August 2010

GEORGIA National HIV/AIDS Strategic Plan for 2011-2016

Table of Contents

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AMT	Agonist maintenance therapy
ART	Antiretroviral treatment
ARV	Antiretroviral
BBS	Bio-behaviour survey
BCC	Behaviour change communication
CCM	Country coordinating mechanism
CSW	Commercial sex worker
DOT	Directly observed therapy
FSW	Female sex worker
FTE	Full time equivalent
GHSPIC	Georgia health and social projects implementation center
GIPA	Greater involvement of people living with or affected by HIV/AIDS
HBV	Viral hepatitis B
HCV	Viral hepatitis C
HIV	Human immunodeficiency virus
IDU	Injecting drug user
IEC	Information, Education & Communication
IO	International organization
M&E	Monitoring and evaluation
MARA	Most at risk adolescent
MARP	Most at risk population
MARY	Most at risk youth
MoLHSA	Ministry of Health, Labor and Social Affairs
MSM	Men having sex with men
NCDCPH	The National Center for Disease Control and Public Health
NGO	Non-governmental organization
NGO	Non-governmental organization
NSP	National HIV/AIDS Strategic Plan
OI	Opportunistic infection
OST	Opioid Substitution Treatment
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis
PIT	Provider initiated treatment
PLWH	People living with HIV/AIDS
QA	Quality Assurance
RCC	Rolling continuous channel (The Global Fund mechanism)
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
USAID	Unites States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

1. INTRODUCTION

This National HIV/AIDS Strategic Plan (NSP) is the third for the country, which in its initial section evaluates national response and achieved outcomes as of October 31st, 2009. Based on this analysis identifies priorities for the *National HIV/AIDS Strategic Plan* (NSP) for 2011-2016. Proposed priorities are placed in the overall health reform context of the country, which is affecting many conventional approaches, including those related to HIV/AIDS.

The document elaborates details of the NSP and sets specific targets to be attained by 2013 and by 2016. In the given global financial crisis with uncertain economic outlook NSP budget provides two scenarios. While first scenario includes all activities planned under NSP, scenario two only looks at those most essential activities without which reducing HIV spread in the country will face challenges.

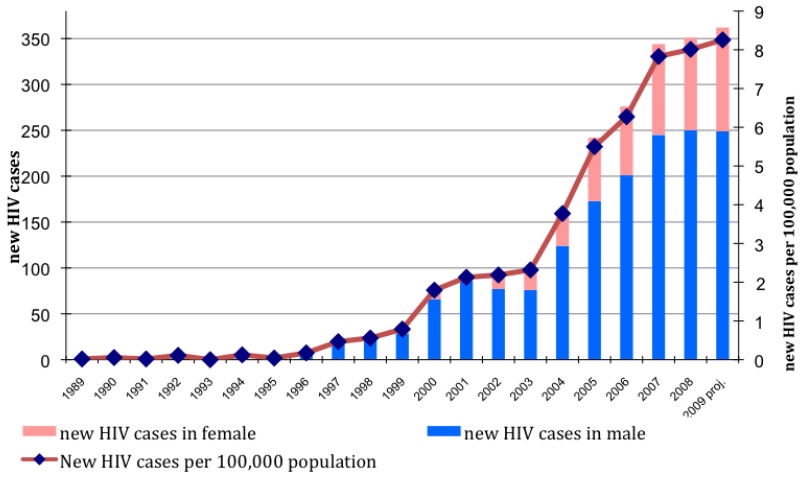
All priorities presented hereby were elaborated through transparent and participatory national process that involved topic-specific working groups, steering committee members and broad group of stakeholders that participated in the three national consultations held on December 25, 2009, April 21, 2010 and on July 5, 2010. The document was externally reviewed by *AIDS Strategy and Action Plan* (ASAP) of the World Bank. And all key decisions were made and approved by the Country Coordinating Mechanism (CCM).

2. ANALYSIS OF EPIDEMIC AND NATIONAL RESPONSE

EPIDEMIC UPDATE

The first case of HIV in Georgia was detected in 1989. Thereafter the number of annually detected cases was small. Detection significantly accelerated after arrival of the Global Fund financing. The new resources helped beef-up diagnostic capacity of the country and increase availability of HIV tests. Consequently, annual number of detected cases grew sharply from around hundred during 2000-2003 to over 250 since 2006. As of today, detected HIV cases are still growing but growth pace reveals declining trend over past three years.

Figure 1 HIV Cases in Georgia (1989 – 2009)



Geographically HIV cases widened unevenly. Samegrelo Zemo-Svaneti, Adjara and Tbilisi are leading the list with highest cumulative HIV cases 74.4; 72.6; 66.2 per 100,000 population respectively [1]. However, when comparing region-specific data on cumulative HIV cases for 2007/09 [2] with 2004/06 (three-year averages), Abkhazeti and Shida Kartli show fastest increase in reported cases by 322% and 140% respectively, while national increase amounted to only 55% during the same period. Racha-Lechkhumi, Samtskhe-Javakheti and Guria reveal declining trend in HIV reported cases by -100%; -82.4% and -26% respectively. Such uneven geography for epidemic development permits focusing interventions on the priority locations as opposed to mounting nationwide response.

The recent HIV surveillance data confirms that infection remains located among male population and the risk groups - IDUs, MSM and CSW (but primarily IDUs) remain to be the drivers for infection spread. *Behavior Biomarker Surveys* (BBS) regularly implemented among these groups since 2002 reveal increasing HIV prevalence. Prevalence among IDUs range from 0% to 4.5% depending on the locality[3], among CSWs between 0.8% in Batumi to 1.8% in Tbilisi and among MSMs -3.7% in Tbilisi. These rates are significantly higher than the prevalence among general population - 0.038% in 2009. Furthermore, HIV prevalence among pregnant women and blood donors is seen to be even lower (0.02% and 0.013%, respectively). During 2008, intravenous injecting route for HIV infection transmission contributed 56.1% of cases and heterosexual transmission was responsible for 37.3% of cases. However, every second individual infected via heterosexual transmission was a sexual partner of the risk group member, emphasizing importance of the risk-groups as primary drivers of HIV spread.

[1] Projected data for 2009 based on 10 month data

[2] Ten month data for 2009 has been extrapolated for 12 month to assure comparison

[3] In Batumi 4.5%, Kutaisi -3.1%, Tbilisi – 2.5%, Zugdidi 2.2%, Telavi 1.5% and Gori 0%, Bio-Behavioral Surveillance Surveys Among IDUs in Georgia, December 2009, Curatio International Foundation.

The data presented above is from routine HIV surveillance system, which was recently designed and piloted in two regions of Georgia. However, it requires cautious interpretation until thorough epidemiological research is conducted and more explicit conclusions about epidemic drivers are made. Meantime, available evidence points towards the need for furthering preventive interventions among Most at Risk (MARP) and bridging populations.

Based on the available evidence among males and females alike population older than 25 years is most affected with HIV infection. However, number of HIV cases found among 15-24 year old females is almost three times higher than among males of the same age group. This is most likely due to relatively timely detection of infection among females as opposed to males, where infection gets detected with a significant delay. Since 2004, on average 45% of annually detected HIV cases are already with developed AIDS disease. The problem of late detection is further confirmed by steadily growth of AIDS incidence (it increased from 0.36 per 100,000 population in 2000 to 5.3 in 2008), while in Western Europe these rates have been on a decline and in Central Europe it reveals constant trend. High share of late HIV detection negatively affects ARV treatment outcomes, which is described later in this report.

NATIONAL RESPONSE TO DATE

ADVOCACY, PUBLIC POLICY AND HIV/AIDS NATIONAL GOVERNANCE

Georgia has committed to the UNAIDS "Three Ones" principle and prioritized attainment of all three targets within the National HIV/AIDS response. Country endorsed one agreed HIV/AIDS National Strategic Framework for 2006-2010 (revised and modified in 2007); in 2005, established National AIDS Coordinating Authority (legislated in 2009 by Parliament) and initiated process for National Monitoring and Evaluation framework development, albeit without significant progress.

The responsibility for providing an effective HIV/AIDS response has been divided between various state institutions and agencies, which include: a) The Country Coordinating Mechanism; b) the Ministry of Labor, Health and Social Affairs; c) The Georgia Health and Social Projects Implementation Center – the principle recipient of Global Fund grant(s); d) The National Center for Disease Control and Public Health (NCDCPH) and e) The Infectious Diseases, AIDS and Clinical Immunology Research Center. While significant progress has been made in coordinating national response, lack of adequate M&E system imposes significant limitations. Therefore, more work is required to strengthen the CCM secretariat, establish and/or improve reporting links and requirements among various players and most importantly develop *One National Monitoring and Evaluation Framework*, which has to render critical information for decision-making and better coordination.

Furthermore, responsibility for execution of the national program lies with the Ministry of Labor, Health and Social Affairs (MoLHSA). However, there is hardly any designated department and/or person charged with this responsibility. This responsibility is distributed among various units, which undermines effectiveness of the execution arrangements.

National efforts under NSP 2006-2010 have helped achieving some progress, namely:

- In its 2009 fall session Parliament of Georgia adopted new law on HIV/AIDS, which improved overall legal environment for national response. However, this law does not address regulatory barriers for drug users and prisoners stemming from criminal code of the country;

- HIV/AIDS Surveillance function has been formally re-assigned to NCDCPH and local technical assistance has been secured to strengthen HIV/AIDS surveillance system of the country. The new HIV/AIDS routine surveillance system along with BBS and sentinel surveillance is being implemented and rolled out nationwide. It is expected that this system will significantly improve the quality and availability of epidemiological data as well as will form indefinite part of the national M&E framework;
- With the funding from the Global Fund (Round 2, 6, 9 and RCC with total approved funding of 53.2 million $US[4]), resources available for national response have increased significantly, albeit they were not matched with adequate amount of national resources. Nevertheless, increased funding allowed scaling-up activities and delivering more preventive and curative services to those in great need;
- Civil society participation in planning and budgeting of the national response and their role in delivering preventive, curative and supportive services has significantly increased. In Georgia the civil society is a full partner in HIV/AIDS national response. NGOs are increasingly involved in advocacy efforts, research and community outreach activities to prevent the spread of the epidemic. The STI/HIV Prevention Task Force (PTF) has been established and is now active to ensure better coordination between governmental, international and non-governmental agencies and avoid duplication of activities. PTF has also secured seat in CCM on a rotational basis.

On the other hand, advocacy efforts have not fully rendered expected results. Stigma and discrimination of the risk groups and HIV infected remains to be a major challenge. Negative societal attitudes and low public awareness remain to be a major obstacle. Beyond societal attitudes, state criminal laws, regulations and policies relevant to drug use and preventive work among IDUs and prisoners are further limiting factors. The laws on drug addiction prevention and control are not adequate for implementing effective interventions (in public and penal sectors). Efforts to decriminalize drug use and create more conducive environment for interventions are not rendering expected results. Therefore, issue-focused and targeted advocacy efforts aimed at reducing legal barriers to epidemic response, seem to be essential for future success.

HIV Prevention

Prevention activities in the NSP 2006-2010 included almost all activities proposed by international community and included:

- Assuring safe blood supply;
- Preventing mother to child transmission;
- Preventing infection spread among *Most at Risk Population* (MARP) which included IDUs, MSMs, CSWs and prisoners;
- Prevention of TB/HIV co-infection;
- Prevention of HIV among youth, uniform services and at workplaces;
- Post-exposure prophylaxis.

However, the analysis of implementation revealed that national response has not placed equal importance on the listed interventions. Most efforts and resources were put towards priority areas/groups for prevention and least relevant activities to Georgian reality received low or no

[4] http://www.theglobalfund.org/programs/country/?countryID=GEO&lang=en

attention. Importance of MARP, prevention of mother to child transmission and assuring safe blood supply received priority attention. Namely:

- Since 2006, all blood donors are being tested for HIV, HCV, HBV and syphilis assuring higher safety of blood products. However, *External Quality Assurance* (QA) for laboratories, envisioned in the previous NSP, has not been implemented and quality and safety of blood and blood products still pose a risk. Timely development and implementation of the *QA* system will further increase blood safety. Furthermore, the share of voluntary blood donations has been slowly growing and reached only 5% in 2008 and commercial donors provided 85% of blood. HIV prevalence rates among all donors are three times lower than in general population, which indicates that commercial donorship in Georgia is not affiliated with the high risk for HIV infection, commonly seen in the neighbouring countries. **Nonetheless, advancing voluntary blood donation, considering new approaches to donor blood testing along with QA system for laboratories will be next logical step for increasing blood and blood product safety in the country.** Current blood safety is assured with the tests (HIV, HCV, HBV and syphilis) funded out of state budget or from donor funds, in the environment where blood-producing units are all private and they sell products to health care providers and/or patients. Thus, existing system of financing blood safety in Georgia raises sustainability concerns in medium to long term. These public subsidies for private sector are not justified in the context of health sector reforms that are being implemented by the government. Therefore, alternative approaches are warranted to assure blood safety and reduce government's (and donor) role in co-financing private business.
- During recent years, Georgia introduced universal HIV testing policy for pregnant women and currently the state assures 100% coverage with antenatal testing. This approach allowed detecting 34 HIV positive women during 2006-2008, which helped prevent mother to child transmission in all these cases. However, during 2007-09 there were nine HIV cases detected among children <3 years, indicating that not all mothers get tested and vertical transmission still takes place. While testing of pregnant has to continue, operational research is needed to understand implementation weaknesses, prevent vertical transmission, and save children. HIV prevalence among pregnant are lower than among general population (0.02% vs. 0.038% respectively) confirming that Georgia still faces concentrated epidemic linked to MARP. However, data for past three years shows that HIV rates are slowly increasing among all groups (pregnant, blood donors, general population and MARPs) indicating that infection spread has not been stabilized yet.
- Since 2006, Georgia with the help of the Global Fund scaled up prevention programs among IDUs. Geographic reach of the projects expanded as well as number of clients served with diverse preventive services. Namely:
    - As of 2009, there are nine methadone substitution centres throughout the country serving 1,705[5] clients (twelve-fold increase since 2006). However, coverage with substitution or detoxification services in the country is quite low and barely reaches 4%[6] of those in need. Major focus is retained on *Opioid Substitution Treatment* (OST) and state financing and provision of other treatment options for drug users

[5] This number is inclusive of 92 HIV positive patients.

[6] Bio-Behavioral Surveillance Surveys among IDUs in Georgia; December 2009; Curatio International Foundation, Tbilisi.

are very low (only 78 patients in 2009), which leaves the patients with limited treatment choices. Georgian Orthodox Church also offers treatment services covering around 50-100 IDUs annually, which is significantly low compared to the need. BBS studies show that demand for drug dependence treatment, other than OST, is significant among IDUs. During 2007-2008 the state generated US$ 12.3 and US$ 16.7 million respectively through fines imposed for drug consumption[7]. This is twice the annual cost of the national HIV/AIDS program and there seems to be sufficient national resource to consider funding drug dependence treatments beyond OST and expanding other treatment choices for drug dependant patients.

- Since 2008, OST centre was opened even in the pre-detention facility of the penal system where 235 drug users received services as of October 2009. However, when these figures are compared with those imprisoned during 2008 due to drug use (3072 individuals), it becomes obvious that treatment capacity in the prison system is significantly lower relative to the need. Therefore, current achievements do not provide ground for satisfaction and further efforts in penal system are warranted.
- In 2008 harm reduction programs among IDUs reached 14,744 beneficiaries. However, BSS findings show that only 3% - 8.4%[8] (depending on location) undertook HIV tests during past 12 months prior to interview[9]. Preventive interventions had positive impact on increasing knowledge about HIV, slightly reducing unsafe injecting practices, increasing condom use at last sexual intercourse up to 80% almost in all project locations. However, coverage of risk groups with preventive programs remains low (see Figure 2) and uneven in various project/program areas. Furthermore, BSS studies indicate that clients do not receive comprehensive package of preventive services and quality of such interventions are questionable[10]. Increased knowledge has not been translated into safe behaviour and risk of contracting HIV is still high. Therefore, improving quality of preventive packages, scaling up interventions and reaching higher number of IDUs with comprehensive preventive services (primarily focused on behaviour change) seem essential for containing infection growth among IDUs.
- Preventive projects among *Commercial Sex Workers* (CSWs) show better performance with regard to condom use (92-98% CSW reported using condoms with their clients), however HIV testing rate during last 12 months remain low (27.5% in Tbilisi and 23.3% in Batumi). Based on BBS studies HIV infection is showing growing trend among this group. This could be attributed to low knowledge about HIV transmission (only 6% of CSWs in Batumi correctly answered the questions about HIV transmission)[11]. BBS in Batumi shows good reach of preventive programs achieving 85.8% coverage (above 2010 target of 80% under NSP). Furthermore, four *Health Cabinets* have been operational in Tbilisi, Kutaisi, Batumi and Zugdidi. The fifth one will become operational in 2012 in Telavi. *Health*

[7] These amounts reflect fines and charges imposed under criminal code and under administrative code.

[8] Target for this indicator under the NSP 2006-2010 was set at 45% and it is obvious that will not be achieved.

[9] Bio-Behavioral Surveillance Surveys among IDUs in Georgia; December 2009; Curatio International Foundation, Tbilisi.

[10] Ibid.

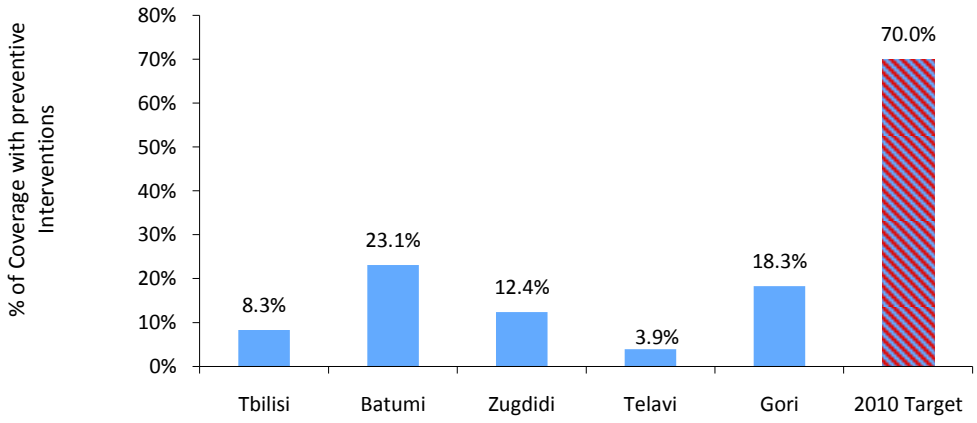
[11] Bio-Behavioral Surveillance Surveys among CSWs in Georgia; December 2009; Curatio International Foundation, Tbilisi.

Cabinets provide integrated HIV/STI diagnostic and STI treatment services to CSWs and MSM.

- Since 2005 HIV testing rates among Tbilisi MSM increased significantly and reached 44 per cent in 2007.[12] However, outcome indicators of knowledge about HIV transmission show that only 24% of MSM are knowledgeable of transmission routes. Nevertheless, condom use among this group is sufficiently high 61.5% but not adequate for effective prevention.
- Similar progress has not been observed with the interventions aimed at prisoners due to highly restrictive state regulations and attitudes of prison authorities. These issues require adequate attention under advocacy to facilitate preventive service provision to those in a penal system.

Bio-Behavioural Surveys since 2002 show that preventive interventions have increased in all MARPs, however lack of standardized prevention package limits achievements of the national goals. Survey findings suggest that quality improvements are necessary. Therefore, new NSP has to consider developing interventions, which can prove its effectiveness in Georgian context and thereafter scale up to assure adequate coverage of MARPs and consequently behavioural change.

Figure 2 IDU Coverage with preventive service/programs in 2008



Preventive interventions aimed at youth were considered as priority under the NSP 2006-2010. During last three years (2006-2008), these interventions consumed significant financial resources (2.3 times exceeding estimated financial needs under NSP 2006-2010). Detailed analysis revealed that most funds for these projects were supplied by donor organizations and channelled through various international and national NGOs and IOs[13]. Unfortunately, impact of these interventions was not evaluated properly at the time of the strategy preparation. BSS studies among IDUs show that drug injecting starts at early years among youth and also individuals that start injecting early have higher odds of contracting HIV. Furthermore, young adults are particularly vulnerable to STIs due to high prevalence of unprotected sex among this group. Based on national statistics[14] in 2008

[12] Bio-Behavioral Surveillance Surveys among MSM in Tbilisi 2007.

[13] Authors of this report do not assume responsibility for the data supplied by donor organizations and their partners. Sole responsibility for the data quality, classification of expenses by type of expenditure and intervention rests only with respective organizations that supplied information.

[14] National Centre for Disease Control 2009: Health Care Statistical Yearbook 2008.

odds of gonorrhoea infection among young males (15-29 years) was 4.6 times higher compared to older age group[15]. Also, the Bio-BSS among IDUs (2008-2009) revealed syphilis prevalence rate 2.1% among 18-24 years age group, which possibly indicates a newly acquired infection. Furthermore, HIV sentinel surveillance among Tbilisi STI patients in 2009 revealed 2.33% HIV prevalence rate (23/988). Due to the study limitations the findings cannot be generalized, however 11 (55%) cases were identified among < 20 years age group, which is alarming. Therefore, youth remain to be important target group for epidemic prevention and control and have to be considered under NSP.

