substance disorders treatment service), which would otherwise demonstrate the government's coherent approach to HIV prevention interventions and a well-coordinated policy between different government sectors.

The sustainability of the needle and syringe programmes is very low due to the following factors:

- There are no legal acts of the Ministry of Health on needle and syringe programmes;
- To date, governmental funding has not been available for such programmes; they fully rely on the Global Fund. Further, the mechanisms of reimbursement to NGOs for HIV prevention services are not in place or vague;
- Governmental institutions were not engaged in needle-syringe programme provision; and
- The stigmatization and absence of cooperation from the law enforcement sector creates difficulties for NGOs in implementing HIV prevention services among PWID.

4. Cross-cutting issues

Human rights and legislation

Without legal permission of routine take-home methadone, OST patients face serious barriers for their social integration, normal cycle of work and leisure activities. As a result of existing practices, patients on OST also face significant barriers in applying for a job at government institutions or applying for driver's license, etc.

Potential police arrests of PWID and administrative penalties for drug use even for those who try to access HIV prevention services significantly interfered with effective service implementation of NGOs.

Due to legislation in Georgia, only commercial testing kits can be used in clinical care and the procurement of testing kits via the state system has been chosen based on price. WHO recommends that countries undertake a small scale validation study of available products in their country to help decide which would best suit their own testing situation, and to use cost as a secondary variable for product selection. It should be noted, however, that the expected massive increase in the demands of not only HIV antibody testing kits but also in commercial kits for HIV RNA quantification, genotypic resistance testing as well as for HCV RNA quantification and HCV genotyping will result in a major cost burden on the health care system in Georgia. In view of the high competence in diagnostic molecular virology at the laboratory of the NAC, major cost reductions for molecular diagnostics could be obtained if "home-brew/in house diagnostic assays" would be allowed to be used in clinical care. However, with the present Georgian legislations on the approval of the use of diagnostic assays in clinical care, this is presently not possible, and the monitoring costs of HIV and/or HCV treatment are predicted to be unnecessarily high.

5. National Strategic Plan feedback

Feedback was provided by the mission team while in Georgia in three stages:

1. To the NSP consultant writing team
2. To the NSP writing group
3. To the CCM

The draft NSP was commented on in writing three times and included hundreds of tracked changes and comments. Some of the main feedback includes:

- Reduce the descriptive overview to <2 pages, keeping the treatment cascade (Fig 8). The NSP should be concise and supporting material can be included as an annex.

- Set a hierarchy of priorities focusing on increased detection and prevention for key populations

- Clearly delineate between the NSP and operational/action issues so the strategic vision is clear.

- The Plan conveys a sense that all is good, and there is limited self-criticism and suggestions for more bold ideas on institutional, programme and financing for the next 5 years. In this sense, how strategic is the Plan?

- Structurally, the document is still difficult to follow when reading, in part due to the length. Perhaps an executive summary of 2 pages which would list the strategic thinking and areas would help.

- One of the most groundbreaking infectious disease initiatives in the world right now is the Georgian intent to eliminate HCV. As discussed with stakeholders and at the CCM and NSP meetings we suggest that scaled up HIV testing for key populations can be linked to this initiative (so-called tandem testing) and the NSP should address this, even if the HCV plan is not yet elaborated. (NB we did see the “Provide treatment and care for viral hepatitis to all PLHIV (funded by HCV program)” indicator at the end of the doc)

- Another general comment from the team is that the NSP remains too "declarative" and lacks specificity in suggestions/measures to be taken to sustain the gains institutionally, programmatically and financially. We know of the PHC private providers’ rejection of HIV patients, but strategically what should be done about it? We know that HIV patients suffer from limited financial protection, what to do about it?

- The current NSP draft covers the topic of harm reduction extensively. The monitoring and budget indicators are the ones we saw when in Georgia. We have no further major comments regarding them.

- Concerning treatment issues in the text, we have no specific comments beyond those in the main mission report.

- One main comment is the use of "sex workers," implying female SW. What about male SW? Maybe there is no knowledge or it is too "cultural sensitive" even to mention it. There were some areas in Tbilisi where cruising and male sex work took place, for example. And at least one NGO was providing outreach services in some of these areas but on a limited basis.

- The AIDS Centre is located in privatized property (see below).

