THE GEORGIAN NATIONAL HIV/AIDS STRATEGIC PLAN FOR 2016–2018

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Tables and Figures:

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral treatment
ARV	Antiretroviral
BBS	Bio-behavioural survey
BCC	Behaviour change communication
CBO	Community-based organisation
CCM	Country coordinating mechanism
CSO	Civil society organization
FSW	Female sex worker
GAVI	GAVI Alliance
GBV	Gender Base Violence
GHPP	USAID Georgia HIV Prevention Project
GoG	Government of Georgia
HBV	Viral hepatitis B
HCV	Viral hepatitis C
HIV	Human immunodeficiency virus
IBBSS	Integrated bio-behavioural surveillance study
IDU	Injecting drug use
IEC	Information, Education & Communication
KAP	Key affected populations
M&E	Monitoring and evaluation
MoLHSA	Ministry of Health, Labour and Social Affairs
MSM	Men who have sex with men
NCDCPH	The National Centre for Disease Control and Public Health
NGO	Non-governmental organisation
NSP	National HIV/AIDS Strategic Plan
OI	Opportunistic infection
OST	Opioid substitution therapy
OVC	Orphans and other vulnerable children
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis
PrEP	Pre-Exposure Prophylaxes
PIT	Provider initiated testing
PLHIV	People living with HIV
PTF	Prevention Taskforce
PWID	People who inject drugs
PWUD	People who use drugs
QA	Quality assurance
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organization

INTRODUCTION

The significant achievements of the national response to the HIV epidemic, the strengthened capacity of organizations delivering essential HIV prevention, treatment and care services, improved data on key population sizes and bio-behavioral determinants of HIV vulnerability, a clearer understanding of future priorities, as well as significant changes in the HIV funding landscape have led to the need to develop this fourth revision of the Georgian National HIV/AIDS Strategic Plan (NSP).

The NSP builds on the implementation experience of the National HIV/AIDS Strategy for 2011-2016. It describes the achievements and current state of the national response to HIV epidemic, defines priorities for its next phase (2016–2018), highlights innovations in the delivery of essential HIV services, calls for regulatory improvements and emphasizes the need for new partnerships, which will allow for maintaining the achievements and prepare for a reversal of the HIV epidemic in Georgia.

The plan presents key directions of work and sets new targets to be attained by the end of 2018. Achieving these targets will require the concerted efforts of all stakeholders and adequate financial support from domestic and external sources.

The NSP is the result of the inclusive collaborative work of all stakeholders involved in the implementation of HIV related interventions and international experts, who provided technical assistance to ensure the compliance of the proposed interventions with international standards and good practices.

1 HIV EPIDEMIC UPDATE

The HIV epidemic remains a significant public health concern in Georgia. Since the detection of the first case of HIV in 1989, the rate of new HIV diagnoses in the country has been increasing steadily and reached 10.9 per 100,000 in 2013.[1] The latest estimate of the number of people living with HIV (PLHIV) in Georgia is 6,800,[2] and 45% of these people are not aware of their status. 4,695 PLHIV were officially registered by the end of 2014. Although the infection is mainly located among the male population (69% of total reported cases), the proportion of women affected increased from 25% to 31% in 2014.

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

(a) A growing concern is the increasing HIV prevalence among MSM, from 7% in 2010 to 13% in 2012.[3] MSM have been shown to have the highest rates of recent HIV infection.[4] Coupled with the recent increase in HIV prevalence among MSM as well as continuing high-risk practices such as frequent change of partners of both sexes, insufficient use of condoms and involvement in group sexual practices, this calls for significant strengthening of interventions targeting this key population.[i] High prevalence of sex with female partners among the MSM raises concerns about their bridging role in HIV transmission to the general population. 51.4% of MSM reported having female partner in the last 12 months. In 2010 it was even higher: 62.2%.[3]

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

(b) The estimated number of PWID in Georgia is 45,000.[5] The estimated HIV prevalence ranges from 0.4% to 9.1% among PWID. The percentage of drug use, as a transmission mode among newly registered HIV cases, decreased from 43.2 % in 2012 to 35% in 2013 while heterosexual transmission increased from 44.8% in 2012 to 49% in 2013. Both these trends indicate the growing spread of HIV among the sexual partners of PWID. Moreover, PWID are less likely to initiate HIV care, to remain in care and to achieve viral suppression.[6] Together with survival data, these data indicates on the need of scaling-up efforts to improve outcomes among IDUs through providing comprehensive care including drug abuse related care and other rehabilitation/supportive services.

(c) The data on the magnitude of the HIV problem among male sex workers is limited. This group is included in MSM. HIV prevalence among FSW ranges from 0.8% to 1.3%.[3] However IBBSS findings highlight fluctuations in condom use rates, which indicate the need for continuous outreach and delivery of prevention information and services.