While outcome and impact of the preventive interventions among youth supported under NSP 2006-2010 are not known, some critical conclusions still can be drawn: a) better donor coordination is required to avoid future "overspending" relative to budgeted needs or if the needs change, budgets should be amended accordingly and b) more thorough evaluation of interventions aimed at youth and general public are warranted to increase effectiveness and efficiency of the national response. Consequently, there is a need to set aside sufficient portion of funds to adequately evaluate similar interventions/projects, assess the impact and/or derive lessons, which could form evidence-base for future planning. Such allocations could be part of the donor-funded projects or could be allocated under the national M&E plan to fund independent evaluations. **BSS studies show that youth are at most risk initiating drug injection. Therefore, preventive interventions among youth should remain strategic focus under new NSP; however careful approach to the design of actual interventions seems necessary.**

Furthermore, general stigma towards MARP and HIV infected people, prevent delivering effective interventions and remain to be a major obstacle for the national response. Formative and operational research seems to be essential to evaluate these barriers, their nature and identify possible solutions/interventions, which could help reduce stigma and deliver effective services to those in need.

National response under NSP 2006-2010 has almost ignored the needs of uniform services. According to stakeholders, in a given context their needs are not critical and could be regarded as irrelevant for the time being. Similar conclusions could be made about the HIV prevention in a workplace, with the exception of health care providers, in which risk of contracting HIV is still high, knowledge levels are low, and use of general precaution measures are not evident.

It is obvious that National efforts aimed at prevention of HIV spread are showing initial positive results. However, attained outcomes yet do not offer ground for satisfaction. Further efforts are vital. They have to capitalize on the accumulated knowledge and experience, have to increase scale, but most importantly quality of the interventions, and primarily among MARPS. Priority focus should be retained on IDUs and IDU prisoners, due to the size of these groups and due to significant risk to HIV exposure.

HIV/AIDS Treatment

As of October 31st 2009, there were registered 2157 HIV/AIDS cases and 471 AIDS related deaths in Georgia. Out of those still alive, 606 are undergoing ART treatment (see Table 1). Numbers of

[15] According to the national statistics newly diagnosed STI cases are decreasing during last 5 years due to lack of state financing for this program. It is believed that the statistics does not reflect real distribution of STIs due to significant underreporting of cases and due to high prevalence of self-treatment. According to experts ≈60% of STI cases are not reported and registered in the national statistics.

those enrolled in the treatment have grown significantly with the help of the Global Fund. Free treatment attracted more patients than expected under the *National Strategic Plan (2006-2010).* Based on the recent Spectrum estimates, current coverage with ART amounts to 88% and is slightly below 2010 target set under NSP 2006-2010(target >95%).

Table 1 Treatment of AIDS patients

	2006	2007	2008	2009
No of patients on treatment	266	346	498	606
Estimated No of Patients (UNAIDS, Spectrum), n	349	443	556	686
Coverage Indicator (%)	***76.2***	***78.1***	***89.6***	***88.3***

Source: Infectious Diseases, AIDS and Clinical Immunology Research Center2009

While, Georgia achieved almost universal coverage with treatment, outcome is significantly lower than NSP 2006-2010 target (see Table 2). Patient survival rates declined from 85% at 36 month for the cohort of patients enrolled in treatment during 2005 (see yellow cells in the table below) to 69% among patients who started treatment in 2006 (see blue cells in the table). The rates are also not favorable for 2007 cohort of patients (see pink cells in the table) with survival rate at 24 month already down to 75% and obviously, fewer patients are expected to survive at 36 month. Investments in ARV treatment will be wasted if survival rates for the patients are not improved under the new NSP and if lives are not saved.

Gender-specific survival rates show significant difference between males and females (see Figure 3). While survival rates for females remain stable over past three years, rates for males decline sharply. Such differences could be explained with several factors:

- Seventy one per cent of patients on ART are males and 74% of those are current or former IDUs;
- National surveillance data shows that late detection mainly occurs among male IDUs, consequently male cohorts who enter ART have AIDS with significantly lower CD count;
- International evidence proves that IDUs have significant adherence problems not only with ART but also with any other treatment (including OST and treatment for Hepatitis "C")[16].
- Co-infection with HCV is common among men (60.8%), reaching 73.4% among IDUs and resulting in significant proportion of deaths from end stage liver disease[17]

Table 2 Survival rates at 1, 2, and 3 years after enrolment in ART treatment

	2005	2006	2007	2008
Survival at 12 month	87%	74%	83%	77%
Survival at 24 month	-	87%	71%	75%
Survival at 36 month	-	-	85%	69%

Source: Infectious Diseases, AIDS and Clinical Immunology Research Center

Note: Colors identify the cohort of patients and the year of their enrollment in the ARV treatment

Consequently, high share of male IDUs in the treatment cohort along with cases detected at the stage of AIDS seem to be most important factors explaining different survival rates among males and females.

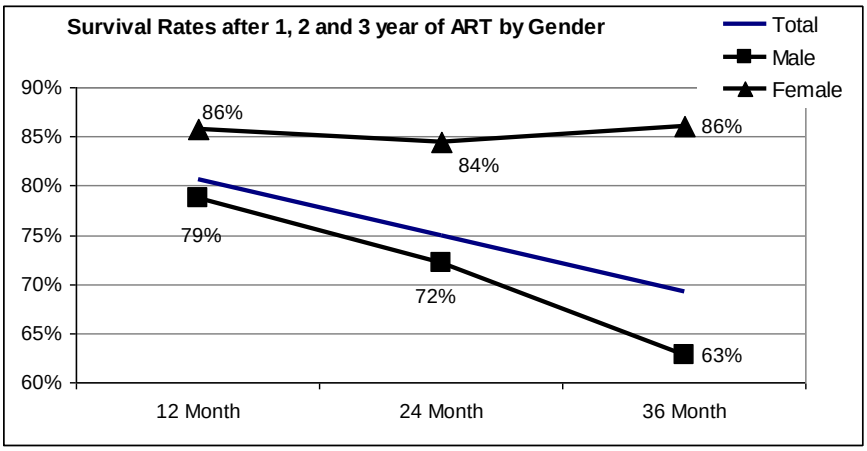
[16] UNAIDS, AIDS Epidemic Update 2009, http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf

[17] Source: National HIV/AIDS Center

In conclusion probably several factors explain poor treatment outcomes and suggest strategic objectives for the new NSP:

Late detection reduces effectiveness of HIV treatment. Almost every second HIV case in Georgia is detected with a delay and this trend has been stable for almost past five years. Therefore, scale-up of ART treatment during 2007-2009 enrolled many of those that were detected with developed AIDS disease, which worsened survival rate. BBS surveys show that awareness levels among MARPs about VCT services are high (around 70-80%), but this knowledge is not translated into behavior and actual testing rates, as stated earlier, are quite low (share of ever tested for HIV among IDUs[18]is around 25% and among MSM[19]- 41%). HIV testing rates increased among CSWs (90-98%[20]) probably indicating better quality of preventive interventions and/or scale within this group. Therefore, there is a need to increase HIV testing rates among IDUs and MSM, which could help identify HIV infected at an early stage of infection, timely enroll in ART and improve treatment outcome – save lives. A number of countries have successfully used a range of approaches for these purposes and Georgia needs to learn from these experiences. Furthermore, recent reforms in the health sector provide additional opportunities to pre-test for HIV all those enrolling with the health insurance companies. This approach may help to reach out ≈ 1.3 million residents. Individuals infected with HIV could be enrolled in ART funded by the state or the Global Fund. Thereafter, all those who will develop infection after enrollment in insurance, could be treated at the cost of insurance companies. This approach may provide dual benefit: a) help identify HIV infected timely and b) gradually shift responsibility for ART financing over to insurance pools as opposed to state budget and/or donor. Proposed, strategy could be complemented with the provider initiated counseling and testing. Proposed approaches are additional and cannot replace the need for increased testing among MARPs.

Figure 3 Survival rates at 1, 2, and 3 years after enrolment in ARV treatment by Gender



- Another strategy for early detection could be strengthened HIV surveillance: i.e. contact tracing and quality epidemiological investigation, which will play critical role in detecting more cases and timely enrolling in ARV treatment. HIV surveillance system is being improved in Georgia, but effective implementation of the surveillance regulations will rest on the well-trained and capacitated individuals, who possess adequate resources (financial and infrastructural). Therefore, new NSP needs to identify interventions that will help strengthen this critical function of the public health system and ensure its sustainability. And finally, provider initiated testing at STI clinics, narcology centers and TB facilities, will help increase number of those being tested and will help uncover HIV at an early stage of infection.

[18] Based on BBS studies conducted during 2008-2009

[19] Based on BBS studies conducted among MSM in Tbilisi in 2007

[20] In 2008 - 98% in Tbilisi and 92% in Batumi

- Populations at most risk of HIV exposure, such as injecting drug users, face considerable barriers to HIV treatment adherence. For active drug users it is essential to receive ART along with OST. Better operational linkages between ART and OST, reduced barriers to both treatments will be critical for improved treatment outcomes. However, punitive regulations against drug use and weak operational linkages between ART and OST treatment sites pose challenges, which have to be addressed in future.
- Finally, people living with HIV/AIDS are required to achieve high level of adherence to benefit from antiretroviral regimens. However, adherence to treatments poses challenges for ART sites. Several internationally recommended interventions have been put in place by the national AIDS center that are aimed at facilitating adherence with the help of social workers, monitoring drug dispatch frequency, etc. Furthermore, mobile units for the provision of adherence monitoring are affiliated with AIDS treatment centers in 4 cities – Tbilisi, Kutaisi, Batumi and Zugdidi. Mobile unit consists of three persons: Physician, Nurse, and Driver. Overall human resources of ART mobile units consist of 12 persons countrywide. Mobile units aim at improving adherence to ART. Main functions of mobile units are monitoring of adherence at home, through pill count, identification of pills by shape and color, etc. Mobile units also help Identify barriers to adherence through in-depth interview/dialogue with the patient, solving these barrier/problems through discussion involving primary physician and social workers if necessary. During 2009 these mobile units reached 266 patients and conducted 576 outreach visits (i.e. on average 2.17 per patient)[21]. Annual cost of operating these units amounted to US$ 319 per patient or US$ 147 per home visit. Although formal research to assess the effectiveness of ART mobile units has not been conducted, indirect measures to evaluate outcomes are available: i.e. adherence of 82% in 2008 increased to 93% in 2009. In addition out of 81 patients who discontinued treatment 42 re-started and currently are on ART[22].

Beyond stated reasons, there are factors related to clinical care, which also deserve attention. Leading cause of death among AIDS patients still remains to be TB and end stage liver diseases 24% and 18% respectively. In 11.7% of death cases the AIDS center suspects atypical mycobacterium and fungal diseases, but they could not be confirmed due to lack of necessary laboratory capacity in the country. Almost every second HIV infected individual is co-infected with TB (active or latent) and 48% have hepatitis “C”. Under NSP 2006-2010, Georgia increased HIV testing among TB patients; joint TB/HIV strategy for 2007-2011 was developed and clinical guidelines for managing TB and HIV co-infection were elaborated. Trainings and refresher trainings for VCT were provided to TB doctors. Consequently, testing rates among TB patients increased from 13% in 2006 up to 46% in 2008 and national TB program started detecting up to 20% of annually detected HIV cases.

Detected HIV and TB cases undergo free ARV and anti-TB treatment funded by the state and the Global Fund, however free treatment for other co-infections and diseases are not available. Therefore, when accessing general medical services, PLWH face financial access barriers similar to those seen among general population. Unfortunately, these problems cannot be resolved only for PLWH. However, recent health sector reforms aim at increasing the number of individuals covered with the health insurance program. Insurance is seen as a mean to reduce/remove financial access barrier. PLWH would significantly benefit from such insurance coverage, however

[21] Source: Infectious Diseases, AIDS and Clinical Immunology Research Center2010

[22] Ibid.

yet HIV/AIDS is not insurable risk, because significant part of personal services for this group is funded either by government or by donors. In a given context it becomes important to assure that gradually PLWH will be covered under insurance program and such coverage will not only provide free ART and TB treatment, but will also finance other medical services, which patients may require.

Beyond financial access barriers, stigma and confidentiality issues also place important access barriers for PLWH. PLWH are afraid that medical staff will reveal their status to other people in a community. In addition, there are reports that some medical providers reject patients after learning their status[23]. Therefore, under the new NSP special attention has to be placed on reducing stigma and primarily among healthcare providers.

CARE AND SUPPORT FOR PLWHA

Since 2008, Georgia established four centers with ten beds placed in Tbilisi, Kutaisi, Batumi and Zugdidi for palliative care purposes. Besides there are five teams (two in Tbilisi and one in each location) that offer home-based services to those in need. The main goal of this service is to relieve suffering and improve the quality of life for persons who are living with or dying from a life-threatening illness. Hospices provide wide-range medical care depending on underlying disease, and patients are ensured with appropriate nutrition. Mobile units provide home-based medical care, which may include post-operative care, administration of medicines, transfusions, etc. In addition, mobile units, through non-medical component, offer psychological counseling for patients and their family members.

During 2009, total 60 patients were hospitalized, 340 patients received home-based support and mobile teams conducted 637 home visits to these patients. In 2009 annual cost of running hospice services amounted to US$ 1,887 per patient or US$ 185 per day of patient stay at the hospice. Annual cost of running mobile services amounted US$ 179.6 per patient visit[24].

In addition, nutritional support was secured through *World Food Program* (WFP) and monthly beneficiaries on average amounted to 210 individuals. Operational research revealed that food supplementation had shown positive impact on the treatment adherence.

GFATM supported activities for HIV/AIDS have helped creating social networks through HIV self-support centers. These centers were established in Tbilisi, Kutaisi, Batumi and Zugdidi and employ ~~10~~ 13 counselors throughout the country including 4 in Tbilisi and 3 at each regional Center. These centers allowed PLWHA to meet and exchange information, better understand their health problems and eventually become more open about their HIV status. Currently self-support networks offer psychosocial support through peer groups as well as through trained psychologist and hot-line services.

Contribution of self-support network is highly valued among PLWHA:

> *"... I met other infected people in the center, now I can share my problems with them and as a result, I do not consider my own status the biggest*

[23] Curatio International Foundation, 2008, Effects of GFATM on Georgia's Health System Development. www.curatiofoundation.org

[24] Source: Infectious Diseases, AIDS and Clinical Immunology Research Center2010

problem as earlier. I am trying to help others and overcome these difficulties together with them…"[25]

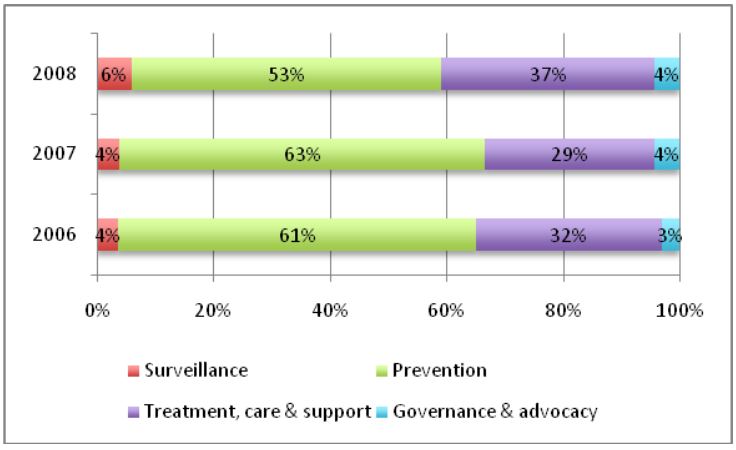
These projects are being supported by the Global Fund grant and their sustainability in future poses major challenges. Therefore, new NSP has to give significant attention to identifying sustainability dimensions and if required scaling geographic scope of such networks. Furthermore, *greater involvement of people living with or affected by HIV/AIDS* (GIPA) in various aspects of the national response should form the backbone for the new NSP.

FUNDING NATIONAL RESPONSE

Financial analysis of the national response reveals that over the period of three years (2006-2008) national program was well resourced and received US$ 19.3 million, which was 4.5% more than originally planned. The Global Fund grants were the single most important funding source rendering 59% of overall financing. Government spending has been growing steadily, but its share stood around 12% of annual funding for HIV/AIDS. Scaling up of various preventive and curative interventions have significantly increased annual cost of the national program, which grew from US $ 5.2 million in 2006 to US$ 8.0 million in 2008. Further increase in the annual cost of the program is expected due to: a) the need to improve quality and increase scale of preventive services; b) due to recently issued WHO treatment guidelines, which would result in increasing number of patients on ART[26] as well as increasing unit costs of treatment due to suggested changes in drug regiments.

Projections for 2010-2012 show that share of the Global Fund in total HIV/AIDS financing will further increase up to 73%[27], which is above the Global Fund's eligibility threshold for Georgia[28]. Therefore, country is faced with the risk of losing future TGF funding for HIV/AIDS if state budget financing will not increase by at least US $ 4-5 million per annum. Risk of accessing TGF grants further increase in light of global financial crisis and the TGF board decision for Round 10 to introduce new prioritization rules, which would adversely affect lower-middle income countries with concentrated HIV epidemic. Therefore, advocating for increased national financing becomes very important under the new NSP.

Figure 4 Funding by strategic priorities of NSP



[25] Curatio International Foundation, 2008, Effects of GFATM on Georgia's Health System Development. www.curatiofoundation.org

[26] According to National Infectious Diseases, AIDS and Clinical Immunology Research Center number of patients on ART is expected to increase from 606 in 2009 to 1,210 in 2011 and 1,630 in 2013.

[27] These estimations are based on already approved Global Fund financing and estimates from various sources. They also assume that government funding will increase with the pace observed during past several years.

[28] The Global Fund - Country Eligibility Criteria http://www.theglobalfund.org/en/eligibility/?lang=en

Analysis of NSP spending by strategic priorities revealed that share of funds spent on treatment and surveillance are increasing at the cost of declining share for prevention (see Figure 4). However, this decline should be interpreted cautiously, because in actual dollar amounts prevention received more funds than budgeted under NSP 2006-2010.

In addition, comparison of budgets with actual spending show that funds were not disbursed according to NSP priorities resulting in under funding on some priorities and overspending on others. Such discrepancies highlight the need for improved planning and budgeting and for improved coordination. National M&E framework will be a critical precondition for such improvements to occur. Therefore, it is essential to develop and implement national M&E framework under the new NSP as well as equip CCM with effective administrative tools/mechanisms (regulations and decrees) that will help influence performance of the executive branch of the government and other stakeholders involved in the national response.

3. STATE OF HIV/AIDS INFRASTRUCTURE AND AVAILABLE HUMAN RESOURCES

National response under NSP 2006-2010 is being delivered through joint efforts of public, private and non-governmental sector. As a result of recent investments (public, donor and private) the service delivery capacity increased significantly but some challenges still remain.

VOLUNTARY COUNSELING AND TESTING SERVICES

As of December 2009 there were 32 VCT sites in Georgia and 12 new VCT centres will become operational since 2010. Five VCT sites serving youth and supported by the Global Fund seized operations in December 2009, but further support is expected from USAID funded project. These centres employ 107 trained consultants. Out of those only 22 individuals are involved in state funded VCT sites and others are funded through donor-supported projects.

As of 2009 a total of 10 VCT sites were operating in the detention facilities and additional eight sites are expected to open in 2010, which will assure 100% coverage of all penal facilities in the country.

The data about operation of these sites is very limited, though some conclusions from the available evidence could be drawn. Namely, during 2009 there were 128,000 HIV tests conducted in the country out of which 109,000 were among the groups (pregnant, blood donors, military) that did not receive counselling. If all remaining tests were through VCT sites the workload per employed person would amount 1.42 contacts per day. Therefore, currently installed capacity for VCT is significantly higher relative to current workload and has ample room to increase volume of services without further investments in capacity[29].

Besides these sites there are two mobile laboratories funded by USAID and Oxfam/Novib and being operated by NGO "Tanadgoma." Medical Mobile Laboratory services are reaching out for risk groups in Tbilisi and West Georgia (Kutaisi and Batumi). During 2009 these two laboratories contributed 14% of all tests among groups at high risk. Estimated annual recurrent cost of operating such laboratory is $US 14 per person tested.

[29] Conditioned that current knowledge level of those employed at VCT sites meets expected standards, which was not evaluated during the process of NSP production.

Drug Dependence Treatment Services

During 2008 there were only six providers (in public and private sector) that offered *Drug Free Treatment* with total bed capacity up to 60 beds. During same year these clinics served 841 patients with detoxification services and limited psychological rehabilitation. In 2009 number of these clinics declined to five. All clinics are located in Tbilisi with the exception of one, which is serving Batumi. Up until 2009 *Drug Free Treatment* was not subsidised by the state and cost of treatment ranged between US$ 1,100 – 1,500. Prohibitive high cost along with geographical access barriers, pose significant challenge to those in need. During 2009 state provided funding for 78 patients, which is negligible compared to the needs and fate of this program in 2010 is not known.

Rehabilitation services are at an early stage of development. Currently there is only one centre in the country and several small units offering only day care services. However, funding for these centres is very limited and qualification of staff questionable. Georgian Orthodox Church operates ten sites that receive patients after detoxification, however their cumulative capacity is fairly small.

There are plans to construct long-term rehabilitative facility not far from capital city, with the capacity to host 80 individuals. However, these plans are not yet adequately resourced.

All of this indicates significant shortage of actual capacity (infrastructure and human resources) that is required to develop and deliver adequate drug free treatment and rehabilitative services to those with drug addiction.