Suggestion for additional goals/target indicators in National Strategic Plan by 2018 – beyond what was commented on directly in the text:

- **OST** – at least 4000 PWID or 9% of estimated PWID 45,000 (0- 20% coverage of OST a low-level target) *(20).*

- **Needle and syringe programmes** – 30,000 or 67% of estimated PWID 45,000 received with basic intervention combination (>60% coverage of NSP a high-level target) *(20).*

- **HIV testing and counselling among PWID** – 27,000 or 60 % of estimated PWID 45,000 (40-75% coverage of a mid-level target) *(20).*

- **Number of needles and syringes distributed on the average per PWID** – 120 (100-200 syringes per PWID is mid-level target) *(20).*

- **ART** - The targets suggested in the NSP start with a baseline of 2541 people on ART. Based on Spectrum, the ART targets increase to 3800 in 2016, 4300 in 2017 and 4800 in 2018, based on estimates of newly diagnosed and in need of treatment according to national treatment protocol.

6. Recommendations

Priority Area 1: Optimizing HIV Testing

Main recommendation: Increase HIV diagnosis and enrolment into care of key populations

Specific recommendations:

- Develop more effective strategies for identifying the undiagnosed population (estimated at 50% of those living with HIV) and decreasing the proportion of late testers. This includes strengthening data collection on reasons for testing and risk factors in order to evaluate the coverage of key populations, including people who inject drugs (PWID), men who have sex with men (MSM) and male and female sex workers (SW), and changes over time as well as increased testing in community settings. Further, care pathways should be carefully organized to ensure linkage to care for these populations when tested in community settings.
- Ensure that all patients presenting with TB at TB clinics and all patients of STI clinics are offered an HIV test. Make it a universal offer, never obligatory. People with clinical or lab markers of viral hepatitis should be routinely offered an HIV test.

- Continue and increase targeted testing – with clear targets set in the new National Strategic Plan of at least 50% of key populations by 2017 (cumulative) – through community testing using friendly non-judging mobile teams and peer outreach workers; introduce even more rapid tests and develop targets for their use in the NSP.
- Develop a strategy and costed implementation plan in 2015 on how the coming scale up of HCV testing can benefit HIV testing, so-called tandem testing – particularly for key populations and rural populations. The National AIDS Centre should remain in its key role as the technical normative and clinical referral point for HIV and AIDS, e.g. with regards to all confirmatory HIV testing in the country.
- In the implementation of above mentioned scale-up of testing, ensure that number of HIV tests by (risk) group and number of people testing positive is recorded and monitored to ensure (cost) effectiveness of interventions.
- Additionally, the NAC should have a key role in the implementation of the new National Strategic Plan with regard to training health care staff including family doctors and TB screeners to provide HIV testing, including counselling and linkage to care.

Priority Area 2: Optimize HIV Treatment

Main recommendation: Employ a public health approach in delivering ART and HIV care, ensuring support for key populations

Specific recommendations:

- Continue and establish firmly the recently adopted cost-effective public health approach (with detailed switch targets up to 31 December 2018) to the use of ART both in the first-line and in the second/third-line of therapy. Ensure that this ART regimen developed by the NAC is included in the new NSP.
- Decrease the mean number of clinical visits to the National AIDS Centre, from every second-third month to every sixth month when clinically feasible, in line with the current progress in this area.
- Develop by the end of 2015 a comprehensive plan for ensuring health care capacity and ARV drugs for the PLHIV that remain undiagnosed, with special attention paid to key populations and maintaining the ART levels for those diagnosed, in line with the new NSP.
- Ensure the clinical management of TB/HIV coinfected patients, particularly outside of the capital, where it was reported to be less efficient and less coordinated, in part due to stigma and discrimination of these infections and key populations. Both the NTP and NAC should be involved in this process.
- Reduce stigma related to HIV and key populations in all health care settings through targeted campaigns and education.
- Ensure the health capacity and competence for the clinical management and treatment of HCV/HIV coinfected patients, who are expected to increase substantially in number as a result of the national HCV elimination plan, which should go into effect in 2015. Educational campaigns for all relevant health care providers should be put into place and nationwide information campaigns launched once the plan goes into effect. Ensure that retention in care is continuously developed and take into consideration the specific patient group of PWIDs and any specific needs for share care models as more PWIDs are tested and enter the care system.

Priority Area 3: Ensure leadership and governance at the highest level

Main recommendation: Restore the health system leadership and governance of the MoLHSA and strengthen the role of the NCDC

Specific recommendations:

- Leadership and Governance
  - In order to restore the leadership and governance role of the MoLHSA, a jointly developed MoLHSA and NCDC HIV/Health System Action Plan in the context of the NSP and for the Global Fund concept note is needed. This Joint Action Plan should include a clear role of the State and the private sector in counselling, diagnostics and treatment, and require STI providers to service PLHIV. This type of action in these same terms is already included in the NSP 2011-2016, but should be evaluated and fully implemented.