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

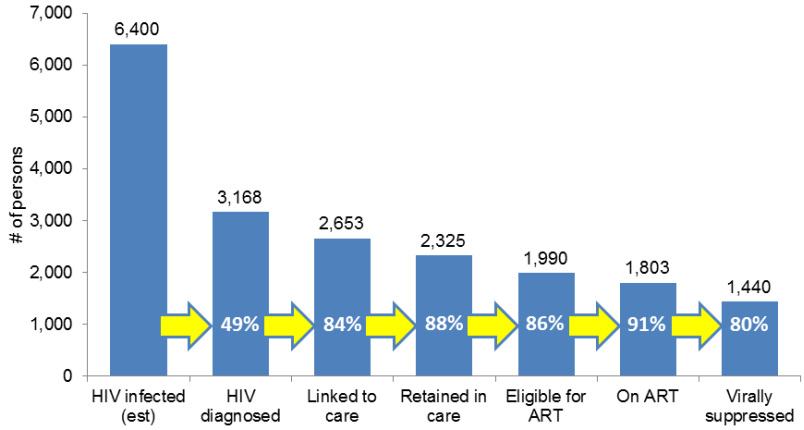
(e) HIV prevalence among pregnant women and blood donors is lower (0.04% in both sub-populations) than in general population (0.07% in 2013). On-going preventive interventions among these groups allow for avoiding spread of HIV infection and maintaining the low prevalence rate.

Thus despite low HIV prevalence (0.07%) in the general population, Georgia faces a significant risk of an expanding epidemic due to widespread high-risk practices and growing HIV prevalence among PWID and MSM, significant risk of sexual transmission of HIV through bridging populations, and patterns of high mobility specific to key populations.

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

Analysis of engagement in the HIV continuum of care in Georgia shows that the major gap occurs in the stage of HIV testing/diagnosis (Figure 1.1).

Figure 1.1. Engagement in the HIV Continuum of Care in Georgia



Out of estimated 6400 persons living with HIV, almost half are undiagnosed. This gap is primarily the result of low HIV testing coverage of key populations at risk and missed opportunities to test for HIV in health sector.[1] This has serious implications both from individual and public health standpoints. On the one hand, a delay in HIV testing leads to late

diagnosis and to increased risk of mortality. On the other hand, individuals with undiagnosed HIV who continue to engage in risk behaviors can contribute to the ongoing transmission of the virus.

2 National Response to HIV: General Approach, Goal and Strategic priorities

The national response to HIV epidemic prioritizes the development of an effective prevention to care continuum. Priority directions include the further scale up of the outreach and basic prevention services targeting key affected populations, radical increase in the uptake of VCT leading to more effective and earlier detection of HIV cases, comprehensive measures to ensure expedient progression to care and treatment for HIV positive people, as well as improved adherence and retention in quality care leading to suppression of viral load. Improved accessibility and quality of essential services (including opioid substitution treatment), optimized treatment regimens, strengthened surveillance and monitoring, removal of legislative and regulatory obstacles to effective service delivery, protection of human rights, and implementation of stigma reduction measures support the realization of these priorities. Greater collaboration between the governmental structures responsible for HIV interventions and the civil society including people living with HIV and the key affected populations is a significant asset in the enhanced national response designed to achieve the epidemic reversal. A revised case management approach embracing not only clinical but also social aspects of care and involving collaboration of service providers across sectors will be utilized to facilitate progression of clients along the service continuum.

The **overarching goal** of the national strategy for 2016 -2018 is to turn the HIV epidemic in Georgia in the reversal phase through strengthened interventions targeting key affected populations (KAP), and significant improvement in health outcomes for PLHIV.

Strengthened commitment of the government, greater involvement of civil society, and optimal integration of various branches of the prevention and care continuum will ensure sustainably strong response to the epidemic.

In order to achieve this goal NSP will concentrate on the following three objectives:

1. HIV Prevention and Detection: Improve the effectiveness of outreach and prevention and ensure timely detection of HIV and progression to care;

2. HIV Care and Treatment: Improve HIV health outcomes through ensuring universal access to quality treatment, care and support;

3. Leadership and Policy Development: Ensure sustainably strong response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society.