Clinical Services

Specialized clinical services for HIV/AIDS are represented by the National HIV/AIDS centre in Tbilisi and regional AIDS centres located in Kutaisi, Batumi and Zugdidi. These centres operate:

- **Inpatient departments** with 22 beds (18 located in Tbilisi and two in each region, with the exception of Kutaisi that will install beds in 2010). In 2009 these facilities served 385 patients, with average length of stay 12 days and occupancy rate 57%.
- **Outpatient departments** delivered 11,570 visits during 2009 or 3.29 visits per FTE[30] (*Full Time Equivalent*) per day (or 109 minutes of staff time per patient)[31].
- **Laboratory departments**, which performed 14,939 tests or 4.0 tests per FTE[32] per day. Obviously the daily workload for lab-physician at the National HIV/AIDS centre was higher 4.8 tests per day compared to regional ones 0.8 tests (CD4 count) per day.
- Besides these departments, the National AIDS centre also operates **division of epidemiology** involved in treatment and care services and carrying out following functions: counseling, management of patient database and fulfilling social worker functions. Epidemiologist and counselors serve as a link for establishing HIV related clinical care.

[30] For ratio estimation only full-time staff (doctors and nurses) were taken into account and only 6-hour day was factored in calculation. Visits included ART and outpatient visits, both. The data for calculation was provided by the National HIV/AIDS centre.

[31] The same ratio if only doctors are used amounts to 5.12 outpatient contacts per day per doctor with average duration of the visit 70 minutes.

[32] For ratio estimation only full-time laboratory staff (12 in Tbilisi and 1 in each region) were included. Calculation included only number of HIV screening/confirmation tests, and three major tests employed for the disease monitoring (CD4 count, viral load and HIV drug resistance)

Epidemiologists along with a social worker and mobile units work to identify patients missing clinical appointments or those who are lost to follow-up to bring them back to the regular clinical care. The unit employs ten FTEs and during 2009 conducted 9,191 counseling (or 12 sessions per counseling FTE per day) and served 460 individuals with the help of a social worker (or 1.84 patients per day)[33].

- Capacity for palliative care provision and for ART mobile units were described earlier in this report.

The fourth regional centre operates in conflict region of Abkhazia. Sokhumi centre provides only outpatient services. Facilities are equipped with equipment for performing CD4 counts. Setting-up the virology diagnostic component of the laboratory is planned in 2010.

Staff of the centre consists of 4 full-time positions: 2 physicians, 1 nurse and 1 lab-physician. During 2009 this centre provided ART to 65 patients, served 580 outpatient visits, performed 337 CD4 counts and 187 HIV screening tests.

Human resources countrywide involved in the clinical care provision throughout the country are detailed in table 3.

At present, the building of the National HIV/AIDS Centre – country's referral institution is in a poor condition – the AIDS in-patient department is accommodated in the air-borne infection department of the infectious hospital, which poses additional risks for AIDS patients for contracting highly contagious microorganisms. Outdated facility was not designed to prevent risk of transmission of TB to other patients and health-care workers. Absence of a ventilation system and negative pressure rooms increases the risk of nosocomial transmission in the facility. In a given situation, while HIV infected individuals are at greater risk of progression from latent TB to active disease, severely immunosupressed patients, those hospitalized patients, who become newly infected with M. tuberculosis, have an even greater risk for developing primary active TB.

Table 3 Human Resources for AIDS clinical care countrywide

Staff Category	No.
Clinical personnel	**38**
Physicians, full-time	14
Physicians, part-time	5
Nurses	13
Aides	6
Lab personnel	**21**
Lab-physician	16
Supporting personnel	5
Epidemiology division	**10**
Epidemiologist	3
Counsellors	3
Database management group	3
Social worker	1
ART mobile units	**12**
Palliative care	**40**
Hospice	16
Mobile units medical staff	12
Mobile units non-medical staff	12
Self-support centres	**13**
TOTAL	**134**

Laboratories at current state do not comply with bio safety level II requirements, including ventilation, lockable doors, furniture, etc. The Centre does not have bio safety level III laboratory, which is essential for performing assays on Mycobacterium and other highly contagious microorganisms. The country lacks capacity to implement several laboratory methods such as laboratory diagnostics of non-tuberculosis mycobacterium and fungi, blood tests for diagnosing latent TB. Novel diagnostic tools for the monitoring of ART are also not available.

The National HIV/AIDS centre in Georgia lacks instrumental diagnostic capacity such as CT, MRI. X-Ray, which prevents from making accurate diagnosis and providing appropriate treatment of AIDS-

[33] Source: Infectious Diseases, AIDS and Clinical Immunology Research Center2010

and Non-AIDS related conditions at this clinical site. The AIDS service also lacks endoscopy diagnostic capacity (gastroscopy, bronchoscopy, colonoscopy), and ultrasound for cardiovascular diseases (CVD). The latter represents barrier for the effective management of cardiovascular complications of AIDS and ART. Although these diagnostic capacities are available in close proximity to the National HIV/AIDS centre, transportation of AIDS patients is not usually possible because of infections control issues, severity of the patients' condition and financial burden.

4. HEALTH SECTOR REFORM CONTEXT

The health sector in Georgia is undergoing a profound re-structuring that would affect all levels of service delivery and financing, including for HIV/AIDS. New reforms address the problem of out-of-pocket payments that have emerged as significant financial access barriers to care. These barriers exist for PLWHA when they seek non-specific treatment. Since 2007, government introduced a voucher system for most poor layer of the society, which is 100% funded out of state budget. Population exchanges these vouchers for insurance policy at the private insurance company of their choice. Insurance premiums for this coverage are fully paid by the government and most services included in this package are not subject to patient cost sharing. During 2009, this program expanded to the next layer of the society, where government subsidizes 70% of the annual premium and the remaining is paid by the individual/family. Beyond these schemes certain occupation groups (teachers, police) have purchased insurance for their staff out of their own budgets. Because of these reforms towards the end of 2009 Georgia already had 1.3 million individuals (or almost third of the population) insured under various schemes.

There are long-term plans to create universal state health insurance program and enrol all population in it. This insurance program is expected to cover all basic medical services for the individual, which potentially could include HIV/AIDS, TB and other diseases that affect HIV infected individuals. Therefore, in a long-term perspective, NSP 2011-2016 has to make decision about retaining and funding HIV preventive and curative services solely out of public funds or thinking and integrating HIV care and financing in the insurance package and eventually paying for these services out of insurance risk pools.

Furthermore, Government embarked on large-scale privatization of the service provider network and has already sold significant stock of medical facilities including PHC and hospitals countrywide. As a result, private sector providers are emerging and they are being contracted and reimbursed for service provision by private insurance companies and/or public purchaser (for the time being). This new context defines new role for the public sector during years to come, which is protection of public health through funding and providing public health services aimed at groups of population. Therefore, NSP 2011-2016 is faced with the challenge of defining which part of the national HIV/AIDS institutions (diagnostic and treatment sites) have to be retained by the state and which part could be transferred to private ownership and how these services will be planned, funded and provided. These decisions will obviously have to touch upon the laboratory network for HIV/AIDS diagnosis and confirmation, facilities involved in safe blood provision, providers offering OST, ART and other specific preventive and curative services, etc.

5. PROGRAM GOAL AND OBJECTIVES

Based on the presented analysis following emerge as a priority for NSP 2011-2016:

Overarching Goal of the National Strategic Plan for 2011-2016 is to stabilize epidemic growth, primarily within the most-at-risk population and improve health outcomes for PLHA, through improved coordination and strengthened advocacy of the national response.

In order to achieve this goal NSP has to concentrate on following strategic objectives:

1. Enhance coordination and advocacy efforts of the national response;
2. Improve quality and increase scale of preventive interventions;
3. Maintain universal access to ART and improve treatment outcomes;
4. Assure adequate care and support for the PLHA;
5. Strengthen Health System capacity for effective HIV response.

Each strategic objective, its targets, relevant strategic priorities and interventions are elaborated later in this document.

Expected outcomes from effective implementation of NSP are:

- By 2016 HIV prevalence among MARPS is contained under 5%
- By 2016 HIV prevalence among pregnant is contained under 0.04%
- Rate of late HIV detection is reduced from 46% to 25% by 2016
- By 2016 survival rate at 12month of those on ART is > 85 %

6. IMPLEMENTATION PRINCIPLES

This National Strategic Plan builds on "Three Ones" principle to which Georgia is signatory. Country has already established and single national coordinating body – CCM for the national response to HIV and AIDS. Current document serve the purpose of a single national action plan in response to epidemic and proposes finalization to single national M&E framework.

In addition, the national strategic program implementation will be based on the following principles:

- Continuum of prevention, testing, early detection and timely enrolment into treatment with the objective of saving lives, is the main principle for the national response;
- All activities will promote, protect and respect human rights and assure gender equality and greater involvement of people living with or affected by HIV/AIDS;
- Implementation will be based on close and fruitful cooperation between government, non-government and private sector, which will be founded on the principles of transparency, partnership and mutual confidence;
- Focus will be retained on reducing access barriers (i.e. legal, geographical, financial, cultural) to preventive, curative, support and care services;

- Peer driven models will be widely used in order to promote a supportive and enabling environment for vulnerable groups and help them engage in and benefit from the interventions planned under the national program. The concept of a supportive and enabling environment will recognize that "*the most effective responses to the epidemic grow out of people's action within their own community and national context*."[34]
- Better quality preventive interventions will achieve coverage and intensity necessary for making critical difference in controlling the infection spread. Preventive interventions will also aim at increasing testing rates among risk groups as well as at the clinical settings by promoting Provider Initiated Testing in narcology, STI, TB clinics and ANC centres;
- Interventions will be differentiated and locally adapted to the relevant epidemiological, economic, socio-cultural and health sector context in which they are to be implemented. In Georgia, this includes taking into account the reforms taking place in the country, ensuring that the interventions are designed to fit the reform directions, with activities tailored to the needs of local populations (including ethnic minorities), using activities, messages and channels based on community knowledge and culturally sensitive to community beliefs;
- HIV prevention will be supported with evidence, based on what is known and proven effective from all available data, and the generation and use of the new country-specific evidence will be expanded and strengthened;
- Where national capacity is lacking external technical assistance will be mobilized to achieve relevant design and adaptation of interventions to the existing socio-cultural, political and economic context and/or for generating new evidence.

7. PROGRAMMATIC ACTIVITIES AND EXPECTED RESULTS

The proposed programmatic activities are grouped around five strategic objectives listed in Section 5. The brief description of the planned interventions and expected outcomes are provided in this section. However, more details per each activity are available in the Annex 1.

STRATEGIC AREA 1: ENHANCE COORDINATION AND ADVOCACY EFFORTS OF THE NATIONAL RESPONSE

Three strategic objectives are envisioned under this area:

Strategic Priority 1.1 - *Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function*. This would require:

a. **Developing new CCM bylaws**, in line with the provisions of recently adopted Law on HIV/AIDS, and equipping CCM with the needed regulations-instruments required for effective execution of its roles and responsibilities;
b. **Increasing capacity of the CCM's secretariat** through regular participation in HIV/AIDS related events/conferences on an international and regional level and through assuring sustainable financing and provision of the needed technical assistance.
c. **Developing, implementing and fully operationalizing one M&E framework** for the country. For this purposes Georgia will strive to: i) assure sustainable functionality of the national HIV/AIDS surveillance program, which renders critical epidemiological and programmatic

[34] Handbook for Legislators on HIV/AIDS, Law and Human Rights. Geneva, UNAIDS/IPU 1999.

information about national response; ii) develop national M&E framework for HIV/AIDS and its implementation arrangements; iii) conduct required operational research to inform policies and practice.

Strategic Priority 1.2 - *Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment services.* This would entail:

a. **Provision of technical assistance to the MoLHSA for improved budget planning** in close collaboration with the Ministry of Finance (MoF) ensure sustainable financing of the HIV/AIDS services;
b. **Provision of technical assistance to the MoLHSA** for exploring opportunities and developing recommendations for inclusion of HIV/AIDS coverage under insurance schemes;
c. **Conducting economic evaluation of various preventive and curative interventions** to inform resource allocation decisions and to conduct National AIDS Spending assessment and financial gap analyses to inform policy decisions.

Strategic Priority 1.3 - *Carry out necessary advocacy to create conducive environment for national response.* This advocacy will aim at:

a. **Reducing legal and regulatory barriers for drug users and prisoners** through: i) support to multisectoral group working on legal and regulatory issues stemming from criminal code and concerning IDUs and prisoners; ii) technical assistance to related ministries for elaborating policies aimed at eliminating legal barriers to effective HIV/AIDS interventions among IDUs and prisoners; iii) organizing policy forums and roundtable meetings for all stakeholders to discuss policy alternatives;
b. **Mounting advocacy focused on stigma and discrimination**, primarily among the health care providers. This would include: i) conducting operational research aimed at identifying key factors related to stigma and developing evidence-informed interventions; ii) planning and implementing adequate interventions aimed at combating stigma among the health care providers; iii) building media capacity to ensure effective communication of HIV related messages and iv) organizing effective information campaigns to build public support.
c. **Greater involvement of people living with or affected by HIV/AIDS** (GIPA) in the national response through: i) establishing grant programs for PLHA to support advocacy efforts, peer education and networking; ii) improving information availability for PLHA on the HIV/AIDS national response; and iii) developing training materials and conducting trainings for NGOs as well as governmental agencies on how to implement GIPA principles.

Strategic Area 1 - Expected outcomes from effective implementation are:

- Coordination of the national multi-sectoral response is effective and is based on the operational and strategic information, which is available for strategic and operational decision making;
- Adequate resources are mobilized and required investments assured for the delivery of quality prevention, treatment, care and support services;
- Supportive policies, along with changed societal attitudes and greater involvement of affected communities, provides conducive environment for the national response.

STRATEGIC AREA 2: IMPROVE QUALITY AND SCALE OF PREVENTIVE INTERVENTIONS

Comprehensive set of preventive interventions is envisioned under the program. Primary focus will be on preventing HIV spread among most-at-risk population by providing comprehensive preventive services. However, this will be complemented with prevention of infection spread within health care settings, through preventing vertical transmission and through reducing youth vulnerability to drug use and sex and consequently to HIV. Therefore following strategic objectives have been defined for this area of work:

Strategic Priority 2.1 - *Prevent HIV spread among most-at-risk population (IDUs; CSWs; MSM; Prisoners and MARA)*. This strategic priority will aim at increasing scale, scope and quality of preventive interventions in those geographical locations that are already functional. Broadening geographical focus will occur if and when epidemiology points toward the need. Prevention activities will also aim at increasing share of those tested on infection by emphasizing importance of VCT. In order to deliver adequate preventive services following is envisioned under NSP:

a. **Increase the scale and scope of integrated preventive interventions**, which will be achieved through: i) providing VCT services and increasing uptake of HIV testing among MARPs (including MARA); ii) scaling up *Agonist Maintenance Therapy* (AMT) for IDUs; iii) expanding drug dependence treatment services, which are currently in short supply; iv) implementing needle exchange and other harm reduction services and increasing access to preventive commodities with the help of peer-driven interventions and v) developing and implementing effective *Behaviour Change Communication* (BCC) strategies utilizing multiple channels of communication. Implementation of these activities will be accompanied with trainings aimed at upgrade of professional skills for staff of AMT, VCT, drug dependence centres.
b. **Improve the quality of preventive interventions through**: i) developing and implementing standard national guidelines for preventive interventions that will aim to standardize minimal set of interventions and their quality and ii) through monitoring and evaluating effectiveness of HIV preventive interventions in order to adjust programmatic decisions-interventions. This monitoring will be informed by client views to feed back and adjust interventions focused on quality improvement.

Strategic Priority 2.2 - *Prevent HIV transmission within health care setting*

a. **Enhance Blood Safety** through: i) assuring that all donated blood is screened in a quality assured manner and ii) promoting voluntary donorship. This area of work envisions development of state regulations and policies on donor blood testing, external quality assurance and for new approaches of financing safe blood production described under the *Strategic Priority* 5 - health system-strengthening component of the NSP.
b. **Reduce post-exposure HIV transmission** primarily within health care setting, where risks of being exposed are the highest. This will be assured through provision of education and PEP treatment to all health care workers in the country.
c. **Implement provider initiated testing (PIT)** in clinical settings will aim at increasing number of those that are tested in order to early detect infected individuals and timely enrol in treatment, if required. In order to increase PIT following will be accomplished: i) developing standards and guidelines for PIT; and ii) implementing PIT in narcology, STI, TB clinics and ANC centres (TB and ANC already covered by routine surveillance) in order to increase number of those tested; iii) providing trainings to health care workers of the relevant institutions.

Strategic Priority 2.3 - *Prevent Mother-to-child HIV transmission* through:

d. **Reducing HIV transmission from mother-to-child** by i) assuring universal screening of all pregnant women for HIV; ii) providing preventive ARV treatment to all HIV positive pregnant and iii) providing preventive ARV therapy and social care to all newborns.

a. **Improve the quality of PMTCT program** through i) whenever feasible integrating PMTCT program with existing Perinatal Hepatitis B Prevention Program, also funded and implemented by the state; ii) updating PMTCT guidelines and iii) providing training in PMTCT to health care workers of the relevant institutions. Integration of PMTCT services will be preceded with operational research, which should help identify current implementation bottlenecks and address those during integration.

Strategic Priority 2.4 - *Reduce Youth Vulnerability to HIV.* This strategic priority will be addressed by enabling young people protecting themselves and their peers from HIV Infection through: i) developing and implementing effective BCC focused on youth; ii) advocating for integrated drug and HIV prevention training course into National Education Plan and iii) developing and implementing *Drug-Free School Policies*.

Strategic Area 2 - Expected outcomes from effective implementation are:

- HIV prevalence among MARPS is contained under 5% by 2016
- HIV prevalence among pregnant is contained under 0.03% by 2013 and under 0.04% by 2016
- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016

STRATEGIC AREA 3: MAINTAIN ACCESS TO ART AND IMPROVE TREATMENT OUTCOMES

Assuring adequate coverage with ART and improving treatment outcomes for man and women alike receives strategic importance under this program. This will be achieved through:

a. **Maintaining and, if possible, increasing current access levels to ART** that will be achieved through: i) providing ARVs to all patients in need; b) providing regular laboratory and clinical examination of patients in treatment and c) maintaining treatment and care services in conflict region of Georgia – Abkhazia, where currently several dozen patients depend on the support offered and provided from Georgia proper.

b. **Improving treatment adherence among patients on ART** through: i) providing home-based adherence monitoring and support and ii) integrating HIV and TB services to offer one stop service to the patients. For both areas operational research will be carried out to identify areas for improvement as well as possibilities for integration, which should help patients access and receive treatment.

c. **Strengthening ART management capacity** through: i) implementing modern hi-tech laboratory tools (equipment and diagnostics) for ART monitoring; ii) implementing HIV drug resistance (HIVDR) prevention and assessment; iii) updating regularly clinical guidelines using emerging scientific evidence; iv) implementing clinical audits; v) maintaining HIV/AIDS clinical database, which helps monitoring treatment process and outcomes and vi) training necessary human resources for curative HIV/AIDS services.

d. **Scaling up management of opportunistic infections (OIs) and other co-morbidities** through: i) investing in modern instrumental diagnostics (CT scan, MRI, X-ray, ultrasound and other equipment); ii) improving management of latent and active Tuberculosis; iii) developing capacity for management of infections caused by non-tuberculosis mycobacterium, fungi and HPV; iv) improving management of HIV/HCV co-infected patients by offering HCV treatment up to 110 patients a year; v) providing management (prevention, diagnosis and treatment) for other common OIs and vi) providing in-patient care for all patients in need.

Strategic Area 3 - Expected outcomes from effective implementation are:

- Throughout program implementation 95% of those that require treatment receive ARVs.
- By 2013 survival rate at 12month of those on ART is above 85% and maintained at this level
- By 2013 survival rate at 24 month of those on ART is above 80% and maintained at this level
- By 2013 survival rate at 36 month of those on ART is above 75% and maintained at this level
- Treatment adherence rate for patients on ART are maintained above 95% throughout the program implementation.

STRATEGIC AREA 4: ASSURE ADEQUATE CARE AND SUPPORT TO THE PLHA

NSP 2011-2016 aims at assuring current level of care and support to PLHA. Although, needs driven expansion is also envisioned for future. Continuous care and support services will offer: i) counselling and psychological assistance to adults and children; ii) palliative care services (both institutional and home-based); iii) nutritional support to all those in need and iv) trainings to specialists involved in care and support services.

Strategic Area 4 - Expected outcomes from effective implementation are:

- Share of PLHA that have access to free basic external support (including health, psychological or emotional and other social and material support) is increasing.

STRATEGIC AREA 5: STRENGTHEN HEALTH SYSTEM CAPACITY FOR EFFECTIVE HIV RESPONSE

Some activities, which are essential for adequate national response to HIV epidemic, could also significantly contribute to health system strengthening in Georgia. Therefore, all those interventions, which may have impact beyond HIV response have been collected and presented in this strategic area of the NSP. Health system strengthening activities will focus on two strategic priorities: a) strengthening regulatory system to assure higher quality services in the health care settings and b) assuring necessary investments in human resources and in infrastructure. Details of these priorities are spelled out below:

Strategic Priority 5.1 - *Strengthen regulatory system and assure higher quality services in the health care settings* is expected to be achieved through following strategic objectives:

a. **Develop and Implement new regulations for Blood Safety –** this will aim at: a) developing, implementing and enforcing state regulations for *Laboratory Testing Standards* mandatory for blood safety; b) developing and implementing *accreditation standards* for blood and blood product producing units, which would include mandatory provisions for professional liability insurance for both private and public institutions; c) developing and implementing state regulations for *Laboratory Quality Assurance* (QA). These regulations will be for all laboratories in the country, including HIV/AIDS labs involved in blood testing for donated blood as well as for VCT and/or PIT. These requirements are intended to facilitate implementation of overall QA system for labs, which would also include *External Quality Assurance;* d) assisting MoLHSA with the elaboration and implementation of mechanisms geared towards transition from state/donor financed safe blood programs towards the system of sustainable self-financing.
b. **Develop and implement QA regulations for medical facilities for infection control.** These regulations will be aimed at improving overall infection safety within all health care facilities in the country. This will be achieved through: a) development and implementation of mandatory state regulations for infection control within health care setting, which along with other infection control regulations would also include *"Universal precautions"* aimed at preventing transmission of HIV, hepatitis B and C, and other blood or body fluid borne pathogens and b) enforcement of these regulations through facility accreditation system.