- Financing
  - Ensure adequacy of state budget allocations for HIV prevention, testing, linkage to care treatment and retention in care to sustain and scale-up the national response, including during and after the end of any Global Fund support
  - Include HIV in the State Universal Health Care Programme for financial protection in access and coverage of services; increase budget allocations to the National AIDS Centre to maintain the level of services and include performance payments for PHC level counselling, testing and linkage to care. This is in line with Ordinance 724, December 2014, which states, "*The necessity to ensure future financial sustainability of the state expenditure for medical services supported financially by international donor organizations (incl. Global Fund, Global Alliance of Vaccines and Immunization, USAID) is an important challenge for the health care system of the country).*

- Monitoring and Evaluation
  - Develop and implement a national M&E framework in the context of the NSP and the Global Fund concept note to improve forecasting for HIV prevention, treatment and care on a rolling basis. Consider the likely increase in new cases as the HCV elimination plan is put into effect.

- Inter-institutional coordination
  - Reinforce inter-institutional coordination. Under leadership of the MLHSP-NCDC and National AIDS Centre strengthen the formal mechanisms of coordination with:
    - Ministry of Finance (regarding budget allocations)
    - Social Health Insurance (regarding HIV and TB in package of services and financial protection)
    - Ministry of Education (regarding sex education in schools and universities)
    - Ministry of Interior/Police/Ministry of Justice (regarding drug policy and training of law enforcement)
    - Ministry of Corrections (regarding HIV services in prisons)

Priority Area 4: Ensure services for key populations

Main recommendation: Scale up harm reduction services for PWID, including OST

Specific recommendations:

- To increase OST coverage (to at least 4000 by 2018), and improve geographical access where such service is needed;
- To make OST more accessible by making its provision in line with WHO Guidelines (2009), allowing methadone “take-homes”, taking into account the general and individual needs of patients;
- To offer both options of OST (maintenance and reduction) for inmates in penitentiary institutions;
- To develop and adopt legal acts on HIV prevention services among PWID, which will define minimal standards of services (service package, requirements for staff, reporting, etc.) and to ensure that this is included in the NSP;
- To involve governmental medical institutions (HIV or substance disorders treatment centres) in needle and syringe programme implementation (e.g. stationery services);
- Increase PWID’s access to HIV testing and counselling at NSPs, outreach sites and through community-based services with the expanded use of rapid tests and active linkage to care for further HIV care.
- To develop a clear mechanism in the existing legal framework which will allow for the purchase with government funds of HIV prevention services among PWID, provided by NGOs;
- To interact with the Ministry of Justice, Ministry of Interior, General Prosecutor Office and other relevant parties in shaping a consistent national drug policy for the NSP for 2016-2018 implementation.

7. References

1. Spectrum EPP 2014, version 5.03.
2. Country Coordinating Mechanism Georgia. The Georgian National HIV/AIDS Strategic Plan for 2016-2018, CCM Georgia, 15 April 2015.
3. World Health Organization. HIV/AIDS treatment and care in Georgia. Evaluation report, Prepared by WHO Collaborating Centre for HIV and Viral Hepatitis, WHO, September 2014.
4. HIV/AIDS Treatment and Care in Georgia [brief overview document from the Infectious Diseases, AIDS & Clinical Immunology Research Center (IDACIRC)] 2014.
5. GARPR Online Reporting Tool. Georgia – 2013. UNAIDS.
6. Georgia. Country progress report, January 2012 - December 2013. Global AIDS Response Progress Report. National Centre for Disease Control and Public Health. Tbilisi; 2014.
7. The Cascade of Care in the Eastern European Country of Georgia. By N. Chkhartishvili, O. Chokoshvili, L. Sharvadze, J. DeHovitz, C. del Rio. & T. Tsertsvadze. In HIV medicine, Online, April 2014.
8. Schecter K, "The Privatization of the Georgian Healthcare System", American International Health Alliance, Anthropology of East Europe Review 29(1) Spring 2011.
9. Chanturidze T, et.al, 2009, Georgia Health System Review.‖ Health Systems in Transition, The European Observatory on Health Systems and Policies 11(8).
10. 2015 Revision of the Georgia National HIV Strategic Plan: 2016 – 2018, 23 February 2015 Draft, p 4.
11. Prof. Tengiz Tsertsvadze. NAC. Personal communication, March 2015.
12. World Health Organization. Consolidated Guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva, WHO, June 2013.
13. Estimation of Injecting Drug Use Prevalence In Georgia, 2012. Report, Bemoni Public Union.
14. Personal communication from Georgian Harm Reduction Network, March 2015.
15. Badridze et al. Georgian Med News. 2008 Dec;(165):54-60.
16. Chkhartishvili N, McNutt LA, Smith PF and Tsertsvadze T. Characteristics of HIV-infected women and factors associated with HCV seropositivity in the Republic of Georgia. AIDS Research and Therapy 2011, 8:25.
17. Soriano V, Sulkowski M, Bergin C, et al. Care of patients with chronic hepatitis C and HIV coinfection: recommendations from the HIV–HCV International Panel. AIDS 2002;16:813-28.
18. Oxfam International. Health-Care Reform in Georgia - A Civil-Society Perspective: Country Case Study. Oxfam International Research Report, May 2009.
19. Chanturidze T, et. al, 2009, Georgia Health System Review. Health Systems in Transition, The European Observatory on Health Systems.
20. WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision. 2012, Geneva, World Health Organization.
21. World Health Organization. Guidelines for the psychosocially Assisted Pharmacological Treatment of Opioid Dependence. WHO, Geneva, 2009.