Expected Impact, Outcomes and Coverage targets by end 2018 are:

1. Increased funding of HIV response from state budget from 32% (2013) to 62% (2018);
2. By the end of 2018 HIV prevalence among PWID and SW is contained under 5% each[ii];
3. By the end of 2018 HIV prevalence among MSM is contained under 15%;
4. Rate of late HIV detection is reduced from 62% to 30% by 2018;
5. AIDS related mortality is reduced below 2.0 deaths per 100,000 population;

STRATEGIC AREA 1: HIV PREVENTION AND DETECTION

Achievements and Remaining Challenges: HIV Prevention and Detection

a. Since 2006, significant increase has been observed in coverage with preventive services of PWID. The scope of services has been expanded and geographic reach improved through establishing new sites for delivering harm reduction (including 4 sites delivering women-friendly services) and VCT services as well as more active outreach. The GF program monitoring data shows an increase in the uptake of VCT in the community settings over the last three years (Annex 1. Figure A.1.). Preventive efforts among PWID resulted in positive behavior change with 78.4% (Batumi) and 89% (Tbilisi) of PWID using sterile injecting equipment.
b. Opioid substitution services (OST) have become more accessible both in civil sector (20 sites) and in penitentiary system (2 sites). By the end of 2014 there were about 2,600 patients receiving OST, which is significantly below the NSP target of 4,000 set for 2014.
c. HIV testing services have become increasingly available for MSM. The estimated size of this group is 17.000.[7] HIV testing has been provided both indoors by three specialized clinics (*Healthy Cabinets)* in Tbilisi, Kutaisi and Batumi and outdoors during outreach with the mobile laboratories. MSM coverage by preventive interventions has been increasing since 2010 and reached 48.6% in 2012.
d. Programs targeting sex workers in Georgia have been introduced. These programs are aimed at female sex workers and MtF (male to female) transgenders that are involved in sex business[iii]. Male sex workers have been reached through MSM-targeted prevention interventions. An estimated size of FSW is 6525 people.[8] HIV prevention interventions targeting sex workers (SWs) have achieved considerable progress with regard to condom use with commercial clients (85-98%), as well as increased HIV testing rates during the last 12 months (40.6% in Tbilisi and 66.7% in Batumi). In addition to street-based outreach, five specialized clinics (*Healthy Cabinets)* in Tbilisi, Kutaisi, Batumi, Zugdidi

ii: HIV prevalence data will be disaggregated by age (below 25 and more) and the length of drug using career (less than 3 years and more) in order to obtain proxy incidence data;
iii. Based on outreach work observations the number of MtF sex workers is low. However, the accurate size estimate for MtF is not available.

and Telavi provide HIV and STI diagnostic and STI treatment services to SWs. Based on 2014 IBBSS data coverage of SWs with prevention interventions is 64.3%.

e. HIV voluntary counseling and testing services have been available at all penitentiary facilities in Georgia.[9] Despite universal availability of HIV voluntary counseling and testing services in all penitentiary facilities of Georgia, only 18.3% of prisoners were reached by preventive program.[iv] Obvious gaps in prevention among prisoners are: low coverage by preventive programs and low rates of providing test results to the prisoners.31.2% of the prisoners were tested for HIV during the last year while in prison and 21.3% had been tested for HIV and informed about their test results.
f. Despite the achievements described above, the preventive interventions so far have not resulted in a significant progress in terms of avoiding infection spread in communities where HIV is most heavily concentrated including MSM, PWID and SW. The growing prevalence of HIV[v], poor knowledge about HIV transmission and risk behaviors among MSM[10] and PWID call for further scale-up of coverage and improvements in quality of interventions in order to fully control the epidemic.
g. In spite of a stable nature of the HIV epidemic among SW[vi], low knowledge on HIV transmission routes [8] highlights the need for intensified preventive efforts in this group.
h. Heavy reliance on donor support for funding preventive interventions is another challenge this strategy aims to address. The state will gradually take over the responsibility for funding preventive interventions currently financed by the GF including but not limited to OST, harm reduction services, VCT etc.
i. Considering the gaps and challenges in access to and coverage with preventive services, MSM, PWID and SW will remain the primary focus for HIV Preventive interventions during the planned strategic cycle. Further gradual increase of program coverage will be implemented in 2016-2018 in line with the required growth in the capacity of service providers as well as further rollout of the new outreach strategies.
j. Intensive preventive efforts aimed at ensuring safety of donor blood, preventing mother to child transmission of the virus and post-exposure prophylaxis among health care workers allowed for controlling HIV spread in these groups. Continuous support will be provided to sustain the established prevention practices and to improve quality of interventions for maintaining coverage and maximizing potential benefits.
k. Several other groups have been named to be at increased risk of HIV transmission but were not prioritised in the national response so far. Notably, these include youth with high risk behaviours, migrants and other mobile populations.[vii] The awareness raising on sexual and reproductive health and rights, including HIV prevention, among youth is addressed by the Georgian National Youth Policy.[viii] This strategy will focus on ensuring access to youth friendly HIV prevention and treatment services. The specific interventions of migrants and other mobile groups will be planned based on the epidemiologic surveillance data and IBBSS findings.
l. Limited role of primary care providers in delivering HIV preventive services poses