Strategic Priority 5.2 - *Assure necessary investments in the infrastructure and human resources.*

a. Strengthen Human Resource capacity for quality preventive and curative HIV services. This objective will be achieved through trainings described in the previous sections of the NSP under different strategic priorities (see Annex 1 for details). Furthermore, NSP will set aside funds to assure participation of Georgian specialists in various international forums related to HIV/AIDS.
b. **Assure necessary investments in the infrastructure,** which is required for curative and preventive services. For these purposes investments are planned for:
   i. Developing adequate physical infrastructure for AIDS treatment facilities in Tbilisi and in three regions of Georgia, which includes:
      - Construction of AIDS hospital in Tbilisi;
      - Refurbishment of three AIDS treatment facilities in the regions
      - Equipping and furnishing these facilities with diagnostic and clinical laboratory equipment (e.g. CT Scan, MRI, X-ray, etc.)
   ii. Based on the needs assessment developing physical infrastructure for HIV prevention services, which includes:
      - Refurbishment of VCT centres in the regions
      - Establishment of mobile laboratory for IDUs
      - Refurbishment of facilities for Agonist Maintenance Therapy
      - Refurbishment of Agonist Maintenance Therapy centres in prisons
      - Construction/refurbishment of drug dependence residential treatment centres

Strategic Area 5 - Expected outcomes from effective implementation are:

- Laboratory *Quality Assurance* system is effectively functioning in the country and assures high quality tests in the accredited facilities;
- Quality of curative and preventive services for HIV is improved due to enhanced infrastructure and trained human resources.

8. IMPLEMENTATION TIMELINES AND RESPONSIBLE INSTITUTIONS

Detailed list of activities and sub-activities proposed for each strategic priority is provided in the Annex 1. The table also offers information about responsible institutions and collaborating partners.

One of the key principles for NSP implementation will be close collaboration between government, non-government and private sector. The role of civil society played thus far: for advocacy, for delivering preventive interventions to groups at-most-risk, for delivering care and support services, etc. will be further expanded under the current NSP. The Government of Georgia recognizes that without effective engagement of civil society and without broadening their role, state response to epidemic will be inadequate.

Furthermore, the responsibility for providing an effective HIV/AIDS response will be divided between various state institutions and agencies, which will include:

a) The Country Coordinating Mechanism that encompasses function of AIDS National Coordinating Authority will assume responsibility of leading and coordinating national response on operational as well as on a strategic level;
b) The Ministry of Labour, Health and Social Affairs, which will oversee the delivery of health care services and development and implementation of national policies-regulations;
c) The Georgia Health and Social Projects Implementation Center, which will manage funds from the Global Fund and projects funded from these resources;
d) The National Center for Disease Control and Public Health (NCDCPH)-which has primary responsibility for HIV surveillance; and
e) The Infectious Diseases, AIDS and Clinical Immunology Research Center-sole provider of AIDS treatment services and coordinator for care and support services.

9. PROGRAM MONITORING AND EVALUATION

The Country Coordination Mechanism (CCM) will assume overall responsibility for coordinating implementation of the *National Strategic Plan*. CCM's decisions will be informed by programmatic information supplied by the responsible department of the MoLHSA and by *Georgia Health and Social Projects Implementation Centre* (GHSPIC). Programmatic data will be complemented by routine epidemiological information generated through HIV/AIDS national surveillance system and collected by the *National Centre for Disease Control and Public Health* (NCDCPH). Besides, the CCM will periodically commission studies and/or will hire consultants to undertake specific evaluation and/or analysis of the data for further action. The CCM will review this information and develop recommendations for further actions. Recommendations will be shared with the Government of

Georgia and with the MoLHSA that has ultimate responsibility for the health outcomes of the nation.

Designated department within MoLHSA will be responsible entity to collect programmatic and epidemiological data and information within health care system in accordance with the monitoring and evaluation plan for the *National Strategic Plan,* and deliver to the CCM. The CCM will commission studies or task for compiling proposed indicators[35] and for preparing reports for national and international consumption[36]. Annual Monitoring and Evaluation Report will be produced and submitted to the Cabinet of Ministers as well as posted on CCM and MoLHSA websites.

Information on HIV/AIDS epidemiological situation in Georgia (in regions and in towns) will be included in the „Epidemiological Bulletin" prepared and issued by the *National Centre for Disease Control and Public Health* and will be included in the annual report submitted to the Cabinet of Ministers as well as posted on the CCM, MoLHSA and NCDC websites for open public access.

National coordination and multisectoral response will be strengthened through moving away from information sharing to using M&E framework, monitoring the progress of implementation, uncovering the implementation weaknesses, taking decisions on corrective measures and advocating for the needed governmental decisions on the level of government or sector ministries.

Detailed output and outcome indicators and quantitative-qualitative targets for the NSP are provided in Annex 1.

Furthermore, national monitoring will be complemented/informed by the studies already planned under NSP and listed below.

LIST OF PLANNED STUDIES

Considering global and national financial situation the studies planned under the NSP were distributed in two groups. The group one represents the list of studies, which are essential for the national response. All other studies that are as well necessary ended in the second group, which will be considered if sufficient financial resources will be secured. Therefore, following studies are being planned under NSP:

- Undertake thorough epidemiological research/analysis using routine surveillance data and other data sources (e.g. safe blood database etc.) to derive conclusive evidence about the HIV/AIDS epidemic and its drivers;
- Continue with Bio-BSS among high risk groups according to the national surveillance plan:
    - Bio-BSS among IDUs combined with size estimation study
    - Bio-BSS among FSW
    - Bio-BSS among MSM
    - Bio-BSS among Prisoners

[35]According to Commitment Declaration on HIV/AIDS implementation monitoring Guidelines on Establishing Basic Indicators." UN General Assembly Special Session on HIV/AIDS „Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators" July 2005

[36] UN Millennium Declaration UN Assembly General, New York, September 6-8, 2000

- Continue with sentinel surveillance among Hepatitis B and C patients according to the national surveillance plan;
- Conduct KAP survey among youth;
- Conduct operational research to identify factors associated with HIV treatment outcomes;
- Conduct operational research to identify factors affecting adherence to ART;
- Conduct operational research to identify factors associated with late HIV diagnosis;
- Conduct operational research to evaluate PMTCT program implementation;
- Conduct MPTCT coverage and quality assessment study;
- Conduct operational research to identify the barriers for IDUs (including female IDUs) in accessing VCT services;
- Conduct operational research aimed at identifying key factors related to stigma and develop recommendations for evidence-based interventions;
- Conduct research among PLHA on awareness of and accessibility to the health and social care services;
- Conduct HIV vulnerability baseline study among labour migrants;
- Conduct economic evaluation of selected curative and preventive interventions (e.g. economic evaluation of regional level laboratory staff performance under the curative program; peer-driven interventions among IDUs);
- Conduct National AIDS spending assessment and financial gap analyses to inform policy decisions.

Studies to be implemented if sufficient funding will be secured:

- Conduct Bio-BSS among MARA;
- Conduct population size estimation studies among FSWs and MSM;
- Conduct HIV vulnerability follow-up study among labour migrants;
- Conduct operational research on integration of HIV, TB and drug treatment services;
- Conduct assessment of HIV/AIDS care and support services;
- Evaluate effectiveness of Behaviour Change Communication (BCC) interventions targeting MARPs in Georgia.

Surveillance studies will be undertaken routinely according to the established schedule under the national surveillance plan. Operational research around certain issues is planned for 2011-2012. However, additional funds that will be used during 2013-2016 have been allocated and the topics for this operational research will be defined later in the NSP implementation.

10. REQUIRED POLICY CHANGES

In order for Georgia to implement NSP and counteract epidemic spread, it is necessary to amend and enact new policies-regulations that will create conducive environment for the national program implementation. Proposed changes are as following:

- Develop regulations which streamline coordination and execution of the national response and clearly designate responsible state entities by developing CCM bylaws and introducing changes in other documents;
- Develop legislation and regulation(s) which reduce and/or remove services delivery barriers for IDUs and prisoners;
- Develop new regulations for laboratory quality assurance system in the country;
- Develop and implement accreditation requirements for the facilities to improve quality of services;
- Revise state policies with regards to safe blood program to assure transition to sustainable self-financing of this system;
- Revise state policies of health care financing for transition towards insurance covered curative service provision for PLWHA;
- Develop and implement patient-centred preventive and health services that could be delivered to the groups at risk.

11. NECESSARY FINANCIAL RESOURCES

Current global financial crisis affects potential for resource mobilization, therefore Georgia faces challenges and in support of NSP implementation two funding scenarios have been elaborated.

Scenario #1 assumes that required financial resources could be mobilized fully and NSP could be completely implemented. Alternative *scenario #2* considers the case, when global as well as national financial crisis will challenge NSP implementation, consequently only activities with greatest importance could be funded under the current NSP. As a result future funding requirements and gaps have been analyzed for both scenarios. The necessary financial resources for both scenarios were estimated and are presented in Annex 2 through Annex 4, providing summary as well as detailed funding estimates.

Table 4 UNIT Costs for different interventions per beneficiary

Intervention	UNIT COST (US $)
Peer driven intervention per IDU	158
Peer education and outreach per IDU	106
Drug dependent treatment/per IDU	2,550
Agonist Maintenance Therapy (AMT)/per IDU	1,500
Agonist Maintenance Therapy (AMT) in prison/per IDU	1,650
Peer outreach interventions through peer educators/per CSW	255
Peer outreach interventions through peer educators/per MSM	671
VCT (including confirmation)/per IDUs	17.0
VCT (including confirmation)/per MSMs	17.0
VCT (including confirmation)/per FSWs	15.9
VCT/per STI patient	15.9
Testing/ per pregnant woman	7.27
3 day training in Tbilisi/per participant	200
3 day training in region/per participant	88
Initial visit for laboratory and clinical examination	534
Repeat visit for laboratory and clinical examination	399
ARVs for initial regimen	978
ARVs for subsequent regimen	5,140
Prevention of OIS	67
Treatment of OIS	463

The costing method used for budget estimation is *economic costing* model, which covers all cost elements, including free items. Calculations were based on *inputs* necessary required for planned activities. Inputs (type of input and volume/quantity) were sourced from the strategic plan. Key assumptions for the capital investments and investments in human resources were drawn from various programs and are based on historical costs.

Using economic costing approach, *intervention-based* unit costs were calculated per expected beneficiary, which are presented in Table 4. These unit costs include (where applicable) staff wages, communications and expenditures for office/space rent, shared capital costs, as well as commodities (condoms, needles, test kits, drugs) whether provided by a donor or directly purchased.

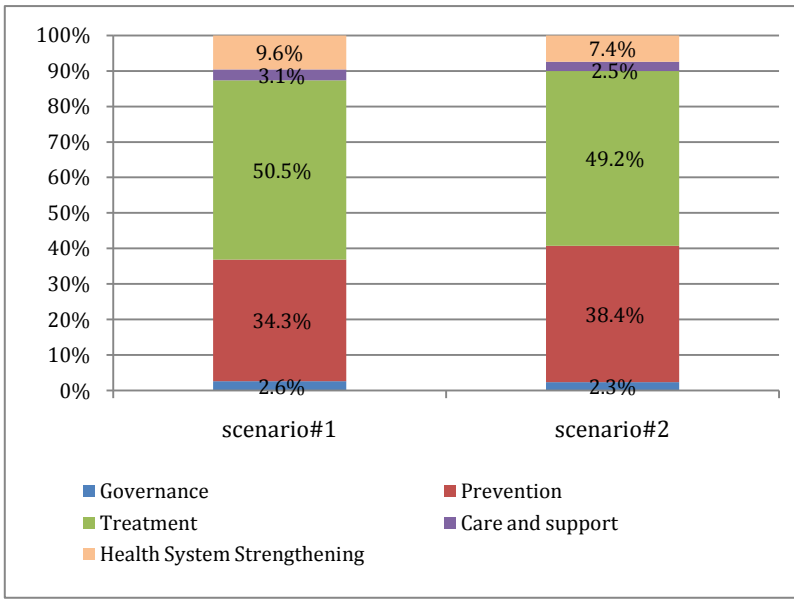
FUTURE RESOURCE REQUIREMENTS

Total estimated need for the period of six years amounts to US$ 156.6 million for scenario #1 and US$ 135.3 million for scenario #2. Annual funding needs grow from US $ 21.2 million in 2011 to US $ 31.2 million in 2016 under scenario #1 and from US$ 19.22 million to US$ 26.8 million under scenario #2 respectively. These estimates are based on the critical assumption that preventive and curative services will be scaled-up to the levels necessary to counteract HIV spread.

Resource distribution between strategic areas under different funding scenarios is detailed in Figure 5. In both instances most resources will be devoted to ***maintaining access to ART and improve treatment outcomes*** (≈ 50% of funds) and to ***improving quality and scale of preventive interventions*** (≈ 34-38%). Therefore this distribution points towards the importance of treatment and prevention areas under NSP. Also highest share of prevention funds are programmed for the interventions aimed at high-risk-groups.

Resource needs for MARPs are estimated at approximately US $ 47 million or 89% of all preventive interventions. And more than 82% of these funds will be spent on IDUs.

Figure 5: Share of resource requirements by strategic areas



It should be mentioned that Health system strengthening activities focusing on two strategic priorities: a) strengthening regulatory system to assure higher quality services in the health care settings and b) assuring necessary investments in human resources and in the infrastructure form 9% of overall program budget and amount to approximately US$ 15.0 million under first scenario. This amount is reduced by US$ 5 million under second scenario. Most of these funds are infrastructural investments and only US$ 800,000 is allocated for regulatory changes. Resources assigned to the Local and International Technical Assistance for the entire period equal to approximately US $ 1.5 million under both scenarios. This amount comprises ≈ 1% of total budget (see Annex 6 and 7).

FINANCIAL GAP ANALYSIS

For financial gap estimation NSP budgets were compared with the available resources[37] for 2011-2013. Consequently secured funds will not be sufficient to cover NSP needs even for initial three-year period. Funding shortfall for initial three-year period amounts to US $ 29.35 million under scenario one or 42% of total resource requirement. It is reduced to 32% under scenario #2. Existing funding gap will not permit implementing all activities under the NSP unless significant advocacy efforts are mounted to mobilize needed financial resources (domestic or external) and to fill the funding gap.

12. TECHNICAL ASSISTANCE FOR NSP IMPLEMENTATION

In order to implement NSP 2011-2016 technical assistance needs have been identified and planned for:

- Strengthening the oversight role of the CCM;
- Developing national monitoring & evaluation framework and its implementation arrangements;
- Conducting certain evaluations and/or studies;
- Conducting cost-effectiveness studies;
- Developing and implementing lab quality assurance system;
- Developing and implementing quality assurance system on infection control for medical facilities through facilities accreditation system.

Financial needs for local and international technical assistance are supplied in Annex 5 and 6.

[37] Considering already approved Global Fund financing (RCC and Round 9) and other donors' funds and assuming that government funding will increase with the pace observed during past several years

ANNEX 1. MONITORING AND EVALUATION FRAMEWORK

NOTE: All activities and/or targets marked with * and in *Italic* will be implemented in case of securing sufficient financing for NSP

Strategic Area 1: Governance and Advocacy

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[38] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
1.1	**STRATEGIC PRIORITY:** **Increase capacity of the CCM's secretariat and enable with the required systems/ instruments that assure effective implementation of the coordinating function**										
1.1.1	Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS, and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities.	New bylaws for CCM developed and adopted (work in progress)	2010	done						CCM & MoLHSA	International organizations
1.1.1.1	Provide technical assistance to the MoLHSA in developing new bylaws for the CCM	Technical assistance solicited (work in progress)	2010	2 LTA[39]						To be commissioned by MoLHSA	International organizations
1.1.1.2	Widely disseminate information about the new role of the CCM through various media sources	Updated information posted on web page; Flayers disseminated (NA)		done						CCM	International Organizations
1.1.2	Increase capacity of the CCM's secretariat									Cabinet of Ministers of Georgia CCM	International organizations
1.1.2.1	Support regular participation of the CCM's secretariat and its members in HIV/AIDS international events and conferences on an international and regional level;	Participation in international forums annual per person		8	8	8	8	8	8	CCM	International organizations

[38] Funding partners other than the State are mentioned

[39] # of month consultancy of Local Technical Assistance

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[38] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
1.1.2.2	Assure sustainable financing of CCM's secretariat;	% of CCM budget mobilized and used		100%	100%	100%	100%	100%	100%	Cabinet of Ministers of Georgia & CCM	International organizations
1.1.3	Develop, implement and fully operationalize one M&E framework									MoLHSA/ NCDCPH	UN agencies The Global Fund /Local NGOs
1.1.3.1	Assure sustainable functionality of the national HIV/AIDS surveillance program, which renders critical epidemiological and programmatic information about national response.	Integrated annual HIV/AIDS surveillance report produced (first rep. will be produced)	2010	Report available in public domain	Report available in public domain	Report available in public domain	Report available in public domain	Report available in public domain	Report available in public domain	NCDCPH	/NGOs
1.1.3.1.1	Routine HIV/AIDS surveillance is underway	Up to date data produced by HIV/AIDS surveillance database	2010	Report	Report	Report	Report	Report	Report	NCDCPH	/NGOs
1.1.3.1.2	BSS among IDUs combined with size estimation studies	# of studies implemented (6 BSS & size estimation)	2009	6		6		6		NCDCPH	/NGOs
1.1.3.1.3	BSS among FSW	# of studies implemented (2 BSS)	2009	2		2		2		NCDCPH	/NGOs
1.1.3.1.4	BSS among MSM	# of studies implemented (1 BSS)	2010		1		1			NCDCPH	/NGOs
1.1.3.1.5	BSS among Prisoners	# of studies implemented (1 BSS)	2008		1			1		NCDCPH	/NGOs
1.1.3.1.6	KAP survey among youth	NA		1			1			NCDCPH	/NGOs
1.1.3.1.7	Sentinel surveillance among B and C hepatitis patients	Sentinel underway	2010	Report	Report	Report	Report	Report	Report	NCDCPH	Center for Infectious diseases and clinical immunology

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[38] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
1.1.3.1.8	*BSS among MARA**	*NA*			*1*		*1*		*1*	*NCDCPH*	*NGOs*
1.1.3.1.9	*Population size estimation study for CSWs and MSMs **	*NA*			*2*					*NCDCPH*	*NGOs*
1.1.3.2	Develop national M&E framework and its implementation arrangements	National M&E framework and op manual developed (work in progress)	2010	done						CCM/ MoLHSA	International organizations (UNAIDS)/ NCDCPH, AIDS center, NGOs
1.1.3.3	Conduct required operational research to inform policies and practice									To be commissioned by CCM and/or MoLHSA	International organizations / Research institutions, NCDCPH, AIDS center, NGOs
1.1.3.3.1	Thorough epidemiological research/analysis to derive conclusive evidence about the HIV/AIDS epidemic and its drivers	# of studies implemented		1		1		1		CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs
1.1.3.3.2	OR to identify factors associated with HIV treatment outcomes	# of studies implemented			1					CCM / MoLHSA	Research institutions, AIDS center
1.1.3.3.3	OR to identify factors affecting adherence to ART	# of studies implemented			1					CCM / MoLHSA	Research institutions, AIDS center
1.1.3.3.4	OR to identify factors associated with late HIV diagnosis	# of studies implemented		1						CCM / MoLHSA	Research institutions, AIDS center
1.1.3.3.5	OR to evaluate MPTCT program implementation bottlenecks	# of studies implemented		1						CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs
1.1.3.3.6	MPTCT coverage and quality assessment study combined with the Multiple Indicator Cluster Survey & Women's Reproductive Health Surveys (conducted by UNICEF; UNFPA; USAID)	# of studies implemented		1				1		CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[38] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
1.1.3.3.7	OR to identify barriers for IDUs (including female IDUs) in accessing VCT services	# of studies implemented		1						CCM / MoLHSA	Research institutions, NGOs
1.1.3.3.8	HIV Vulnerability study among labor migrants (mobile populations)	# of studies implemented		1			*1**			CCM / MoLHSA	Research institutions, NGOs
1.1.3.3.9	OR upon emerged needs	# of studies implemented				2	2	2	2	CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs
1.1.3.3.10	*OR on integration of HIV, TB and drug treatment services **	*# of studies implemented*		*1*						*CCM / MoLHSA*	*Research institutions, NCDCPH, AIDS center, NGOs*
1.1.3.3.11	*Assessment of HIV/AIDS care and support services **	*# of studies implemented*			*1*					*CCM / MoLHSA*	*Research institutions, NCDCPH, AIDS center, NGOs*
1.1.3.3.12	*Evaluate effectiveness of existing Behavior Change Communication interventions targeting MARPs in Georgia **	*# of studies implemented*			*1*					*CCM / MoLHSA*	*Research institutions, NGOs*