8. Annex: Mission Agenda

Mission members and flight schedules:

No.	*Name*	*Abbr.*	*Organization*	*Arrival*		*Departure*	
				Date, time	*Flight*	*Date, time*	*Flight*
1	Jeffrey Lazarus	JL	Public Health expert, WHO CC on HIV and Viral Hepatitis, Denmark	01 March, 17:25	TK 382 (from Istanbul)	06 March, 18:15	TK 383
2	EmilisSubata	ES	Harm Reduction expert, WHO CC on Harm reduction, Lithuania	01 March, 00:10	PS517(from Kyiv)	07 March, 05:15	
3	Hernan L. Fuenzalida-Puelma	HF	Health Systems Strengthening expert, an independent consultant	02 March, 18:10	KLM 3108	07 March, 06:10	
4	Anders Sönnerborg	AS	Professor, clinical expert, KarolinskaInstiutute, Sweden	02 March, 17:25	TK 383 (from Istanbul)	06 March, 18:15	TK 383

Monday, 2 March 2015

Time	***Activity***	***Contact Person***	***Participants***	***Remarks***
10:00	Pick-up from the Costé Hotel *Address: Kostava Street 45A*	WHO representative w. +995 32 299 80 73 m. +995 599 56 72 44 (Nino)	***JL*** ***ES***	Meeting with WHO Georgia Country office representatives before leaving for the meetings
11:00 – 12:30	**Irma Khonelidze** NCDC PH, Deputy General Director, Global Fund PIU, Programme Director ***Address:*** *9 M. Asatianist.*	Irma Khonelidze, m: +995 595 01 14 10	***JL*** ***ES***	General overview of the HIV/AIDS situation and policies in the country
12:30-13:30	**Lunch**			
13:45-15:45	**Khatuna Todaze** Center for Mental Health and Prevention of Addiction, GFATM funded methadone substitution therapy program ***Address:****N21 A Kavtaradzestr*	Khatuna Todadze: m: +995 599 103 009	***JL*** ***ES***	Meetings with OST beneficiaries and outreach workers/peer educators.
16:00-17:30	**Iza Bodokia** HIV/AIDS Patients' Support Foundation, Director ***Address:****Mosashvili 20, ground floor*	Iza Bodokia, m: +995 577 47 31 23	***JL*** ***ES***	Meeting with the beneficiaries of the organisation.

Tuesday, 3March 2015

Time	*Activity*	*Contact Person*	*Participants*	*Remarks*
9.30-10:45	**Mission team meeting**	Jeffrey Lazarus	***All***	In lobby or breakfast room until the pick-up
11:00-13:00	**Vyacheslav Kushakov** FEI Expert **Katerina Boiko** FEI Expert ***Address:*** *UN House, Eristavist. 9* *UN Meeting Room*	Vyacheslav Kushakov m: +380 503 12 32 05	***All***	Discussion of the National Strategic Plan for HIV/AIDS.
13:00-13:50	**Lunch**			
14:00 – 15:00	**UN Thematic Group on HIV/AIDS** ***Address:*** *UN House, Eristavist. 9* *UN Meeting Room*	Nino Mamulashvili, WHO CO Georgia m. +995 599 56 72 44 (Nino)	***All***	Discussion of HIV/AIDS related interventions carried out by different UN agencies
15:00-17:30	**Meeting with CCM member CSOs active in HIV/AIDS field and other relevant stakeholders from non-governmental sector** ***Address:*** *UN House, Eristavist. 9* *UN Meeting Room*	Maka Maglakelidze m: +995 599 79 0110	***All***	Organisations present on the meeting: “Tanadgoma”, Curatio International Foundation, Georgia Plus Group, Institute of Human Rights, Georgian Harm Reduction Network, Addiction Research Center, Hera XX