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iv . meaning prisoners reported having received information on preventive methods and been offered confidential HIV testing during last 12 months

v. Annex 1. Figure A.2 HIV Prevalence rates among MSM in 2007, 2010, 2012

vi. Annex 1. Figure A.3 HIV Prevalence among Sex Workers in Tbilisi (2002-2014) and Batumi (2004-2014)

vii. Data suggest that more than half of PLHIV have been infected outside Georgia (Policy research in the area of HIV and mobility in Georgia. World Vision, Georgia, September 2011).

viii. Developed by the Ministry of Sport and Youth Affairs of Georgia, and approved by #553 Decree, April 2 2014, of the Government of Georgia http://msy.gov.ge/files/Youth_Policy_%28Engl%29_Final_July_2014.pdf

significant challenge as this impedes health system's capacity to timely detect those needing referral to HIV diagnostic services. The level of HIV related stigma in general health care settings is very high. The latter prevents primary care physicians and nurses to offer services that are patient friendly and gain the trust of those infected with or at high risk of HIV. Greater involvement of primary care providers is required to ensure timely referral to HIV diagnoses and to provide adequate management of non-infectious comorbid conditions in HIV (See Objective 3 for interventions aimed at stigma reduction among health care workers).

Objective 1 of the strategy aims at improving the effectiveness of outreach and prevention and ensuring timely detection of HIV and progression to care.

In line with the latest epidemiological trends, the national strategy prioritizes further development of HIV outreach and prevention interventions targeting PWID and MSM. It also intends to improve detection of HIV in these populations followed by expedient progression to necessary HIV care and treatment services.

The achievements in ensuring safety of donor blood, PMTCT, and post-exposure prophylaxis will be sustained. Provider initiated testing on clinical and behavioral indications will be further developed, and PEP will be made available to the victims of sexual violence.

This objective will be achieved through three strategic interventions and a set of activities which proved to be effective for early detection and prevention of HIV.

Strategic intervention 1.1. Prevent HIV transmission, detect HIV, and ensure timely progression to care and treatment among the key affected populations

Effective outreach and community-based interventions among KAPs are essential elements of the national response to HIV epidemic. They enable behavioral changes that reduce the risk of HIV transmission. Community-based outreach allows for effective detection of HIV cases in KAPs. The NSP prioritizes significant scale-up of outreach and prevention activities targeting KAPs, namely

- People who inject drugs (PWID) and their sexual partners; This category includes people with history of injecting drug use as well as those at risk of transitioning to injecting.
- Men having sex with men (MSM) and their female sexual partners;
- Sex workers (female sex workers, including transgender individuals), their clients and regular sexual partners;
- Prisoners and other detainees.

Targets for coverage by essential **prevention** services and HIV testing by the end of 2018 are as follows:

KAPs	2016	2017	2018	
PWID coverage	25650 (57%)	27900 (62%)	30150 (67%)	Cumulative
PWID testing	23085 (51%)	25110 (56%)	27135 (60%)	Cumulative
OST Capacity	3100	3600	4000 (9%)	Non-cumulative
PWID on OST	4800	5500	6000	Cumulative
MSM coverage	4250(25%)	5950 (35%)	8500(50%)	Cumulative
MSM testing	3060(18%)	4250(25%)	6800(40%)	Cumulative
FSW coverage	2610(40%)	3263(50%)	3915(60%)	Cumulative
FSWs testing	1958(30%)	2610(40%)	3263(50%)	Cumulative
Prison coverage	4000 (40%)	5000 (50%)	5500 (55%)	Cumulative
Prison testing	5500 (55%)	6000 (60%)	6500 (65%)	Non-cumulative

In order to deliver adequate preventive services the following is envisioned:

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 KAPs. The service package will be designed based on the most appropriate HIV testing approaches in line with WHO strategies and recommendations.

ii) Scaling up *Opioid Substitution Therapy* (OST) for PWIDs. Greater utilization of HIV prevention benefits offered by opioid substitution maintenance and other treatment and rehabilitation options will be achieved through gradual increase in the capacity of service delivery system, improvements in service quality (including revision of the current dosing and other regulations), targeted promotion of OST services, strengthened psychosocial support of OST patients, improved accessibility of services for disadvantaged patients, accommodating the needs of women, and introduction of long-term OST in penitentiary institutions.

iii) Implementing needle-syringe programs and other harm reduction services and increasing access to preventive commodities with the help of peer-driven interventions and expanding mobile services.

iv) Developing and implementing effective Behavior 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 OST, VCT, and other relevant entities. One important component of BCC strategies targeting MSM will include increasing knowledge and acceptability of ART-based prevention strategies, namely, Pre Exposure Prophylaxes (PrEP).[ix]. The final goal is to explore overall possibility to use PrEP as an additional HIV prevention choice combined with extensive condom programming in the future.

ix. Rolling out PrEP as a prevention package component will also aim at demonstrating PrEP feasibility on a small MSM sample selected based on the high risk sexual practices criteria.