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[40] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
1.2	**STRATEGIC PRIORITY:** **Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**										
1.2.1	Advocate for increased state/national financing for HIV/AIDS	% of state/national financial allocations among NSP financial requirements (13%)	2008							CCM & MoLHSA	International organizations
1.2.1.1	Provide technical assistance to the MoLHSA for improved budget planning in close collaboration with the MoF to ensure sustainable financing of HIV/AIDS services	% level of disbursement and utilization of MTEF funds (TBD[41])	2010	2 LTA	2 LTA	2 LTA				To be commissioned by MoLHSA	International organizations
1.2.1.2	Provide technical assistance to MoLHSA for exploring opportunities for inclusion of HIV/AIDS coverage under insurance schemes.	# of insurance schemes covering HIV/AIDS services		1 ITA[42] & 2 LTA						To be commissioned by MoLHSA	International organizations
1.2.1,3	Conduct economic evaluation of various preventive and curative interventions to inform resource allocation decisions	# of studies conducted (NA)			1					To be commissioned by MoLHSA	International organizations
1.2.1.4	Conduct National AIDS Spending Assessment (NASA) and financial gap analyses to inform policy decisions (including UNGASS reporting)	# of studies conducted (NASA conducted)	2010		1		1		1	To be commissioned by CCM	International organizations
1.3	**STRATEGIC PRIORITY:** **Carry out necessary advocacy to create conducive environment for national response**										
1.3.1	Reduce legal and regulatory barriers for drug	Drafted and endorsed policies / legal				done	done			CCM & MoLHSA	International organizations/ Local

[40] Funding partners other than the State are mentioned

[41] To be determined

[42] # month consultancy of International Technical Assistance

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[40] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
	users and prisoners	documents									NGOs, PLHA organizations
1.3.1.1	Support the multisectoral group working on legal and regulatory issues concerning IDUs and prisoners	# of WG meetings (work in progress)	2010	5	5	5	5			CCM	International organizations / Local NGOs; PLHA organizations
1.3.1.2	Provide technical assistance to related ministries for elaborating policies aimed at eliminating legal barriers to effective HIV/AIDS interventions among IDUs and prisoners	technical assistance solicited			1 ITA & 2 LTA	1 ITA & 2 LTA				To be commissioned by CCM	International organizations
1.3.1.3	Organize policy forums and roundtable meetings for all stakeholders to discuss policy alternatives	# of roundtable meetings and policy forums		4	4	2	2	2	2	CCM	International organizations
1.3.2	Mount advocacy focused on stigma and discrimination, primarily among the health care providers	stigma level among health care providers, media and public (TBD)	2011	TBD						CCM & MoLHSA	International organizations / Local NGOs
1.3.2.1	Conduct operational research aimed at identifying key factors related to stigma, develop recommendations for evidence-informed interventions.	# of research studies		1				1		To be commissioned by CCM/MoLHSA	International organizations /NGOs
1.3.2.2	Plan and implement adequate interventions aimed at combating stigma among the health care providers.									CCM	International organizations /NGOs
1.3.2.3	*Support media capacity building to ensure effective communication of HIV messages **	*# of media representatives trained through workshops*		*40*	*40*					*CCM*	*International organizations / NGOs*
1.3.2.4	*Organize effective information campaigns to build public support **	*# population reached; # of media campaigns (MC) carried out*		*1 MC*[43]	*1 MC*	*1 MC*	*1 MC*	*1 MC*	*1 MC*	*To be commissioned by CCM/*	*International organizations / NGOs*

[43] Media Campaign

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding[40] / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
										MoLHSA	
1.3.3	Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response	# of advocacy activities (stakeholder meetings, media events) with GIPA								MoLHSA	
1.3.3.1	Establish grant programs for PLHA to support advocacy efforts, peer education and networking.	# of grant programs implemented by PLHA (TBD)	2010	5	5	5	5	5	5	MoLHSA	International Organizations GHSPIC / PLHA organizations
1.3.3.2	Improve information availability for PLHA on the HIV/AIDS national response	% of PLHA aware of available health and social services (TBD)	2011	TBD					100%	MoLHSA	International organizations / NGOs
1.3.3.3	*Develop training materials and conduct trainings for NGOs as well as Gov. agencies on how to implement GIPA principles **	*% of NGOs and Gov. agencies aware of GIPA principles (TBD)*	*2011*	*TBD*					*90%*	*To be commissioned by CCM/ MoLHSA*	*International organizations / NGOs; PLHA organizations*

Strategic Area 2: Improve quality and scale of preventive interventions

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
2.1	**STRATEGIC PRIORITY:** **Prevent HIV spread among most-at-risk populations (IDUs; CSWs; MSM; prisoners) and MARA**	% HIV prevalence among IDUs (2.1%)	2009	<5%	<5%	<5%	<5%	<5%	<5%	MoLHSA; NCDC;	Public institutions; NGOs
		% HIV prevalence among FSW (1.4%)	2009	<2%	<2%	<2%	<2%	<2%	<2%		
		% HIV prevalence among MSM (3.7%)	2007	<5%	<5%	<5%	<5%	<5%	<5%		
		% HIV prevalence among prisoners (1.4%)	2009	<2%	<2%	<2%	<2%	<2%	<2%		
		HIV prevalence among MARA (TBD)	2012		TBD						

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
2.1.1	Increase the scale & scope of integrated preventive interventions	% of IDUs know where to get confidential test on HIV and received needle/syringe, condom, informational material, educational information from preventive programs during last 12 months (4.6%)	2009	10%		15%		20%		MoLHSA; Ministry of corrections and legal assistance of Georgia	International organizations / GHSPIC; Drug abuse service providers; Penitentiary facilities; NGOs.
		% of FSW know where to get confidential test on HIV and received condoms from preventive programs during last 12 months (75%)	2009	80%		80%			80%		
		% of MSM know where to get confidential test on HIV and received condoms from preventive programs during last 12 months (TBD)	2010		TBD after baseline		TBD after baseline		TBD after baseline		
		% of prisoners received information on preventive methods and offer on confidential HIV testing during last 12 months (TBD)	2011	TBD		TBD after baseline		TBD after baseline			
		% of MARA know where to get confidential test on HIV and received information on preventive methods	2012		TBD		TBD after baseline		TBD after baseline		

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
		during last 12 months (TBD)									
2.1.1.1	Providing VCT services and increasing uptake of HIV testing among MARPs (including MARA)	% of IDUs tested on HIV and know their results during last 12 months (5.7%)	2009	20%		30%		35%		MoLHSA; Ministry of Corrections and legal assistance of Georgia	International organizations (Global Fund, USAID) /GHSPIC; AIDS center; Drug abuse service providers; Penitentiary facilities; NGOs.
		% of FSWs tested on HIV and know their results during last 12 months (Tbilisi-27.5%,Batumi-23.3%)	2009	5% increase		5% increase		5% increase			
		% of MSM tested on HIV and know their results during last 12 months (TBD)	2010		TBD after baseline		TBD after baseline		TBD after baseline		
		% of prisoners tested on HIV and know their results during last 12 months (0.9%)	2008		40%			60%			
		% of MARA tested on HIV and know their results during last 12 months (TBD)	2012		TBD		TBD after baseline		TBD after baseline		
2.1.1.2	Scale up Agonist Maintenance Therapy (AMT) for IDUs	# of IDUs including inmate IDUs covered by AMT (1,985)	2009	2550	3200	3700	4000	4100	4100	MoLHSA; Ministry of Corrections and legal assistance of Georgia	International organizations (Global Fund) / GHSPIC; Drug abuse service providers; Penitentiary facilities; NGOs.

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
2.1.1.3	Expand drug dependence treatment services	# of IDUs covered by drug dependence treatment services (900)	2010	1000	1200	1500	1600	1800	2000	MoLHSA;	International organizations / Drug abuse service providers; NGOs
		among them # of IDUs covered by drug dependence treatment services under the state funding (100)		300[44]	400[44]	500[44]	600[44]	800[44]	1000[44]		
2.1.1.4	Implement needle exchange & other HR programs and increase access to preventive commodities with the help of peer-driven intervention	% of IDUs reached by the programs - during last 12 months received from preventive programs sterile injecting equipment and one of the following: educational information, condom, IEC materials (8%)	2009	14%		19%		21%		MoLHSA	International organizations (Global Fund)/ GHSPIC; NGO sector (Harm Reduction Network)
				*14%**		*22%**		*30%**			
2.1.1.5	Develop and implement effective Behavior Change Communication (BCC) strategies utilizing multiple channels of communication	# population reached by media campaigns (TBD)	2010							MoLHSA	International organizations (Global Fund, USAID) / GHSPIC; NGOs;
		# of media campaigns carried out (TBD)	2010								
		# of MSM reached with peer outreach interventions (400 (projected))	2010	450	500	550	600	650	700		

[44] Budget is based on this targets

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
		# of FSWs reached with peer outreach interventions (240 (projected))	2010	300	350	400	450	500	500		
2.1.2	Improve the quality of preventive interventions	% of MARPs receiving integrated prevention interventions (TBD)		TBD	TBD	TBD	TBD	TBD	TBD	MoLHSA; GHSPIC	International organizations / NGOs;
2.1.2.1	Develop and implement standard national guidelines for preventive interventions	guidelines for preventive interventions are developed and endorsed			Done			U&E[45]		MoLHSA	International organizations / Professional bodies, NGOs;
2.1.2.2	Upgrade professional skills of service providers	# of trained persons			100 *200**	100 *200**	100 *200**	100 *200**	200 *400**	MoLHSA	International organizations / Professional bodies, NGOs;
2.1.2.3	Monitoring and evaluating effectiveness of HIV preventive interventions to adjust programmatic decisions & interventions	% of MARPs receiving integrated prevention interventions (TBD)		TBD		15%		30%		to be commissioned by CCM	International organizations / NGOs
		% of preventive programs monitored /evaluated		50%		80%		80%			

[45] Updated and endorsed

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
2.2	**STRATEGIC PRIORITY:** **Prevent HIV Transmission within Health Care setting**										
2.2.1	Enhance Blood Safety	% of donated blood units screened for HIV in a quality assured manner (0%)	2009	60%	90%	100%	100%	100%	100%	MoLHSA	
2.2.1.1	Assuring that all donated blood is screened in a quality assured manner	# of blood units screened for HIV in a quality assured manner (38,000)	2009	44000	46000	48000	50000	52000	54000	MoLHSA;	Private providers; insurance companies
2.2.1.2	Promoting Voluntary Donorship	% of voluntary donors (4%)	2009	8%	10%	15%	20%	25%	30%	MoLHSA;	International organizations
2.2.2	Reduce post-exposure HIV transmission									MoLHSA	AIDS Center
2.2.2.1	Provision of PEP treatment to all health care workers in the country	% of all HCWs in need of PEP provided with treatment (100%)	2009	100%	100%	100%	100%	100%	100%	MoLHSA	AIDS Center
2.2.3.	Implement provider initiated testing (PIT) in clinical settings	# of HIV cases detected through PIT (TBD)		TBD						MoLHSA	International organizations/ Professional bodies, AIDS center
2.2.3.1	Develop standards and guidelines for PIT	PIT guidelines developed		done						MoLHSA	International organizations/ Professional bodies, AIDS center
2.2.3.2	Upgrade professional skills on PIT guidelines for HCWs	# of trained persons			150	150	150	150	150	MoLHSA	International organizations/ Professional bodies, AIDS center
2.2.3.3	Implement PIT of patients in narcology, STI and TB clinics and ANC centers (TB and ANC covered by routine surveillance)	# of PIT carried out in clinical settings; HIV prevalence among tested patients visiting		TBD						MoLHSA	International organizations / Drug abuse service providers; STI and TB clinics; ANC

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
		clinics (TBD)									
2.3	**STRATEGIC PRIORITY: Prevent Mother-to-child HIV transmission**	# of vertical transmission of HIV cases among children < 1 year (1)	2009	0	0	0	0	0	0		
2.3.1	Reduce HIV transmission from mother-to-child	# of HIV cases detected through PMTCT(TBD)		TBD						MoLHSA	International organizations (Global Fund) /GHSPIC; ANC; AIDS center
2.3.1.1	Assure universal screening of all pregnant women on HIV	% pregnant women screened on HIV (100%)	2009	100%	100%	100%	100%	100%	100%	MoLHSA	ANC
2.3.1.2	Provide preventive ARV treatment to all HIV positive pregnant women	% of HIV + pregnant receiving complete course of ART prevention (100%)	2009	100%	100%	100%	100%	100%	100%	MoLHSA	International organizations / GHSPIC AIDS center
2.3.1.3	Provide preventive ARV therapy to all newborns of HIV positive mothers	% of newborns born to HIV + mothers receiving complete course of ART (100%)	2009	100%	100%	100%	100%	100%	100%	MoLHSA	International organizations / GHSPIC; AIDS center, NGO
2.3.1.4	Provide social care to all newborns of HIV positive mothers	% of newborns born to HIV positive mothers receiving social care services (100%)	2009	100%	100%	100%	100%	100%	100%	MoLHSA	International organizations (Global Fund, UN) / GHSPIC; AIDS center, NGO
2.3.2	Improve the quality of PMTCT program	# of HIV cases detected through PIT (TBD)		TBD						MoLHSA	
2.3.2.1	Integrate PMTCT program with existing Perinatal Hepatitis B Prevention Program	PMTCT and Perinatal hepatitis prevention program is integrated			?	?	?			MoLHSA	

2.3.2.2	Update PMTCT guidelines	guideline is updated and endorsed		U&E		U&E		U&E		MoLHSA	International organizations / AIDS center
2.3.2.3	Upgrade professional skills of HCWs in PMTCT	# of trained persons			200		200		200	MoLHSA	International organizations / Professional bodies, AIDS center

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
2.4	**STRATEGIC PRIORITY:** **Reduce Youth Vulnerability to HIV**										
2.4.1	Enable young people to protect themselves and their peers from HIV Infection	% youth covered with HIV prevention activities (TBD)	2011	TBD			TBD			Ministry of Education and Science; MoLHSA;	International organizations
		% of youth correctly identify ways of HIV transmission and reject major misconception (TBD)	2011	TBD							
		% of 19-24 persons reporting condom use at last sexual contact (TBD)	2011	TBD			TBD				
2.4.1.1	Develop and implement effective BCC focused on youth	BCC strategy focusing on youth developed; # of youth reached with BCC interventions		Strat. develo ped	TBD	TBD	TBD	TBD	TBD		International organizations (USAID)
2.4.1.2	Advocate for integrated drug and HIV prevention training course into National Education Plan	# of schools providing training course		50	150	300	400	500	600		
2.4.1.3	*Develop and advocate for institutionalization of Drug-Free School Policies in secondary schools **	*Policy document developed*		*done*							

Strategic Area 3: Maintain access to ART and improve treatment outcomes

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
3.1	**STRATEGIC PRIORITY:** **Improve ART Survival Rates**	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (81%)	2009			>85%			>85%		
		% of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy (69%)	2009			>80%			>85%		
		% of adults and children with HIV known to be on treatment 36 months after initiation of antiretroviral therapy (72%)	2009			>75%			>80%		
3.1.1	Maintaining and, if possible, increasing current level of access to ART	% of adults and children with advanced HIV infection receiving antiretroviral therapy (95%)	2009	>95%	>95%	>95%	>95%	>95%	>95%	MoLHSA	International organizations (Global Fund), GHSPIC / AIDS center, NGOs
3.1.1.1	Providing regular laboratory and clinical examination of patients	% of HIV cases entering clinical care (TBD)	2010	>95%	>95%	>95%	>95%	>95%	>95%	MoLHSA; AIDS center	International organizations (Global Fund) / GHSPIC, National and regional AIDS centers
3.1.1.2	Providing ARVs to all patients in need	# of patients on treatment (655)	2009	1160	1370	1610	1860	2140	2460	MoLHSA; AIDS center	International organizations (Global Fund) /GHSPIC; National

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
											and regional AIDS centers
3.1.1.3	Maintaining T&C services in conflict region of Georgia	# of patients on ART (71)	2009	130	170	210	250	300	350	MoLHSA; AIDS center	International organizations (Global Fund) /GHSPIC; AIDS center, NGOs
3.1.2	Improving treatment adherence among patients on ART	% of patients on ART picking drugs on time (92%)	2009	>95%	>95%	>95%	>95%	>95%	>95%	MoLHSA	International organizations (Global Fund) / GHSPIC; National and regional AIDS centers
		% of patients with undetectable viral load (TBD)	2011	TBD							
3.1.2.1	Providing home based adherence monitoring and support	# of monitoring visits (1340)	2009	2900	3425	4025	4650	5350	6150	MoLHSA; AIDS center	International organizations (Global Fund) / GHSPIC; National and regional AIDS centers
3.1.2.2	Integrating of HIV and TB services (one stop service)	# of HIV/TB patients benefiting from one stop service (TBD)	2011		TBD after OR					MoLHSA	AIDS center, NCTLD
3.1.3	Strengthening ART management capacity	% of clinical care facilities meeting the standards (NA)			100%	100%	100%	100%	100%	MoLHSA	International organizations (Global Fund) / GHSPIC; AIDS center
3.1.3.1	Implementing HIV drug resistance (HIVDR) prevention and assessment strategy	# ART sites meeting Early Warning Indicators targets		1	4	4	4	4	4	MoLHSA; AIDS center	International organizations (Global Fund); /GHSPIC, National and regional AIDS centers
		# of surveys to monitor HIVDR prevention and associated factors in sentinel ART sites		1	1	1	2	2	2		

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
		# of surveys to evaluate transmitted HIVDR		1	1	1	1	1	1		
		# of WG meeting on HIVDR		3	3	3	3	3	3		
3.1.3.2	Updating regularly clinical guidelines using emerging scientific evidence	# of guidelines updated		2	2	2	2	2	2	MoLHSA; AIDS center	International organizations (Global Fund, WHO) /Professional bodies, Nat. & reg. AIDS centers
3.1.3.3	Implementing clinical audit	clinical audit guidelines developed and implemented		guideline	audit	audit	audit	audit	audit	MoLHSA; AIDS center	International organizations (Global Fund, WHO) / Nat. & reg. AIDS centers
3.1.3.4	Maintaining HIV/AIDS clinical database	HIV/AIDS clinical database functional (work in progress)	2010	done	done	done	done	done	done	MoLHSA; AIDS center	
3.1.3.5	Training necessary human resources for curative HIV/AIDS services	# of trained persons		10	10	20	25	25	25	MoLHSA; AIDS center	International organizations (Global Fund, WHO)/ Professional bodies; National and regional AIDS centers
				*20**	*20**	*20**	*25**	*25**	*25**		
		# of professionals attending international training courses		4	4	4	4	4	4		
				*8**	*8**	*8**	*8**	*8**	*8**		
		# of professionals attending international conferences		4	4	4	4	4	4		
				*8**	*8**	*8**	*8**	*8**	*8**		
3.1.3.6	*Implementing modern hi-tech laboratory tools for ART monitoring ****	*# of HIV tropism tests*		*60*	*70*	*80*	*95*	*110*	*125*	*MoLHSA; AIDS center*	*International organizations/ National and regional AIDS centers*
		# of HIVDR testing for new drug classes		*80*	*100*	*120*	*140*	*160*	*180*		
		# of HIVDR testing for low viral load/low frequency		*60*	*70*	*80*	*95*	*110*	*125*		
		# of therapeutic drug monitoring tests		*120*	*140*	*160*	*190*	*220*	*250*		

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
3.1.4	Scaling up management of opportunistic infections (OIs) and other co-morbidities	% of patients receiving quality care for management of OIs and other co-morbidities (TBD)								MoLHSA; AIDS center	National and regional AIDS centers
3.1.4.1	Investing in modern instrumental diagnostic services	# of investigations provided with CT Scan/MRI imaging services		1530	1850	2360	2770	3180	3640	MoLHSA; AIDS center	National and regional AIDS centers
				*3450**	*4165**	*4950**	*5815**	*6675**	*7645**		
		# of instrumental diagnostic services (including X-Ray, ultrasound and endoscopy)		2850	3440	4160	4900	5630	6670		
				*8000**	*9655**	*11485**	*13485**	*15485**	*18355**		
3.1.4.2	Improving management of latent and active TB	% of HIV/TB patients who received treatment for both TB and HIV (67%)	2009	>80%		>85%			>90%	MoLHSA; AIDS center	National and regional AIDS centers, NCTLD
		% of HIV patients with LTBI who received prevention for TB									
3.1.4.3	Developing capacity for management of infections caused by non-tuberculosis mycobacteria (NTM), fungi and HPV	# patients screened on active mycobacterial infection		100	200	200	200	200	200	MoLHSA; AIDS center	International organizations (Global Fund)/ GHSPIC, National and regional AIDS centers
		# patients treated On NTM infection		45	45	45	45	45	45		
		# patients screened fungal infections		100	200	200	200	200	200		
		# patients treated fungal infections		12	12	12	12	12	12		
		# patients screened on HPV		400	550	650	750	850	950		

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
3.1.4.4	Improving management of HIV/HCV co-infected patients	# of eligible patients on HCV treatment		110	110	110	110	110	110	MoLHSA; AIDS center	International organizations (Global Fund), GHSPIC / Nat. & reg. AIDS centers
3.1.4.5	Providing management (prevention, diagnosis and treatment) of other common OIs	# of eligible patients receiving preventive for OIs		800	1000	1200	1400	1600	1800	MoLHSA; AIDS center	International organizations (Global Fund), GHSPIC /National and regional AIDS centers
		# of eligible patients receiving treatment for OIs		350	400	450	500	550	600		
3.1.4.6	Providing in-patient care for all patients in need	# of patients receiving in-patient care	2009	540	620	720	720	720	720	MoLHSA; AIDS center	National and regional AIDS centers