Wednesday, 4 March 2015

Time	*Activity*	*Contact Person*	*Participants*	*Remarks*
09:30-11:00	**Tamar Gabunia** CCM Vice-Chair, USAID funded TB Prevention Project in Georgia, Chief of Party ***Address:*** *57 Shartavast.*	Tamar Gabunia m: +995 599 07 10 18	***All RK***	
11:15-12:00	**Andrei Mosneaga** Senior Tuberculosis Advisor to the MolHSA, International Union against Tuberculosis and Lung Disease (USAID-Funded Project) ***Address:****Asatianist. 9m*	Andrei Mosneaga m.: +995 599 02 11 47 andrei.mosneaga @gmail.com	***All RK***	
12:00-13:30	**Amiran Gamkrelidze** *NCDC PH, General Director* ***Address:****Asatianist. 9m*	Amiran Gamkrelidze m: +995 599 501 894	***All RK***	
13:30-14:30	**Lunch**			
14:45-16:00	**Marina Darakhvelidze,** *MoLSHA, Head of Healthcare Department* **Ketevan Goginashvili,** *MoLHSA ,Head of Policy Unit, Healthcare Department* ***Address:*** *Address: 144 Tsereteli Ave.*	Marina Darakhvelidze m: +995 577 72 26 42 Ketevan Goginashvili m: +995 577 71 79 84	***All RK***	Discussion of the State programs that include HI/AIDS related components. MoLHSA's vision with regard to HIV/AIDS policy was discussed.
16:15-18:00	**Tengiz Tsertsvadze,** Infectious Diseases, AIDS and Immunology Research Center, General Director ***Address:****16 AlexandrKhazbegi Ave*	Nikoloz Chkhartishvili, m: +995 599 53 53 66 Kaki Abutidze, m: +995 557 31 71 07	***All RK***	

Thursday, 5 March 2015

Time	*Activity*	*Contact Person*	*Participants*	*Remarks*
09:30-11:00	**Zaza Avaliani** National Center for Tuberculosis and Lung Diseases (NCTLD), Director ***Address:*** *50 Maruashvilist.*	Zaza Avaliani, m: +995 599 58 53 36	***All RK***	
11:00-13:00	**Tamta Demurishvili** Ministry of Corrections and Legal Assistance, Head of the Department of Healthcare ***Address:*** *3, Sandro Euli st.*	Tamta Demurishvili m: +995 599 92 30 82	***HF RK***	
11:30-13:30	**Site visit to Prison #8**		***JL ES AS NM***	Getting acquainted with the specifics of OST and of HIV/AIDS services. Discussion with the head of the department of healthcare.
13:30-14:00	**Lunch**			
14:00-15:45	**Nino Tsereteli** "Tanadgoma", Executive Director ***Address:*** *A. Kurdianist. 21*	Nino Tsereteli m: +995 599 15 80 30	***JL HF***	Discussion of the activities of the organisation, meeting with the beneficiaries-MSM, and outreach workers.
14:00-15:45	**Maka Gogia** Georgian Harm Reduction Network, NSP Program Director ***Address:2, Pekin Av., 2nd entrance, 4th floor, 19 Apt.***	Maka Gogia, m: +995 599 21 81 23	***ES***	Discussion of the activities of the organisation, meeting with the beneficiaries.
14:00-16:00	**Site visit to the Infectious Diseases, AIDS and Immunology Research Center.**	*Address:16 AlexandrKhazbegi Ave*	***AS***	Getting acquainted with the specifics of clinical aspects at the Center.
16:00-18:00	**Meeting with HIV NSP Development Working Group** ***Address:*** *NCDC PH, Asatianist. 9m,5th floor, PIU meeting room*	Ketevan Stvilia, m: +995 599 56 44 37	***All***	

Friday, 6 March 2015

Time	*Activity*	*Contact Person*	*Participants*	*Remarks*
9:00-10:30	**Mission Team Meeting**	Jeffrey Lazarus	***All***	Preparation for the presentation of the preliminary findings to be presented on the CCM
11:00 – 12:00	**Valeri Kvaratskhelia** MoLHSA, Deputy Minister ***Address:*** *144 Tsereteli Ave., 11 Floor*	Elza Telia, m: +995 593 757 542	***All***	Discussion of preliminary findings of the mission, and MoLHSA's policies, plans with regard to HIV/AIDS
13:00-16:00	**CCM Meeting** ***Address:*** *144 Tsereteli Ave., 8th Floor, Meeting Floor*	Natia Khonelidze, m: +995 577 40 92 29	***All***	Presentation of preliminary findings of the mission

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