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. The National guidelines will be in line with WHO recommendations and other sound international sources. An indicative list of preventive services aimed at key target groups is outlined in annex 2.

ii) Through monitoring and evaluating effectiveness of HIV preventive interventions in order to adjust programmatic decisions-interventions.

Strategic Intervention 1.2. Prevention and detection of HIV within healthcare settings

a. Enhancing Provider Initiated Testing (PIT) for HIV: PMTCT screening and VCT on clinical and behavioral indications. HIV detection efforts will include universal testing (PMTCT screening) of pregnant women; Provider initiated testing on clinical and behavioral indications; Promotion of VCT among the contacts of those who tested HIV positive.

Observance of essential human rights, confidentiality principles and voluntary acceptance of the offered services will be ensured in all settings. Patients who test positive for HIV will be offered support required for their timely progression to care and treatment.

Implementation of PIT will continue to focus on drug treatment facilities, STI and TB clinics, and antenatal care facilities, with intention to expand indicator disease guided HIV testing and counseling in health sector, including in primary health care. This activity will be supported by the State HIV/AIDS Program component "HIV/AIDS voluntary counselling and testing for risk groups". HIV testing efforts will be expanded in people living with HCV through establishing linkages with national hepatitis C program.[x] The developed PIT standards will be further reviewed, endorsed by the relevant state authorities and rolled-out through in-service training program involving personnel of the mentioned facilities.

b. Ensuring safety of donor blood

The safety of donor blood will be ensured through: i) assuring that all donated blood is screened in a quality assured manner and; ii) promoting voluntary blood donations.

This area of work envisages observance of state regulations and policies on donor blood testing, external quality assurance, and continued development of new approaches to financing safe blood collection.

The scale of donor blood testing will steadily increase in accordance with the planned growth in the number of collected blood units. A steady growth in the share of voluntary donations is also expected.

x. The National HCV elimination strategy which is currently being elaborated envisages provider initiated tandem testing for HCV and HIV.

c. Post-exposure prophylaxis of HIV infection

Continued efforts to prevent HIV transmission associated with unexpected exposure will be implemented. The risk of HIV transmission within healthcare settings will be minimized through provision of education to all health care workers as well as ensuring universal access of exposed health care workers to PEP treatment.

PEP availability for victims of sexual violence will be enhanced within the framework of strengthened efforts of MoLHSA and other stakeholders to violence against women and in line with relevant international guidelines.

Strategic intervention 3: Prevention of Mother to Child Transmission of HIV

a. **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) updating PMTCT guidelines and ii) providing training in PMTCT to health care workers of the relevant institutions.

Expected outcomes from effective implementation of preventive efforts are:

- By the end of 2018 HIV prevalence among PWID, SW and prisoners is contained under 5% each[xi];
- By the end of 2018 HIV prevalence among MSM is contained under 15%;
- Rate of late HIV detection is reduced from 62% to 30% by 2018;

STRATEGIC AREA 2: HIV CARE AND TREATMENT

Achievements and Remaining Challenges: HIV Care and Treatment

a. The provision of HIV/AIDS treatment and care services in Georgia started in the 1990s and universal access to ART has been ensured since 2004 through the state and GF supported programs.
b. Delivery of HIV clinical services in Georgia are led by the Infectious Diseases, AIDS and Clinical Immunology Research Center (National AIDS Center), which is country's referral institution for HIV diagnosis, treatment (including PMTCT, PRER and PEP) and care. Specific clinical services are provided by the dedicated departments of the infectious diseases centers/hospitals in the capital city of Tbilisi and regional facilities in the cities of Kutaisi, Batumi, Zugdidi and Sokhumi.
c. According to UNAIDS data Georgia has the highest ART coverage in the region of Eastern Europe and Central Asia (EECA).[11]The number of patients on ART has been

xi. HIV prevalence data will be disaggregated by age (below 25 and more) and the length of drug using career (less than 3 years and more) in order to obtain proxy incidence data;

increasing annually and exceeded targets set in 2011-2016 National HIV/AIDS Strategic Plan (NSP), largely because of implementing latest 2013 WHO guidelines recommending treatment initiation at CD4 count level of<500 cells/mm(Annex 1. Figure A.4). Latest data indicates that 95% of those diagnosed and known to be in need of treatment were on ART by the end of 2014(Table 2.1). It should be mentioned that Georgia is switching to public health approach in terms of providing standard ART regimens in accordance with 2013 WHO guidelines, and the process is planned to be fully completed by the end of 2015.