ANNEX 1 – NSP Monitoring and Evaluation Framework

Strategic Area 4: Assure Adequate Care and Support to the PLHA

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding & Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
4.1	**STRATEGIC PRIORITY:** **Assuring access to basic care and support services**	% of PLHIV that have access to free basic external support (including health, psychological or emotional and other social and material support (TBD)	2011	TBD							
4.1.1	Assure current level care and support services and future expansion driven by need									MoLHSA	International organizations (Global Fund) / GHSPIC; NGOs
HOCUS POCUS 4.1.1.1	Providing counseling and psychological assistance to adults and children	# hot-line consultations (1533)	2009	1600	1600	1800	2000	2100	2200	HIV/AIDS patient support foundation	Network of self support centers
		# face-to-face consultations (711)	2009	900	1400	1800	2000	2100	2200		
4.1.1.2	Providing palliative care services (both institutional and home-based)	# patients provided palliative care at hospice (60)	2009	80	90	100	100	110	120	MoLHSA	NGOs
		# patients provided home-based palliative care services (447)	2009	450	500	560	630	700	730		
4.1.1.3	Providing trainings to specialists involved in care and support services	# of trained persons		15	15	15	20	20	20	MoLHSA	Professional bodies
4.1.1.4	*Providing nutritional support **	*# patients provided with food assistance (459)*	*2009*	*800*	*960*	*1130*	*1300*	*1500*	*1720*	*MoLHSA*	*NGOs*

Strategic Area 5: Strengthen Health System capacity for effective HIV response

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
5.1	**STRATEGIC PRIORITY:** **Strengthen regulatory system and assure higher quality services in the health care settings**										
5.1.1	Develop and Implement new regulations for Blood Safety	new regulations are developed and enforced								Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations
5.1.1.1	Develop, implement and enforce state regulations for Laboratory Testing Standards mandatory for blood safety.	Laboratory testing standards developed and implemented (NA)		done						Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations (WB)
5.1.1.2	Develop and implement accreditation standards for blood & blood products producing units, which would include mandatory provisions for professional liability insurance for blood and blood products producing units (private and public)	Accreditation standards in place (NA)		done	PI[46]	FI[47]				Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations
5.1.1.3	Develop and implement state regulations for Laboratory Quality Assurance (QA) that are intended to facilitate implementation of overall QA system for labs, which would also include External Quality Assurance	liability requirement developed and in place (NA)		done						Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations
		% of HIV laboratories participating in QA schemes			40%	100%					
5.1.1.4	Assist MoLHSA in elaboration and implementation mechanisms geared towards transition from state/donor	Mechanisms in place (2011). Targets will be set after		done						Parliament of Georgia, Healthcare and	International organizations

[46] Partly Implemented

[47] Fully Implemented

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
	financed safe blood programs towards the system of sustainable self-financing	mechanisms are developed								social issues committee; MoLHSA	
5.1.1.5	Policy dialogues and consensus building meetings for objective 5.1.1	# of high level meetings		10	10					Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations
5.1.2	Develop and implement QA regulations for medical facilities for infection control	new regulations are developed and enforced								Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations
5.1.2.1	Develop and implement mandatory state regulations for infection control within health care setting, which would include "Universal precautions" aimed at preventing transmission of HIV, hepatitis B and C, and other blood or body fluid borne pathogens.	% of functional medical facilities meeting the permits requirements			50%	80%	100%	100%	100%		
5.1.2.2	Enforce these regulations through facility accreditation system	% of functional medical facilities meeting the accreditation requirements					10%	30%	50%	Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations
5.1.2.3	Policy dialogues and consensus building meetings for objective 5.1.2	# of high level meetings		10						Parliament of Georgia, Healthcare and social issues committee; MoLHSA	International organizations

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
5.2	**STRATEGIC PRIORITY:** **Assure necessary investments in the infrastructure and human resources**										
5.2.1	Strengthen Human Resource capacity for quality of preventive and curative HIV services [See relevant sections]									MoLHSA	The Global Fund / GHSPIC, Local service providers, NGOs
5.2.2.	Assure necessary investments in the infrastructure									MoLHSA	The Global Fund / GHSPIC, Local service providers, NGOs
5.2.2.1	Develop adequate physical infrastructure for AIDS treatment facilities in Tbilisi and three regions of Georgia	# of AIDS treatment centers in Regions refurbished		3						MoLHSA	The Global Fund / GHSPIC
		# of AIDS treatment facilities in Tbilisi constructed		1							
		These facilities equipped and furnished with diagnostic and clinical laboratory equipment (e.g. CT scan, X-ray, etc.)			done						
5.2.2.2	Based on needs assessment develop physical infrastructure for HIV prevention services	# of new VCT centers in regions refurbished		1		1		1		MoLHSA; Ministry of Corrections and Legal Assistance of Georgia	The Global Fund / GHSPIC
				*1**	*1**	*1**		*1**	*1**		
		# of AMT Centers refurbished & equipped (15)	2010	1	2	3	2	1			
		# of AMT Centers in prisons refurbished & equipped (1)	2010	1	1						
		# of refurbished drug dependence treatment centers		1	1	1	1	1			
				*2**	*3**	*3**	*1**	*1**			
		# of functional mobile			*1*		*1*		*1*		

ANNEX 1 – NSP Monitoring and Evaluation Framework

No	Objectives and Activities	Baseline		Timeframe and targets						Responsible Agencies	Funding / Implementing Partners
		Indicator (figure)	Year	Y1	Y2	Y3	Y4	Y5	Y6		
		laboratories for IDUs *									
		# of constructed drug dependence residential centers *			*1*	*1*					

ANNEX 2: SUMMARY BUDGET - HIV/AIDS STRATEGIC PLAN 2011-2016[48] - SCENARIO 1

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total
1	**Governance and Advocacy**							
	Enhance coordination and advocacy efforts of the national response	**936,852**	**765,180**	**744,688**	**500,433**	**732,729**	**419,658**	**4,099,539**
1.1	**Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function**	**703,612**	**459,865**	**557,218**	**354,988**	**572,359**	**275,138**	**2,923,179**
1.1.1	Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities	22,956	14,706	14,706	14,706	14,706	14,706	**96,485**
1.1.2	Increase capacity of the CCM's secretariat	97,750	94,300	94,300	94,300	94,300	94,300	**569,250**
1.1.3	Develop, implement and fully operationalize one M&E framework	582,906	350,859	448,212	245,982	463,353	166,132	**2,257,444**
1.2.	**Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**	**43,175**	**92,625**	**8,200**	**4,100**	**-**	**4,100**	**152,200**
1.2.1.	Advocate for increased state/national financing for HIV/AIDS	43,175	92,625	8,200	4,100	-	4,100	**152,200**
1.3.	**Carry out necessary advocacy to create conducive environment for national response**	**190,065**	**212,690**	**179,270**	**141,345**	**160,370**	**140,420**	**1,024,160**
1.3.1.	Reduce legal and regulatory barriers for drug users \and for prisoners	1,665	36,640	36,270	1,295	370	370	**76,610**
1.3.2.	Mount advocacy focused on stigma and discrimination, primarily among the health care providers	151,200	138,000	110,000	110,000	135,000	110,000	**754,200**
1.3.3	Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response	37,200	38,050	33,000	30,050	25,000	30,050	**193,350**

[48] Budget is estimated in USD

ANNEX 2: SUMMARY BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total
2	**Improve quality and scale of preventive interventions**							
	Contain HIV prevalence among MARP <5%; Contain HIV prevalence among pregnant women <0.03%; Contain prevalence among 15-24 years old pregnant women (baseline TBD in 2010);Rate of late HIV diagnoses among newly registered HIV cases from 46% (2009) to 25% by 2016- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016	**6,524,545**	**7,608,953**	**8,550,615**	**9,444,212**	**10,431,289**	**11,155,567**	**53,715,181**
2.1	**Prevention HIV spread among MARPs (IDUS; CSWS; MSM; Prisoners) and MARA**	**5,564,140**	**6,624,220**	**7,573,060**	**8,421,089**	**9,416,479**	**10,103,389**	**47,702,376**
2.1.1.	Increase the scale & scope of integrated preventive interventions	5,539,540	6,593,180	7,533,820	8,390,049	9,360,839	10,041,309	**47,458,736**
2.1.2	Improve the quality of preventive interventions	24,600	31,040	39,240	31,040	55,640	62,080	**243,640**
2.2	**Prevent HIV Transmission through Health Care**	**401,727**	**435,434**	**449,962**	**464,489**	**479,017**	**493,544**	**2,724,174**
2.2.1	Enhance Blood Safety	331,606	346,133	360,661	375,188	389,716	404,243	**2,207,547**
2.2.2	Reduce post-exposure HIV transmission	2,280	2,280	2,280	2,280	2,280	2,280	**13,680**
2.2.3	Implement provider initiated testing (PIT) in clinical settings	67,841	87,021	87,021	87,021	87,021	87,021	**502,947**
2.3	**Prevent Mother-to-child HIV transmission**	**474,584**	**498,929**	**477,594**	**508,634**	**485,794**	**508,634**	**2,954,166**
2.3.1.	Reduce HIV transmission from mother-to-child	458,184	467,889	477,594	477,594	477,594	477,594	**2,836,446**
2.3.2.	Improve the quality of PMTCT program	16,400	31,040	-	31,040	8,200	31,040	**117,720**
2.4.	**Reduce Youth Vulnerability to HIV**	**84,095**	**50,370**	**50,000**	**50,000**	**50,000**	**50,000**	**334,465**
2.4.1.	Enable young people to protect themselves and their peers from HIV Infection	84,095	50,370	50,000	50,000	50,000	50,000	**334,465**

ANNEX 2: SUMMARY BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total
3	**Treatment Care**							
	Improve ART survival rates	**8,479,735**	**10,131,475**	**12,098,287**	**13,999,391**	**15,987,799**	**18,307,159**	**79,003,846**
3.1	**Improve ART Survival Rates**	**8,479,735**	**10,131,475**	**12,098,287**	**13,999,391**	**15,987,799**	**18,307,159**	**79,003,846**
3.1.1	Maintain and, if possible, increase current level of access to ART	3,583,690	4,467,032	5,498,970	6,510,172	7,629,180	8,908,115	**36,597,159**
3.1.2	Improve treatment adherence among patients on ART	411,800	500,050	607,775	720,750	856,000	1,014,750	**4,111,125**
3.1.3	Strengthen ART management capacity	546,435	596,083	701,262	853,614	906,549	962,439	**4,566,382**
3.1.4	Scale-up management of opportunistic infections (OIs) and other co-morbidities	3,937,810	4,568,310	5,290,280	5,914,855	6,596,070	7,421,855	**33,729,180**
4	**Care and Support**							
	Assuring access to basic care and support	**530,400**	**625,680**	**779,630**	**875,720**	**964,700**	**1,026,580**	**4,802,710**
4.1	**Assure access to basic care and support services**	**530,400**	**625,680**	**779,630**	**875,720**	**964,700**	**1,026,580**	**4,802,710**
4.1.1	Assure current level care and support services and future expansion driven by need	530,400	625,680	779,630	875,720	964,700	1,026,580	**4,802,710**

ANNEX 2: SUMMARY BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total
5	**Health System Strengthening**							
	Strengthen Health System capacity for effective HIV response	**4,691,698**	**6,364,703**	**1,712,070**	**982,708**	**900,020**	**323,588**	**14,974,788**
5.1	**Strengthen regulatory system and assure higher quality services in the health care settings**	**680,775**	**125,350**	**-**	**-**	**-**	**-**	**806,125**
5.1.1	Develop and Implement new regulations for Blood Safety	574,000	94,475	-	-	-	-	**668,475**
5.1.2	Develop and implement QA regulations for medical facilities for infection control	106,775	30,875	-	-	-	-	**137,650**
5.2	**Assure necessary investments in the infrastructure and human resources**	**4,010,923**	**6,239,353**	**1,712,070**	**982,708**	**900,020**	**323,588**	**14,168,663**
5.2.1	Strengthen Human Resource capacity for quality of preventive and curative HIV services	-	-	-	-	-	-	-
5.2.2.	Assure necessary investments in the infrastructure	4,010,923	6,239,353	1,712,070	982,708	900,020	323,588	**14,168,663**
	TOTAL	**21,163,230**	**25,495,991**	**23,885,290**	**25,802,464**	**29,016,537**	**31,232,552**	**156,596,064**
	TOTAL adjusted to inflation	**22,221,392**	**28,109,330**	**27,650,209**	**31,363,057**	**37,033,271**	**41,854,607**	**188,231,865**

ANNEX 3: SUMMARY BUDGET - HIV/AIDS STRATEGIC PLAN 2011-2016[49] - SCENARIO 2

Georgia NSP		2011	2012	2013	2014	2015	2016	Total
1	**Governance and Advocacy**							
	Enhance coordination and advocacy efforts of the national response	**773,452**	**479,180**	**626,688**	**345,433**	**622,729**	**289,658**	**3,137,139**
1.1	**Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function**	**678,612**	**299,865**	**557,218**	**309,988**	**572,359**	**255,138**	**2,673,179**
1.1.1	Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities	22,956	14,706	14,706	14,706	14,706	14,706	**96,485**
1.1.2	Increase capacity of the CCM's secretariat	97,750	94,300	94,300	94,300	94,300	94,300	**569,250**
1.1.3	Develop, implement and fully operationalize one M&E framework	557,906	190,859	448,212	200,982	463,353	146,132	**2,007,444**
1.2.	**Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**	**43,175**	**92,625**	**8,200**	**4,100**	**-**	**4,100**	**152,200**
1.2.1.	Advocate for increased state/national financing for HIV/AIDS	43,175	92,625	8,200	4,100	-	4,100	**152,200**
1.3.	**Carry out necessary advocacy to create conducive environment for national response**	**51,665**	**86,690**	**61,270**	**31,345**	**50,370**	**30,420**	**311,760**
1.3.1.	Reduce legal and regulatory barriers for drug users \and for prisoners	1,665	36,640	36,270	1,295	370	370	**76,610**
1.3.2.	Mount advocacy focused on stigma and discrimination, primarily among the health care providers	25,000	20,000	-	-	25,000	-	**70,000**
1.3.3	Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response	25,000	30,050	25,000	30,050	25,000	30,050	**165,150**

[49] Budget is estimated in USD

ANNEX 3: SUMMARY BUDGET - **SCENARIO 2**

Georgia NSP		2011	2012	2013	2014	2015	2016	Total
2	**Improve quality and scale of preventive interventions**							
	Contain HIV prevalence among MARP <5%; Contain HIV prevalence among pregnant women <0.03%; Contain prevalence among 15-24 years old pregnant women (baseline TBD in 2010);Rate of late HIV diagnoses among newly registered HIV cases from 46% (2009) to 25% by 2016- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016	**6,513,975**	**7,502,313**	**8,377,595**	**9,113,692**	**9,864,519**	**10,652,027**	**52,024,121**
2.1	**Prevention HIV spread among MARPs (IDUS; CSWS; MSM; Prisoners) and MARA**	**5,562,140**	**6,517,950**	**7,400,040**	**8,090,569**	**8,849,709**	**9,599,849**	**46,020,256**
2.1.1.	Increase the scale & scope of integrated preventive interventions	5,537,540	6,502,430	7,376,320	8,075,049	8,809,589	9,568,809	**45,869,736**
2.1.2	Improve the quality of preventive interventions	24,600	15,520	23,720	15,520	40,120	31,040	**150,520**
2.2	**Prevent HIV Transmission through Health Care**	**401,727**	**435,434**	**449,962**	**464,489**	**479,017**	**493,544**	**2,724,174**
2.2.1	Enhance Blood Safety	331,606	346,133	360,661	375,188	389,716	404,243	**2,207,547**
2.2.2	Reduce post-exposure HIV transmission	2,280	2,280	2,280	2,280	2,280	2,280	**13,680**
2.2.3	Implement provider initiated testing (PIT) in clinical settings	67,841	87,021	87,021	87,021	87,021	87,021	**502,947**
2.3	**Prevent Mother-to-child HIV transmission**	**474,584**	**498,929**	**477,594**	**508,634**	**485,794**	**508,634**	**2,954,166**
2.3.1.	Reduce HIV transmission from mother-to-child	458,184	467,889	477,594	477,594	477,594	477,594	**2,836,446**
2.3.2.	Improve the quality of PMTCT program	16,400	31,040	-	31,040	8,200	31,040	**117,720**
2.4.	**Reduce Youth Vulnerability to HIV**	**75,525**	**50,000**	**50,000**	**50,000**	**50,000**	**50,000**	**325,525**
2.4.1.	Enable young people to protect themselves and their peers from HIV Infection	75,525	50,000	50,000	50,000	50,000	50,000	**325,525**

ANNEX 3: SUMMARY BUDGET - **SCENARIO 2**

Georgia NSP		2011	2012	2013	2014	2015	2016	Total
3	**Treatment Care**							
	Improve ART survival rates	**7,283,415**	**8,640,095**	**10,315,737**	**11,827,701**	**13,387,509**	**15,186,424**	**66,640,881**
3.1	**Improve ART Survival Rates**	**7,283,415**	**8,640,095**	**10,315,737**	**11,827,701**	**13,387,509**	**15,186,424**	**66,640,881**
3.1.1	Maintain and, if possible, increase current level of access to ART	3,583,690	4,467,032	5,498,970	6,510,172	7,629,180	8,908,115	**36,597,159**
3.1.2	Improve treatment adherence among patients on ART	411,800	500,050	607,775	720,750	856,000	1,014,750	**4,111,125**
3.1.3	Strengthen ART management capacity	354,455	367,413	435,782	537,899	537,899	537,899	**2,771,347**
3.1.4	Scale-up management of opportunistic infections (OIs) and other co-morbidities	2,933,470	3,305,600	3,773,210	4,058,880	4,364,430	4,725,660	**23,161,250**
4	**Care and Support**							
	Assuring access to basic care and support	**384,000**	**450,000**	**572,840**	**637,820**	**690,200**	**711,820**	**3,446,680**
4.1	**Assure access to basic care and support services**	**384,000**	**450,000**	**572,840**	**637,820**	**690,200**	**711,820**	**3,446,680**
4.1.1	Assure current level care and support services and future expansion driven by need	384,000	450,000	572,840	637,820	690,200	711,820	**3,446,680**

ANNEX 3: SUMMARY BUDGET - **SCENARIO 2**

Georgia NSP		2011	2012	2013	2014	2015	2016	Total
5	**Health System Strengthening**							
	Strengthen Health System capacity for effective HIV response	**4,266,855**	**3,486,930**	**1,055,600**	**662,120**	**600,020**	**-**	**10,071,525**
5.1	**Strengthen regulatory system and assure higher quality services in the health care settings**	**680,775**	**125,350**	**-**	**-**	**-**	**-**	**806,125**
5.1.1	Develop and Implement new regulations for Blood Safety	574,000	94,475	-	-	-	-	**668,475**
5.1.2	Develop and implement QA regulations for medical facilities for infection control	106,775	30,875	-	-	-	-	**137,650**
5.2	**Assure necessary investments in the infrastructure and human resources**	**3,586,080**	**3,361,580**	**1,055,600**	**662,120**	**600,020**	**-**	**9,265,400**
5.2.1	Strengthen Human Resource capacity for quality of preventive and curative HIV services	-	-	-	-	-	-	-
5.2.2.	Assure necessary investments in the infrastructure	3,586,080	3,361,580	1,055,600	662,120	600,020	-	**9,265,400**
	TOTAL	**19,221,697**	**20,558,518**	**20,948,460**	**22,586,766**	**25,164,977**	**26,839,929**	**135,320,347**
	TOTAL adjusted to inflation	**20,182,782**	**22,665,766**	**24,250,461**	**27,454,355**	**32,117,596**	**35,968,072**	**162,639,032**

ANNEX 4: DETAILED BUDGET - HIV/AIDS STRATEGIC PLAN 2011-2016[50] - SCENARIO 1

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
1	**Governance and Advocacy**							
	Enhance coordination and advocacy efforts of the national response	**936,852**	**765,180**	**744,688**	**500,433**	**732,729**	**419,658**	**4,099,539**
1.1	**Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function**	703,612	459,865	557,218	354,988	572,359	275,138	**2,923,179**
1.1.1	**Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities**	22,956	14,706	14,706	14,706	14,706	14,706	**96,485**
1.1.1.1	Provide technical assistance to the MoLHSA in developing new bylaws for the CCM.	8,200	-	-	-	-	-	**8,200**
1.1.1.2	Widely disseminate information about the new role of the CCM through various media sources	14,756	14,706	14,706	14,706	14,706	14,706	**88,285**