Table 2.1. ART Coverage in Georgia, 2011-2014

Year	# of PLHIV on ART		Coverage among diagnosed		Spectrum derived coverage	
	NSP Target	Actual achievement	# eligible	% from eligible	Total estimated # of PLHIV	% from estimated*
2011	1290	1245	1295	96%	5400	23%
2012	1540	1640	1750	94%	5900	28%
2013	1820	2092	2300	91%	6400	33%
2014	2110	2541	2675	95%	6800	37%
*A proportion of patients receiving ART among the total estimated number of person living with HIV.						

d. Universal access to ART has led to significant reduction in mortality among people living with HIV in Georgia (Annex 1.Figure A.5). 12-month survival significantly increased from 79% in 2011 to 86% in 2012 (p=0.01) and remained stable through 2014, thus achieving NSP target of 85%. 2013 target for 24-month survival of 80% was achieved in that year with 82% of patients remaining on ART, however the indicator slightly reduced to 79% in 2014. The indicator measuring 36-month survival varied substantially over time, with rates reaching 76% in 2012, them dropping to 69% in 2013 and again increasing to 77% in 2014. Comparison of data with EECA region shows that Georgia has better 12-month survival/retention compared to regional average. Data on 24-month survival in the region is available for 4 countries only with an average rate of 67% (range: 60%-79%). The recent ART program data further confirm that persons with history of IDU are at higher risk of attrition both at 12 and 24 months after starting ART (Annex 1. Figure A.6). Also IDUs have been shown to be at higher risk of disengagement for the entire HIV care. These data underscore the need for directing additional efforts towards HIV positive persons with history of IDU.
e. The National HIV Program pays a particular attention to adherence as an important determinant of treatment success. Special approach to promote medication adherence is in place and includes both clinic-based and out of clinic services delivered by mobile units. The best evidence of effectiveness of available adherence services is the significant improvement of levels of viral load suppression. Evaluation of trends in the engagement in HIV care continuum from 2008 shows that among those on treatment the proportion of virally suppressed patients increased from 68% in 2008 to 80% in 2013 (p<0.0001), significant improvements in viral suppression has been noticed among total diagnosed population with rates increasing from 23% in 2008 to 45% in 2013 (p<0.0001).[12]
f. High TB/HIV mortality is a particular concern given that all co-infected patients have access to free medical care for both diseases. In 2013 88% of estimated number of

TB/HIV co-infected patients received treatment for both diseases. This level of coverage compares favorably to the EECA regional average of 71%. However, high MDR TB rates in Georgia coupled with late diagnosis of both TB and HIV results in increased risk of death from TB[13]. Additional efforts are needed to scale-up timely case finding and to maintain universal access to treatment for both TB and HIV.

g. Co-infection with hepatitis C virus (HCV) is common among HIV patients in Georgia, with up to half of the registered cases carrying antibodies against HCV[14,15]. The burden is even higher among people with a history of IDU (73%). End-stage liver disease, primarily due to HCV infection, is the second leading cause of death among HIV positive patients.[16] Improving management of HIV/HCV co-infection was one of the key activities under previous NSP, which set the target to treat 110 HIV/HCV co-infected patients for hepatitis C annually. Free hepatitis C program (with pegilated-interferon and ribavirin) for HIV patients initiated in December 2011 and since then a total of 422 patients were enrolled. The program will continue in 2015 to ensure that PLHIV have access to HCV testing and HIV/HCV co-infected have access to HCV therapy beyond 2015.

h. Provision of care and support services remains essential components of comprehensive package of care for people living with HIV (PLHIV). Community-based HIV self-support centers operate in Georgia since 2004 that provide psychosocial support through peer groups as well as through trained psychologist and hot-line services. In 2014 the network provided more than 5000 combined hotline, online and face-to-face consultations to PLHIV. The palliative care service provision for PLHIV in Georgia has been established in 2008 and since then has been led by the Georgian National Association of Palliative Care. The program delivers home-based services through operation of palliative care mobile units in Tbilisi, Kutaisi, Batumi and Zugdidi. Services provided include medical, psychological, social and spiritual support for chronically ill patients, and are implemented by health workers and non-health caregivers, including PLHIV. Over the last 3 years the program has been providing care to up to 40 patients on a monthly basis. The number of visits ranged from 1,461 to 1,689 per year.

i. Considering the key role of the National AIDS center in delivering HIV care and treatment services this strategy identifies a lack of adequate physical infrastructure for the AIDS Center as a critical challenge that requires immediate attention. Currently Aids Center occupies privatized premises under lease conditions. This has been a temporary solution until the new building is located and equipped according to the international standards. In order to ensure uninterrupted access to high quality diagnostic, treatment and care services this strategy will support infrastructure development for the Aids Center at an earliest stage of its implementation.

Objective 2: Improve HIV health outcomes through ensuring universal access to quality treatment, care and support

The achievements in ensuring universal access to care and treatment will be further strengthened and remaining challenges addressed in 2016-2018. Measures will be taken to reduce loss of patients at each of the steps of the care cascade including better enrolment and better retention in care. These will be achieved through ensuring access to essential medical care, improved case management, greater involvement of PLHIV organizations in the delivery of psychosocial care and support, as well as introduction of specific targets and activities aimed to improve treatment uptake, adherence and effectiveness among people with history of injecting drug use. Links to TB, HCV and OST services will be strengthened. The

role of civil society organizations including PLHIV support groups in the uptake and provision of HIV care will be strengthened and formalized in the relevant regulations and ToRs. The government will continue supporting access to vital care and treatment services on the occupied territories in collaboration with NGOs operating there. It is expected that by the end of 2018, 4,800 people will be receiving antiretroviral treatment. The target is based on the projected increase in the number of PLHIV detected in the community and clinical settings.

Measures are currently taken to prepare the HIV care system to handle the influx of PLHIV associated with the strengthened detection of HIV in the key populations and scale-up of provider initiated testing. In particular these measures include rationalization and simplifications of utilized drug regimens and better organization of care, which is expected to allow for significant reduction in associated costs and workload without compromising the quality of care. The optimization of HIV treatment will continue further and result in significant reduction of the numbers of possible treatment regimens in the first, second and third line.

These measures are expected to further reduce HIV related mortality in Georgia to not more than 2 deaths per 100,000 population compared to the currently available baseline value of 2.4 per 100,000 (2013).

Strategic intervention 2.1. Ensure uninterrupted delivery of high quality treatment and care

This strategy aims to ensure adequate coverage with ART and improve treatment outcomes for all patients in need. This will be achieved through:

i. Provision of ART drugs and essential clinical care for all people living with HIV (PLHIV) including access of patients to the required outpatient care, in-patient care services, laboratory analyses to monitor disease progression and treatment progress according to the national evidence based guidelines. Provision of ART will be guaranteed to all PLHIV in need in accordance with the latest WHO guidelines, including in the region of Abkhazia.
ii. Provision of quality adherence support services at clinics and through outreach by mobile units. Community-based organizations of PLHIV will be involved in the delivery of psychosocial care and adherence support services to PLHIV. NGOs will also support the AIDS Centers in the delivery of medicines to patients residing in remote regions of the country. Relevant TORs will be developed to facilitate effective cooperation between clinical and NGO services.
iii. Strengthening ART quality assurance system through providing adequate physical infrastructure for the National AIDS center, staff capacity building (in-service training and international conferences), maintaining and improving AIDS health information system to track outcomes and program performance, introducing up to date clinical guidelines and conducting clinical audits to identify quality gaps and measure progress.

Strategic intervention 2.2. Reduce morbidity and mortality due to TB and HCV co-infections and injecting drug use

a) In line with the latest WHO recommendations, NSP envisages intensification of collaborative activities between HIV and TB programs in order to ensure effective TB detection among HIV patients. This will be achieved through:
   i. Provision of VCT for HIV for all TB patients
   ii. Intensified TB case finding among PLHIV
   iii. Provision of both TB and HIV treatment for patients with co-infection, as well as administration of Isoniazid preventive therapy.

b) Providing unlimited access to treatment and care for viral hepatitis to all PLHIV in need through national HIV/AIDS and hepatitis C programs. This will include:
   i. Universal screening for HCV, HBV and HAV of all PLHIV (screening for HDV and HEV as clinically indicated)
   ii. Providing treatment for hepatitis C in accordance with approved national protocols
   iii. Providing Tenofovir-containing ART for those with chronic HBV infection
   iv. Providing vaccination against HBV for eligible patients

c) The NSP envisages a range of measures to reduce the negative influence of injecting drug use on treatment prospects. These include:
   i. Better collaboration with OST and addiction services;
   ii. Provision of additional adherence support to PLHIV with history of injecting drug use;
   iii. Collaboration with relevant NGOs on linkages and case management. The essential treatment targets in the monitoring framework will be disaggregated by the history of injecting drug use.