[50] Budget is estimated in USD

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
1.1.2	**Increase capacity of the CCM's secretariat**	97,750	94,300	94,300	94,300	94,300	94,300	**569,250**
1.1.2.1	Support regular participation of the CCM's secretariat and its members in HIV/AIDS international events and conferences at global and regional levels	32,000	32,000	32,000	32,000	32,000	32,000	**192,000**
1.1.2.2	Assure sustainable financing of CCM's secretariat;	65,750	62,300	62,300	62,300	62,300	62,300	**377,250**
1.1.3	**Develop, implement and fully operationalize one M&E framework**	582,906	350,859	448,212	245,982	463,353	166,132	**2,257,444**
1.1.3.1.	Assure sustainable functionality of the national HIV/AIDS surveillance program, which renders critical epidemiological and programatic information about national response	410,806	250,859	385,912	170,982	401,053	116,132	**1,735,744**
1.1.3.2.	Develop national M&E framework and its implementation arrangements	34,800	-	-	-	-	-	**34,800**
1.1.3.3.	Conduct HIV/AIDS related operational research to inform policies and practice	137,300	100,000	62,300	75,000	62,300	50,000	**486,900**
1.2.	**Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**	43,175	92,625	8,200	4,100	-	4,100	**152,200**
1.2.1.	**Advocate for increased state/national financing for HIV/AIDS**	43,175	92,625	8,200	4,100	-	4,100	**152,200**
1.2.1.1.	Provide technical assistance to the MoLHSA for improved budget planning in close collaboration with the Ministry of finance(MoF) to ensure sustainable financing of HIV/AIDS services.	8,200	8,200	8,200	-	-	-	**24,600**
1.2.1.2.	Provide technical assistance to MoLHSA for exploring opportunities for inclusion of HIV/AIDS coverage under insurance schemes.	34,975	-	-	-	-	-	**34,975**
1.2.1.3.	Conduct economic evaluation of various preventive and curative interventions to inform resource allocation decisions	-	80,325	-	-	-	-	**80,325**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
1.2.1.4.	Conduct National AIDS Spending Assessment and Financial Gap analyses to inform policy decisions (incl. UNGASS reporting)	-	4,100	-	4,100	-	4,100	**12,300**
1.3.	**Carry out necessary advocacy to create conducive environment for national response**	190,065	212,690	179,270	141,345	160,370	140,420	**1,024,160**
1.3.1.	**Reduce legal and regulatory barriers for drug users \and for prisoners**	1,665	36,640	36,270	1,295	370	370	**76,610**
1.3.1.1.	Support the multisectoral group working on legal and regulatory issues concerning prevention of IDU among prisoners	925	925	925	925	-	-	**3,700**
1.3.1.2.	Provide technical assistance to the related ministries for elaborating draft policies aimed at eliminating legal barriers to effective HIV/AIDS interventions among IDUs and prisoners.	-	34,975	34,975	-	-	-	**69,950**
1.3.1.3.	Organize policy forums and roundtable meetings for all stakeholders to discuss policy alternatives	740	740	370	370	370	370	**2,960**
1.3.2.	**Mount advocacy focused on stigma and discrimination, primarily among the health care providers**	151,200	138,000	110,000	110,000	135,000	110,000	**754,200**
1.3.2.1	Conduct operational research aimed at identifying key factors related to stigma, develop recommendations for evidence-informed interventions.	25,000	-	-	-	25,000	-	**50,000**
1.3.2.2	Plan and implement adequate interventions aimed at combating stigma among the health care providers.	-	20,000	-	-	-	-	**20,000**
1.3.2.3	Support media capacity building to ensure effective communication of HIV messages [low priority]	16,200	8,000	-	-	-	-	**24,200**
1.3.2.4.	Organize effective information campaigns to build public support [low priority]	110,000	110,000	110,000	110,000	110,000	110,000	**660,000**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
1.3.3	**Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response**	37,200	38,050	33,000	30,050	25,000	30,050	**193,350**
1.3.3.1.	Establish grant programs for PLHA to support advocacy efforts, peer education and networking.	25,000	25,000	25,000	25,000	25,000	25,000	**150,000**
1.3.3.2.	Improve information availability for PLHA on the HIV/AIDS national response	-	5,050	-	5,050	-	5,050	**15,150**
1.3.3.3.	Develop training materials and conduct training for NGOs as well as governmental agencies on how to implement GIPA principles [Low priority]	12,200	8,000	8,000	-	-	-	**28,200**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
2	**Improve quality and scale of preventive interventions**							
	Contain HIV prevalence among MARP <5%; Contain HIV prevalence among pregnant women <0.03%; Contain prevalence among 15-24 years old pregnant women (baseline TBD in 2010);Rate of late HIV diagnoses among newly registered HIV cases from 46% (2009) to 25% by 2016- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016	**6,524,545**	**7,608,953**	**8,550,615**	**9,444,212**	**10,431,289**	**11,155,567**	**53,715,181**
2.1	**Prevention HIV spread among MARPs (IDUS; CSWS; MSM; Prisoners) and MARA**	5,564,140	6,624,220	7,573,060	8,421,089	9,416,479	10,103,389	**47,702,376**
2.1.1.	**Increase the scale & scope of integrated preventive interventions**	5,539,540	6,593,180	7,533,820	8,390,049	9,360,839	10,041,309	**47,458,736**
2.1.1.1	Providing VCT services and increase uptake of HIV testing among MARPs including MARA	712,244	788,722	807,388	826,053	885,513	903,382	**4,923,303**
2.1.1.2	Scale up Agonist Maintenance Therapy (AMT) for IDUs	2,569,656	2,955,260	3,406,812	3,706,812	3,855,260	3,855,260	**20,349,060**
2.1.1.3	Expand drug dependence treatment services	773,000	1,040,200	1,275,000	1,530,000	2,048,200	2,550,000	**9,216,400**
2.1.1.4	Implement needle exchange & other HR programs and increase access to preventive commodities	1,094,059	1,372,103	1,561,412	1,797,662	1,996,029	2,123,265	**9,944,529**
2.1.1.5	Develop and implement effective BCC strategies utilizing multiple channels of communication	390,581	436,895	483,208	529,522	575,836	609,402	**3,025,444**
2.1.2	**Improve the quality of preventive interventions**	24,600	31,040	39,240	31,040	55,640	62,080	**243,640**
2.1.2.1	Develop and implement standard national guidelines for preventive interventions	16,400	-	-	-	16,400	-	**32,800**
2.1.2.2	Upgrade professional skills of service providers	-	31,040	31,040	31,040	31,040	62,080	**186,240**
2.1.2.3	Monitor and evaluate HIV preventive interventions to inform programmatic	8,200	-	8,200	-	8,200	-	**24,600**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
	decisions							
2.2	**Prevent HIV Transmission through Health Care**	401,727	435,434	449,962	464,489	479,017	493,544	**2,724,174**
2.2.1	**Enhance Blood Safety**	331,606	346,133	360,661	375,188	389,716	404,243	**2,207,547**
2.2.1.1	Assure screening of all donated blood in a quality assured manner	319,606	334,133	348,661	363,188	377,716	392,243	**2,135,547**
2.2.1.2	Promote Voluntary Donorship	12,000	12,000	12,000	12,000	12,000	12,000	**72,000**
2.2.2	**Reduce post-exposure HIV transmission**	2,280	2,280	2,280	2,280	2,280	2,280	**13,680**
2.2.2.1	Provision of PEP treatment to all health care workers in the country	2,280	2,280	2,280	2,280	2,280	2,280	**13,680**
2.2.3	**Implement provider initiated testing (PIT) in clinical settings**	67,841	87,021	87,021	87,021	87,021	87,021	**502,947**
2.2.3.1	Develop standards and guidelines for PIT	4,100	-	-	-	-	-	**4,100**
2.2.3.2	Upgrade professional skills on PIT guidelines for HCWs	-	23,280	23,280	23,280	23,280	23,280	**116,400**
2.2.3.3	Implement PIT of patients in narcology, STI and TB clinics and ANC centers (covered by routine surveillance)	63,741	63,741	63,741	63,741	63,741	63,741	**382,447**
2.3	**Prevent Mother-to-child HIV transmission**	474,584	498,929	477,594	508,634	485,794	508,634	**2,954,166**
2.3.1.	**Reduce HIV transmission from mother-to-child**	458,184	467,889	477,594	477,594	477,594	477,594	**2,836,446**
2.3.1.1.	Assure universal screening of all pregnant women on HIV	399,954	399,954	399,954	399,954	399,954	399,954	**2,399,721**
2.3.1.2.	Provide prophylactic ARV treatment to all HIV positive pregnant women	50,850	59,325	67,800	67,800	67,800	67,800	**381,375**
2.3.1.3.	Provide prophylactic ARV therapy to all newborns	480	560	640	640	640	640	**3,600**
2.3.1.4.	Provide social care services to all newborns	6,900	8,050	9,200	9,200	9,200	9,200	**51,750**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
2.3.2.	**Improve the quality of PMTCT program**	16,400	31,040	-	31,040	8,200	31,040	**117,720**
2.3.2.1.	Integrate PMTCT program with existing Perinatal Hepatitis B Prevention Program	8,200	-	-	-	-	-	**8,200**
2.3.2.2	Update PMTCT guidelines	8,200	-	-	-	8,200	-	**16,400**
2.3.2.3	Upgrade professional skills of HCWs in PMTC	-	31,040	-	31,040	-	31,040	**93,120**
2.4.	**Reduce Youth Vulnerability to HIV**	84,095	50,370	50,000	50,000	50,000	50,000	**334,465**
2.4.1.	**Enable young people to protect themselves and their peers from HIV Infection**	84,095	50,370	50,000	50,000	50,000	50,000	**334,465**
2.4.1.1.	Develop and implement effective BCC interventions focusing on youth	58,200	50,000	50,000	50,000	50,000	50,000	**308,200**
2.4.1.2	Advocate for integrating drug and HIV prevention training course into National Education Plan	17,325	-	-	-	-	-	**17,325**
2.4.1.3	Develop and Implement Drug-Free School Policies for schools	8,570	370	-	-	-	-	**8,940**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
3	**Treatment**							
	Improve ART survival rates	**8,479,735**	**10,131,475**	**12,098,287**	**13,999,391**	**15,987,799**	**18,307,159**	**79,003,846**
3.1	**Improve ART Survival Rates**	8,479,735	10,131,475	12,098,287	13,999,391	15,987,799	18,307,159	**79,003,846**
3.1.1	**Maintain and, if possible, increase current level of access to ART**	3,583,690	4,467,032	5,498,970	6,510,172	7,629,180	8,908,115	**36,597,159**
3.1.1.1	Provide regular laboratory and clinical examination of patients	1,644,500	1,955,580	2,281,380	2,645,260	3,036,360	3,454,320	**15,017,400**
3.1.1.2	Provide ARVs to all patients in need	1,675,540	2,145,100	2,734,950	3,265,300	3,849,800	4,555,770	**18,226,460**
3.1.1.3	Maintain T&C services in conflict region of Georgia	263,650	366,352	482,640	599,612	743,020	898,025	**3,353,299**
3.1.2	**Improve treatment adherence among patients on ART**	411,800	500,050	607,775	720,750	856,000	1,014,750	**4,111,125**
3.1.2.1	Provide home based adherence monitoring and support	411,800	500,050	607,775	720,750	856,000	1,014,750	**4,111,125**
3.1.2.2	Integration of HIV and TB services (one stop service)	-	-	-	-	-	-	**-**
3.1.3	**Strengthen ART management capacity**	546,435	596,083	701,262	853,614	906,549	962,439	**4,566,382**
3.1.3.1	Implement HIV drug resistance (HIVDR) prevention and assessment strategy	275,655	296,813	363,182	464,299	464,299	464,299	**2,328,547**
3.1.3.2	Support regular update of evidence-based guidelines	8,200	8,200	8,200	8,200	8,200	8,200	**49,200**
3.1.3.3	Support implementation of clinical audit	24,600	16,400	16,400	16,400	16,400	16,400	**106,600**
3.1.3.4	Maintain HIV/AIDS clinical database	12,000	12,000	12,000	12,000	12,000	12,000	**72,000**
3.1.3.5	Training necessary human resources for curative HIV/AIDS services	68,000	68,000	68,000	69,000	69,000	69,000	**411,000**
3.1.3.6	Implement modern hi-tech laboratory tools for ART monitoring	157,980	194,670	233,480	283,715	336,650	392,540	**1,599,035**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
3.1.4	**Scale-up management of opportunistic infections (OIs) and other co-morbidities**	3,937,810	4,568,310	5,290,280	5,914,855	6,596,070	7,421,855	**33,729,180**
3.1.4.1	Provide modern instrumental diagnostic services	1,347,350	1,709,530	2,124,600	2,617,315	3,158,010	3,835,215	**14,792,020**
3.1.4.2	Improve management of latent and active TB	39,380	46,340	53,120	62,740	72,840	84,200	**358,620**
3.1.4.3	Develop capacity for management of infections caused by non-tuberculosis mycobacteria, fungi and HPV	170,530	192,580	194,480	196,380	198,280	200,180	**1,152,430**
3.1.4.4	Improve management of HIV/HCV co-infected patients	1,219,900	1,219,900	1,219,900	1,219,900	1,219,900	1,219,900	**7,319,400**
3.1.4.5	Provide management (prevention, diagnosis and treatment) of other common OIs	215,650	260,400	309,300	359,800	415,600	474,600	**2,035,350**
3.1.4.6	Provide in-patient care for all patients in need	945,000	1,139,560	1,388,880	1,458,720	1,531,440	1,607,760	**8,071,360**
4	**Care and Support**							
	Assuring access to basic care and support	530,400	625,680	779,630	875,720	964,700	1,026,580	**4,802,710**
4.1	**Assure access to basic care and support services**	530,400	625,680	779,630	875,720	964,700	1,026,580	**4,802,710**
4.1.1	**Assure current level care and support services and future expansion driven by need**	530,400	625,680	779,630	875,720	964,700	1,026,580	**4,802,710**
4.1.1.1	Provide counseling and psychological assistance to adults and children	105,100	138,600	208,800	232,000	243,600	255,200	**1,183,300**
4.1.1.2	Provide palliative care services (both institutional and home-based)	275,900	308,400	361,040	401,820	442,600	452,620	**2,242,380**
4.1.1.3	Providing trainings to specialists involved in care and support services	3,000	3,000	3,000	4,000	4,000	4,000	**21,000**
4.1.1.4	Provide nutritional support	146,400	175,680	206,790	237,900	274,500	314,760	**1,356,030**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
5	**Health System Strengthening**							
	Strengthen Health System capacity for effective HIV response	**4,691,698**	**6,364,703**	**1,712,070**	**982,708**	**900,020**	**323,588**	**14,974,788**
5.1	**Strengthen regulatory system and assure higher quality services in the health care settings**	680,775	125,350	-	-	-	-	**806,125**
5.1.1	**Develop and Implement new regulations for Blood Safety**	574,000	94,475	-	-	-	-	**668,475**
5.1.1.1	Develop, implement and enforce state regulations for Laboratory Testing Standards mandatory for blood safety	185,250	-	-	-	-	-	**185,250**
5.1.1.2	Develop and implement accreditation standards for blood & blood products producing units, which would include mandatory provisions for professional liability insurance for blood and blood products producing units (private and public)	123,500	-	-	-	-	-	**123,500**
5.1.1.3	Develop and implement state regulations for Laboratory Quality Assurance (QA) that are intended to facilitate implementation of overall QA system for labs, which would also include External Quality Assurance	185,250	92,625	-	-	-	-	**277,875**
5.1.1.4	Assist MoLHSA in elaboration and implementation mechanisms geared towards transition from state/donor financed safe blood programs towards the system of sustainable self-financing.	78,150	-	-	-	-	-	**78,150**
5.1.1.5	Conduct Policy dialogues and consensus building meetings for objective 5.1.1.(at least 10 high-level meetings)	1,850	1,850	-	-	-	-	**3,700**

ANNEX 4: DETAILED BUDGET - **SCENARIO 1**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
5.1.2	**Develop and implement QA regulations for medical facilities for infection control**	106,775	30,875	-	-	-	-	**137,650**
5.1.2.1	Develop and implement mandatory state regulations for infection control within health care setting, which would include "Universal precautions" aimed at preventing transmission of HIV, hepatitis B and C, and other blood or body fluid borne pathogens.	104,925	30,875	-	-	-	-	**135,800**
5.1.2.2	Enforce these regulations through facility accreditation system.	1,850	-	-	-	-	-	**1,850**
5.1.2.3	Conduct Policy dialogues and consensus building meetings for objective 5.1.2.(at least 10 high-level meetings)	1,850	-	-	-	-	-	**1,850**
5.2	**Assure necessary investments in the infrastructure and human resources**	4,010,923	6,239,353	1,712,070	982,708	900,020	323,588	**14,168,663**
5.2.1	**Strengthen Human Resource capacity for quality of preventive and curative HIV services**	-	-	-	-	-	-	**-**
5.2.2.	**Assure necessary investments in the infrastructure**	4,010,923	6,239,353	1,712,070	982,708	900,020	323,588	**14,168,663**
5.2.2.1	Develop adequate physical infrastructure for AIDS treatment facilities in Tbilisi and three regions of Georgia	3,901,923	3,853,765	1,241,070	879,120	841,020	300,000	**11,016,898**
5.2.2.2	Based on needs assessment develop adequate physical infrastructure for HIV prevention services	109,000	2,385,588	471,000	103,588	59,000	23,588	**3,151,765**
	TOTAL	**21,163,230**	**25,495,991**	**23,885,290**	**25,802,464**	**29,016,537**	**31,232,552**	**156,596,064**
	TOTAL adjusted to inflation	**22,221,392**	**28,109,330**	**27,650,209**	**31,363,057**	**37,033,271**	**41,854,607**	**188,231,865**

ANNEX 5: DETAILED BUDGET - HIV/AIDS STRATEGIC PLAN 2011-2016[51] - SCENARIO 2

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
1	**Governance and Advocacy**							
	Enhance coordination and advocacy efforts of the national response	**773,452**	**479,180**	**626,688**	**345,433**	**622,729**	**289,658**	**3,137,139**
1.1	**Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function**	678,612	299,865	557,218	309,988	572,359	255,138	**2,673,179**
1.1.1	**Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities**	22,956	14,706	14,706	14,706	14,706	14,706	**96,485**
1.1.1.1	Provide technical assistance to the MoLHSA in developing new bylaws for the CCM.	8,200	-	-	-	-	-	**8,200**
1.1.1.2	Widely disseminate information about the new role of the CCM through various media sources	14,756	14,706	14,706	14,706	14,706	14,706	**88,285**
1.1.2	**Increase capacity of the CCM's secretariat**	97,750	94,300	94,300	94,300	94,300	94,300	**569,250**
1.1.2.1	Support regular participation of the CCM's secretariat and its members in HIV/AIDS international events and conferences at global and regional levels	32,000	32,000	32,000	32,000	32,000	32,000	**192,000**
1.1.2.2	Assure sustainable financing of CCM's secretariat;	65,750	62,300	62,300	62,300	62,300	62,300	**377,250**
1.1.3	**Develop, implement and fully operationalize one M&E framework**	557,906	190,859	448,212	200,982	463,353	146,132	**2,007,444**
1.1.3.1.	Assure sustainable functionality of the national HIV/AIDS surveillance program, which renders critical epidemiological and programatic information about national response	410,806	140,859	385,912	150,982	401,053	96,132	**1,585,744**
1.1.3.2.	Develop national M&E framework and its implementation arrangements	34,800	-	-	-	-	-	**34,800**

[51] Budget is estimated in USD

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
1.1.3.3.	Conduct HIV/AIDS related operational research to inform policies and practice	112,300	50,000	62,300	50,000	62,300	50,000	**386,900**
1.2.	**Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**	43,175	92,625	8,200	4,100	-	4,100	**152,200**
1.2.1.	**Advocate for increased state/national financing for HIV/AIDS**	43,175	92,625	8,200	4,100	-	4,100	**152,200**
1.2.1.1.	Provide technical assistance to the MoLHSA for improved budget planning in close collaboration with the Ministry of finance(MoF) to ensure sustainable financing of HIV/AIDS services.	8,200	8,200	8,200	-	-	-	**24,600**
1.2.1.2.	Provide technical assistance to MoLHSA for exploring opportunities for inclusion of HIV/AIDS coverage under insurance schemes.	34,975	-	-	-	-	-	**34,975**
1.2.1.3.	Conduct economic evaluation of various preventive and curative interventions to inform resource allocation decisions	-	80,325	-	-	-	-	**80,325**
1.2.1.4.	Conduct National AIDS Spending Assessment and Financial Gap analyses to inform policy decisions (incl. UNGASS reporting)	-	4,100	-	4,100	-	4,100	**12,300**
1.3.	**Carry out necessary advocacy to create conducive environment for national response**	51,665	86,690	61,270	31,345	50,370	30,420	**311,760**
1.3.1.	**Reduce legal and regulatory barriers for drug users \and for prisoners**	1,665	36,640	36,270	1,295	370	370	**76,610**
1.3.1.1.	Support the multisectoral group working on legal and regulatory issues concerning prevention of IDU among prisoners	925	925	925	925	-	-	**3,700**
1.3.1.2.	Provide technical assistance to the related ministries for elaborating draft policies aimed at eliminating legal barriers to effective HIV/AIDS interventions among IDUs and prisoners.	-	34,975	34,975	-	-	-	**69,950**
1.3.1.3.	Organize policy forums and roundtable meetings for all stakeholders to discuss policy alternatives	740	740	370	370	370	370	**2,960**
1.3.2.	**Mount advocacy focused on stigma and discrimination, primarily among the health care providers**	25,000	20,000	-	-	25,000	-	**70,000**
1.3.2.1	Conduct operational research aimed at identifying key factors related to stigma, develop recommendations for evidence-informed interventions.	25,000	-	-	-	25,000	-	**50,000**
1.3.2.2	Plan and implement adequate interventions aimed at combating stigma among the health care providers.	-	20,000	-	-	-	-	**20,000**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

Georgia NSP		2011	2012	2013	2014	2015	2016	Total cost
1.3.3	**Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response**	25,000	30,050	25,000	30,050	25,000	30,050	**165,150**
1.3.3.1.	Establish grant programs for PLHA to support advocacy efforts, peer education and networking.	25,000	25,000	25,000	25,000	25,000	25,000	**150,000**
1.3.3.2.	Improve information availability for PLHA on the HIV/AIDS national response	-	5,050	-	5,050	-	5,050	**15,150**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
2	**Improve quality and scale of preventive interventions**							
	Contain HIV prevalence among MARP <5%; Contain HIV prevalence among pregnant women <0.03%; Contain prevalence among 15-24 years old pregnant women (baseline TBD in 2010);Rate of late HIV diagnoses among newly registered HIV cases from 46% (2009) to 25% by 2016- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016	**6,513,975**	**7,502,313**	**8,377,595**	**9,113,692**	**9,864,519**	**10,652,027**	**52,024,121**
2.1	**Prevention HIV spread among MARPs (IDUS; CSWS; MSM; Prisoners) and MARA**	5,562,140	6,517,950	7,400,040	8,090,569	8,849,709	9,599,849	**46,020,256**
2.1.1.	**Increase the scale & scope of integrated preventive interventions**	5,537,540	6,502,430	7,376,320	8,075,049	8,809,589	9,568,809	**45,869,736**
2.1.1.1	Providing VCT services and increase uptake of HIV testing among MARPs including MARA	712,244	788,722	807,388	826,053	885,513	903,382	**4,923,303**
2.1.1.2	Scale up Agonist Maintenance Therapy (AMT) for IDUs	2,569,656	2,955,260	3,406,812	3,706,812	3,855,260	3,855,260	**20,349,060**
2.1.1.3	Expand drug dependence treatment services	771,000	1,028,200	1,275,000	1,530,000	2,048,200	2,550,000	**9,202,400**
2.1.1.4	Implement needle exchange & other HR programs and increase access to preventive commodities	1,094,059	1,293,353	1,403,912	1,482,662	1,444,779	1,650,765	**8,369,529**
2.1.1.5	Develop and implement effective BCC strategies utilizing multiple channels of communication	390,581	436,895	483,208	529,522	575,836	609,402	**3,025,444**
2.1.2	**Improve the quality of preventive interventions**	24,600	15,520	23,720	15,520	40,120	31,040	**150,520**
2.1.2.1	Develop and implement standard national guidelines for preventive interventions	16,400	-	-	-	16,400	-	**32,800**
2.1.2.2	Upgrade professional skills of service providers	-	15,520	15,520	15,520	15,520	31,040	**93,120**
2.1.2.3	Monitor and evaluate HIV preventive interventions to inform programmatic decisions	8,200	-	8,200	-	8,200	-	**24,600**
2.2	**Prevent HIV Transmission through Health Care**	401,727	435,434	449,962	464,489	479,017	493,544	**2,724,174**
2.2.1	**Enhance Blood Safety**	331,606	346,133	360,661	375,188	389,716	404,243	**2,207,547**
2.2.1.1	Assure screening of all donated blood in a quality assured manner	319,606	334,133	348,661	363,188	377,716	392,243	**2,135,547**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
2.2.1.2	Promote Voluntary Donorship	12,000	12,000	12,000	12,000	12,000	12,000	**72,000**
2.2.2	**Reduce post-exposure HIV transmission**	2,280	2,280	2,280	2,280	2,280	2,280	**13,680**
2.2.2.1	Provision of PEP treatment to all health care workers in the country	2,280	2,280	2,280	2,280	2,280	2,280	**13,680**
2.2.3	**Implement provider initiated testing (PIT) in clinical settings**	67,841	87,021	87,021	87,021	87,021	87,021	**502,947**
2.2.3.1	Develop standards and guidelines for PIT	4,100	-	-	-	-	-	**4,100**
2.2.3.2	Upgrade professional skills on PIT guidelines for HCWs	-	23,280	23,280	23,280	23,280	23,280	**116,400**
2.2.3.3	Implement PIT of patients in narcology, STI and TB clinics and ANC centers (covered by routine surveillance)	63,741	63,741	63,741	63,741	63,741	63,741	**382,447**
2.3	**Prevent Mother-to-child HIV transmission**	474,584	498,929	477,594	508,634	485,794	508,634	**2,954,166**
2.3.1.	**Reduce HIV transmission from mother-to-child**	458,184	467,889	477,594	477,594	477,594	477,594	**2,836,446**
2.3.1.1.	Assure universal screening of all pregnant women on HIV	399,954	399,954	399,954	399,954	399,954	399,954	**2,399,721**
2.3.1.2.	Provide prophylactic ARV treatment to all HIV positive pregnant women	50,850	59,325	67,800	67,800	67,800	67,800	**381,375**
2.3.1.3.	Provide prophylactic ARV therapy to all newborns	480	560	640	640	640	640	**3,600**
2.3.1.4.	Provide social care services to all newborns	6,900	8,050	9,200	9,200	9,200	9,200	**51,750**
2.3.2.	**Improve the quality of PMTCT program**	16,400	31,040	-	31,040	8,200	31,040	**117,720**
2.3.2.1.	Integrate PMTCT program with existing Perinatal Hepatitis B Prevention Program	8,200	-	-	-	-	-	**8,200**
2.3.2.2	Update PMTCT guidelines	8,200	-	-	-	8,200	-	**16,400**
2.3.2.3	Upgrade professional skills of HCWs in PMTC	-	31,040	-	31,040	-	31,040	**93,120**
2.4.	**Reduce Youth Vulnerability to HIV**	75,525	50,000	50,000	50,000	50,000	50,000	**325,525**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

Georgia NSP		2011	2012	2013	2014	2015	2016	Total cost
2.4.1.	**Enable young people to protect themselves and their peers from HIV Infection**	75,525	50,000	50,000	50,000	50,000	50,000	**325,525**
2.4.1.1.	Develop and implement effective BCC interventions focusing on youth	58,200	50,000	50,000	50,000	50,000	50,000	**308,200**
2.4.1.2	Advocate for integrating drug and HIV prevention training course into National Education Plan	17,325	-	-	-	-	-	**17,325**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
3	**Treatment**							
	Improve ART survival rates	**7,283,415**	**8,640,095**	**10,315,737**	**11,827,701**	**13,387,509**	**15,186,424**	**66,640,881**
3.1	**Improve ART Survival Rates**	**7,283,415**	**8,640,095**	**10,315,737**	**11,827,701**	**13,387,509**	**15,186,424**	**66,640,881**
3.1.1	**Maintain and, if possible, increase current level of access to ART**	3,583,690	4,467,032	5,498,970	6,510,172	7,629,180	8,908,115	**36,597,159**
3.1.1.1	Provide regular laboratory and clinical examination of patients	1,644,500	1,955,580	2,281,380	2,645,260	3,036,360	3,454,320	**15,017,400**
3.1.1.2	Provide ARVs to all patients in need	1,675,540	2,145,100	2,734,950	3,265,300	3,849,800	4,555,770	**18,226,460**
3.1.1.3	Maintain T&C services in conflict region of Georgia	263,650	366,352	482,640	599,612	743,020	898,025	**3,353,299**
3.1.2	**Improve treatment adherence among patients on ART**	411,800	500,050	607,775	720,750	856,000	1,014,750	**4,111,125**
3.1.2.1	Provide home based adherence monitoring and support	411,800	500,050	607,775	720,750	856,000	1,014,750	**4,111,125**
3.1.2.2	Integration of HIV and TB services (one stop service)	-	-	-	-	-	-	**-**
3.1.3	**Strengthen ART management capacity**	354,455	367,413	435,782	537,899	537,899	537,899	**2,771,347**
3.1.3.1	Implement HIV drug resistance (HIVDR) prevention and assessment strategy	275,655	296,813	363,182	464,299	464,299	464,299	**2,328,547**
3.1.3.2	Support regular update of evidence-based guidelines	8,200	8,200	8,200	8,200	8,200	8,200	**49,200**
3.1.3.3	Support implementation of clinical audit	24,600	16,400	16,400	16,400	16,400	16,400	**106,600**
3.1.3.4	Maintain HIV/AIDS clinical database	12,000	12,000	12,000	12,000	12,000	12,000	**72,000**
3.1.3.5	Training necessary human resources for curative HIV/AIDS services	34,000	34,000	36,000	37,000	37,000	37,000	**215,000**
3.1.4	**Scale-up management of opportunistic infections (OIs) and other co-morbidities**	2,933,470	3,305,600	3,773,210	4,058,880	4,364,430	4,725,660	**23,161,250**
3.1.4.1	Provide modern instrumental diagnostic services	448,500	570,820	750,360	926,840	1,116,170	1,355,080	**5,167,770**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
3.1.4.2	Improve management of latent and active TB	740	740	740	740	740	740	**4,440**
3.1.4.3	Develop capacity for management of infections caused by non-tuberculosis mycobacteria, fungi and HPV	170,530	192,580	194,480	196,380	198,280	200,180	**1,152,430**
3.1.4.4	Improve management of HIV/HCV co-infected patients	1,219,900	1,219,900	1,219,900	1,219,900	1,219,900	1,219,900	**7,319,400**
3.1.4.5	Provide management (prevention, diagnosis and treatment) of other common OIs	148,800	182,000	218,850	256,300	297,900	342,000	**1,445,850**
3.1.4.6	Provide in-patient care for all patients in need	945,000	1,139,560	1,388,880	1,458,720	1,531,440	1,607,760	**8,071,360**
4	**Care and Support**							
	Assuring access to basic care and support	384,000	450,000	572,840	637,820	690,200	711,820	**3,446,680**
4.1	**Assure access to basic care and support services**	384,000	450,000	572,840	637,820	690,200	711,820	**3,446,680**
4.1.1	**Assure current level care and support services and future expansion driven by need**	384,000	450,000	572,840	637,820	690,200	711,820	**3,446,680**
4.1.1.1	Provide counseling and psychological assistance to adults and children	105,100	138,600	208,800	232,000	243,600	255,200	**1,183,300**
4.1.1.2	Provide palliative care services (both institutional and home-based)	275,900	308,400	361,040	401,820	442,600	452,620	**2,242,380**
4.1.1.3	Providing trainings to specialists involved in care and support services	3,000	3,000	3,000	4,000	4,000	4,000	**21,000**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

	Georgia NSP	2011	2012	2013	2014	2015	2016	Total cost
5	**Health System Strengthening**							
	Strengthen Health System capacity for effective HIV response	**4,266,855**	**3,486,930**	**1,055,600**	**662,120**	**600,020**	**-**	**10,071,525**
5.1	**Strengthen regulatory system and assure higher quality services in the health care settings**	680,775	125,350	-	-	-	-	**806,125**
5.1.1	**Develop and Implement new regulations for Blood Safety**	574,000	94,475	-	-	-	-	**668,475**
5.1.1.1	Develop, implement and enforce state regulations for Laboratory Testing Standards mandatory for blood safety	185,250	-	-	-	-	-	**185,250**
5.1.1.2	Develop and implement accreditation standards for blood & blood products producing units, which would include mandatory provisions for professional liability insurance for blood and blood products producing units (private and public)	123,500	-	-	-	-	-	**123,500**
5.1.1.3	Develop and implement state regulations for Laboratory Quality Assurance (QA) that are intended to facilitate implementation of overall QA system for labs, which would also include External Quality Assurance	185,250	92,625	-	-	-	-	**277,875**
5.1.1.4	Assist MoLHSA in elaboration and implementation mechanisms geared towards transition from state/donor financed safe blood programs towards the system of sustainable self-financing.	78,150	-	-	-	-	-	**78,150**
5.1.1.5	Conduct Policy dialogues and consensus building meetings for objective 5.1.1.(at least 10 high-level meetings)	1,850	1,850	-	-	-	-	**3,700**
5.1.2	**Develop and implement QA regulations for medical facilities for infection control**	106,775	30,875	-	-	-	-	**137,650**
5.1.2.1	Develop and implement mandatory state regulations for infection control within health care setting, which would include "Universal precautions" aimed at preventing transmission of HIV, hepatitis B and C, and other blood or body fluid borne pathogens.	104,925	30,875	-	-	-	-	**135,800**
5.1.2.2	Enforce these regulations through facility accreditation system.	1,850	-	-	-	-	-	**1,850**
5.1.2.3	Conduct Policy dialogues and consensus building meetings for objective 5.1.2.(at least 10 high-level meetings)	1,850	-	-	-	-	-	**1,850**
5.2	**Assure necessary investments in the infrastructure and human resources**	3,586,080	3,361,580	1,055,600	662,120	600,020	-	**9,265,400**

ANNEX 5: DETAILED BUDGET - **SCENARIO 2**

Georgia NSP		2011	2012	2013	2014	2015	2016	Total cost
5.2.1	**Strengthen Human Resource capacity for quality of preventive and curative HIV services**	-	-	-	-	-	-	**-**
5.2.2.	**Assure necessary investments in the infrastructure**	3,586,080	3,361,580	1,055,600	662,120	600,020	-	**9,265,400**
5.2.2.1	Develop adequate physical infrastructure for AIDS treatment facilities in Tbilisi and three regions of Georgia	3,506,080	3,257,580	942,600	579,120	541,020	-	**8,826,400**
5.2.2.2	Based on needs assessment develop adequate physical infrastructure for HIV prevention services	80,000	104,000	113,000	83,000	59,000	-	**439,000**
TOTAL		**19,221,697**	**20,558,518**	**20,948,460**	**22,586,766**	**25,164,977**	**26,839,929**	**135,320,347**
TOTAL adjusted to inflation		**20,182,782**	**22,665,766**	**24,250,461**	**27,454,355**	**32,117,596**	**35,968,072**	**162,639,032**

ANNEX 6: COSTED TECHNICAL ASSISTANCE PLAN 2011-2016 – Scenario 1

	Georgia NSP	LTA	ITA	Total TA
1	**Governance and Advocacy**			
	Enhance coordination and advocacy efforts of the national response	**235,750**	**160,650**	**396,400**
1.1	**Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function**	**151,700**	**-**	**151,700**
1.1.1	Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities	8,200	-	8,200
1.1.2	Increase capacity of the CCM's secretariat	73,800	-	73,800
1.1.3	Develop, implement and fully operationalize one M&E framework	69,700	-	69,700
1.2.	**Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**	**45,100**	**107,100**	**152,200**
1.2.1.	Advocate for increased state/national financing for HIV/AIDS	45,100	107,100	152,200
1.3.	**Carry out necessary advocacy to create conducive environment for national response**	**38,950**	**53,550**	**92,500**
1.3.1.	Reduce legal and regulatory barriers for drug users \and for prisoners	16,400	53,550	69,950
1.3.2.	Mount advocacy focused on stigma and discrimination, primarily among the health care providers	8,200	-	8,200
1.3.3	Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response	14,350	-	14,350
2	**Improve quality and scale of preventive interventions**			
	Contain HIV prevalence among MARP <5%; Contain HIV prevalence among pregnant women <0.03%; Contain prevalence among 15-24 years old pregnant women (baseline TBD in 2010);Rate of late HIV diagnoses among newly registered HIV cases from 46% (2009) to 25% by 2016- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016	**135,300**	**-**	**135,300**
2.1	**Prevention HIV spread among MARPs (IDUS; CSWS; MSM; Prisoners) and MARA**	**73,800**	**-**	**73,800**
2.1.1.	Increase the scale & scope of integrated preventive interventions	16,400	-	16,400
2.1.2	Improve the quality of preventive interventions	57,400	-	57,400
2.2	**Prevent HIV Transmission through Health Care**	**4,100**	**-**	**4,100**
2.2.1	Enhance Blood Safety	-	-	-
2.2.2	Reduce post-exposure HIV transmission	-	-	-
2.2.3	Implement provider initiated testing (PIT) in clinical settings	4,100	-	4,100

ANNEX 6: COSTED TECHNICAL ASSISTANCE PLAN - **SCENARIO 1**

	Georgia NSP	LTA	ITA	Total TA
2.3	**Prevent Mother-to-child HIV transmission**	**24,600**	**-**	**24,600**
2.3.1.	Reduce HIV transmission from mother-to-child	-	-	-
2.3.2.	Improve the quality of PMTCT program	24,600	-	24,600
2.4.	**Reduce Youth Vulnerability to HIV**	**32,800**	**-**	**32,800**
2.4.1.	Enable young people to protect themselves and their peers from HIV Infection	32,800	-	32,800
3	**Treatment**			
	Improve survival and quality of life of persons living with HIV	**155,800**	**-**	**155,800**
3.1	**Improve ART Survival Rates**	**155,800**	**-**	**155,800**
3.1.1	Maintain and, if possible, increase current level of access to ART	-	-	-
3.1.2	Improve treatment adherence among patients on ART	-	-	-
3.1.3	Strengthen ART management capacity	155,800	-	155,800
3.1.4	Scale-up management of opportunistic infections (OIs) and other co-morbidities	-	-	-
4	**Care and support**			
	Assuring access to basic care and support	-	-	-
4.1	**Assure access to basic care and support services**	**-**	**-**	**-**
4.1.1	Assure current level care and support services and future expansion driven by need	-	-	-
5	**Health System Strengthening**			**-**
	Strengthen Health System capacity for effective HIV response	**131,200**	**669,375**	**800,575**
5.1	**Strengthen regulatory system and assure higher quality services in the health care settings**	**131,200**	**669,375**	**800,575**
5.1.1	Develop and Implement new regulations for Blood Safety	102,500	562,275	664,775
5.1.2	Develop and implement QA regulations for medical facilities for infection control	28,700	107,100	135,800
5.2	**Assure necessary investments in the infrastructure and human resources**	**-**	**-**	**-**
5.2.1	Strengthen Human Resource capacity for quality of preventive and curative HIV services	-	-	-
5.2.2.	Assure necessary investments in the infrastructure	-	-	-
	TOTAL	**658,050**	**830,025**	**1,488,075**

ANNEX 7: COSTED TECHNICAL ASSISTANCE PLAN 2011-2016 – Scenario 2

	Georgia NSP	LTA	ITA	Total TA
1	**Governance and Advocacy**			
	Enhance coordination and advocacy efforts of the national response	**219,350**	**160,650**	**380,000**
1.1	**Increase capacity of the CCM's secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function**	**151,700**	**-**	**151,700**
1.1.1	Developing new CCM bylaws in line with the provisions of recently adopted Law on HIV/AIDS and equipping CCM with the needed regulations-instruments for effective execution of its roles and responsibilities	8,200	-	8,200
1.1.2	Increase capacity of the CCM's secretariat	73,800	-	73,800
1.1.3	Develop, implement and fully operationalize one M&E framework	69,700	-	69,700
1.2.	**Assure adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment**	**45,100**	**107,100**	**152,200**
1.2.1.	Advocate for increased state/national financing for HIV/AIDS	45,100	107,100	152,200
1.3.	**Carry out necessary advocacy to create conducive environment for national response**	**22,550**	**53,550**	**76,100**
1.3.1.	Reduce legal and regulatory barriers for drug users \and for prisoners	16,400	53,550	69,950
1.3.2.	Mount advocacy focused on stigma and discrimination, primarily among the health care providers	-	-	-
1.3.3	Advocate for greater involvement of people living with or affected by HIV/AIDS (GIPA) in the national response	6,150	-	6,150
2	**Improve quality and scale of preventive interventions**			
	Contain HIV prevalence among MARP <5%; Contain HIV prevalence among pregnant women <0.03%; Contain prevalence among 15-24 years old pregnant women (baseline TBD in 2010);Rate of late HIV diagnoses among newly registered HIV cases from 46% (2009) to 25% by 2016- The rate of late HIV detection is reduced from 46% to 35% by 2013 and to 25% by 2016	**127,100**	**-**	**127,100**
2.1	**Prevention HIV spread among MARPs (IDUS; CSWS; MSM; Prisoners) and MARA**	**73,800**	**-**	**73,800**
2.1.1.	Increase the scale & scope of integrated preventive interventions	16,400	-	16,400
2.1.2	Improve the quality of preventive interventions	57,400	-	57,400
2.2	**Prevent HIV Transmission through Health Care**	**4,100**	**-**	**4,100**
2.2.1	Enhance Blood Safety	-	-	-
2.2.2	Reduce post-exposure HIV transmission	-	-	-
2.2.3	Implement provider initiated testing (PIT) in clinical settings	4,100	-	4,100

ANNEX 7: COSTED TECHNICAL ASSISTANCE PLAN - **SCENARIO 2**

	Georgia NSP	LTA	ITA	Total TA
2.3	**Prevent Mother-to-child HIV transmission**	**24,600**	**-**	**24,600**
2.3.1.	Reduce HIV transmission from mother-to-child	-	-	-
2.3.2.	Improve the quality of PMTCT program	24,600	-	24,600
2.4.	**Reduce Youth Vulnerability to HIV**	**24,600**	**-**	**24,600**
2.4.1.	Enable young people to protect themselves and their peers from HIV Infection	24,600	-	24,600
3	**Treatment**			
	Improve survival and quality of life of persons living with HIV	**155,800**	**-**	**155,800**
3.1	**Improve ART Survival Rates**	**155,800**	**-**	**155,800**
3.1.1	Maintain and, if possible, increase current level of access to ART	-	-	-
3.1.2	Improve treatment adherence among patients on ART	-	-	-
3.1.3	Strengthen ART management capacity	155,800	-	155,800
3.1.4	Scale-up management of opportunistic infections (OIs) and other co-morbidities	-	-	-
4	**Care and support**			
	Assuring access to basic care and support	-	-	-
4.1	**Assure access to basic care and support services**	**-**	**-**	**-**
4.1.1	Assure current level care and support services and future expansion driven by need	-	-	-
5	**Health System Strengthening**			**-**
	Strengthen Health System capacity for effective HIV response	**131,200**	**669,375**	**800,575**
5.1	**Strengthen regulatory system and assure higher quality services in the health care settings**	**131,200**	**669,375**	**800,575**
5.1.1	Develop and Implement new regulations for Blood Safety	102,500	562,275	664,775
5.1.2	Develop and implement QA regulations for medical facilities for infection control	28,700	107,100	135,800
5.2	**Assure necessary investments in the infrastructure and human resources**	**-**	**-**	**-**
5.2.1	Strengthen Human Resource capacity for quality of preventive and curative HIV services	-	-	-
5.2.2.	Assure necessary investments in the infrastructure	-	-	-
	TOTAL	**633,450**	**830,025**	**1,463,475**