Strategic intervention 2.3. Ensure provision of care and support services for PLHIV

The NSP places a special emphasis on the importance of community-based care and support services for PLHIV, both for those who already receive clinical services and for those who are preparing for future treatment. These services will include

i) The delivery of psychosocial support, peer support to strengthen treatment adherence, advice on coping with complicated issues facing PLHIV, engagement of relatives of PLHIV in care and support as well as in stigma elimination work, mutual support and awareness raising activities for PLHIV, and a telephone hotline for PLHIV, their relatives, and KAP representatives.

ii) Palliative care for chronically ill patients will also be provided.

The AIDS Centers and other relevant clinical facilities will closely collaborate with community-based organizations in order to ensure effective engagement of PLHIV to HIV and other medical care, as well as supportive services.

STRATEGIC AREA 2 HIV CARE AND TREATMENT

Expected outcomes from effective implementation are:

- By the end of 2018 Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy is 90%
- By the end of 2018 Percentage of newly diagnosed persons who are enrolled in care>90%
- By the end of 2018 Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy is 85%
- Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period 4800
- By the end of 2018 at least 50% of estimated number of people living with HIV will be receiving antiretroviral therapy in accordance with the nationally approved treatment protocols [xii]
- PLHIV have access to free basic external support (including health, psychological or emotional and other social support)

STRATEGIC AREA 3: LEADERSHIP AND POLICY DEVELOPMENT

Achievements and remaining Challenges

a. Georgia has attained all three targets within the Joint United Nations Program on HIV/AIDS (UNAIDS) "Three Ones" Principle. All HIV stakeholders act within the frames of endorsed national HIV strategies that are regularly revised and updated. The Country Coordinating Mechanism (CCM) functions as a main platform for country dialogue and participatory decision-making on HIV related issues. The CCM umbrella unites representation from all relevant ministries, government institutions, civil society organisations, bilateral and multilateral agencies, as well as organisations representing people living with HIV and key affected populations. National Monitoring and Evaluation framework endorsed by CCM in 2012 serves as the main for evidence-based decision-making.
b. Greater involvement of Civil Society Institutions has been achieved through effective collaboration of the state institution with the HIV prevention task force (PTF), which is composed of NGOs and professionals working on HIV.
c. Georgia HIV law adopted in 2009 has improved the overall legal environment for national response, but it has not addressed regulatory barriers for drug users and prisoners stemming from criminal code of the country. Strict Drug Law environment represents a severe obstacle for the effective work of the NSP program.
d. A critical factor limiting the effectiveness of the national response to HIV is the widespread stigma towards PLHIV and KAPs among the general public as well as relevant professionals including health care workers.

xii. The percentage for this indicator is derived from spectrum estimated number of PLHIV of 2014 that will change with consequent spectrum exercises in coming years.

Objective 3: Ensure sustainably strong response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society:

The government is committed to sustaining the essential HIV prevention and care services previously funded from external sources including the Global Fund. The state budget allocations will be gradually increasing to ensure all essential interventions are sufficiently funded.

Specific measures will be taken to introduce legislative changes and develop regulations and operational policies required to ensure uninterrupted delivery of essential HIV prevention and care services with special focus on the key affected populations. Improved collaboration of public and civil society service providers with law enforcement agencies and other relevant stakeholders will ensure the most affective practical application of the developed regulations and policies.

The government will collaborate with community-based organizations representing PLHIV and KAPs to design and implement effective stigma reduction strategies, which will have beneficial impact on service uptake and retention.

The stakeholders will sustain the required surveillance and monitoring efforts and continue conducting operational studies to ensure adequate intervention design. Improved knowledge of specific needs and vulnerability factors affecting various segments of KAPs will enable the development of effective and tailored interventions.

Strategic intervention 3.1. Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response

Improving access to quality health services is a top priority declared by the Government of Georgia (GoG). The entire country population has unlimited access to health services with 496,000 citizens covered by private or corporate insurance and the rest by the State Universal Healthcare program.[17]

The political will to further eliminate inequality in access to medical services is stipulated in the Georgian HealthCare System State Concept for 2014-2020.[18] The healthcare concept prioritizes improvements in prevention and management of communicable diseases including the reduction in late detection of HIV infection, and the reduction of HIV/TB co-infection burden. Importantly the government embarks to gradually transfer priority programs funded by external sources (including HIV and tuberculosis) to state financing. This will be achieved through development of financial sustainability plans, detailed allocation of financial obligations, and reflection of these obligations in the financial commitments of the government. The state will ensure uninterrupted supply of required medicines and unlimited access to diagnostic, outpatient and hospital services.

The funds required to maintaining and expanding delivery of necessary services will be reflected in the Medium Term Expenditure Framework (MTEF) for 2016-2019. Furthermore, GoG resolution from June 17, 2014[19] highlights the need for improved efficiency of State funding and for this purpose offers introduction of Disease Related Groups (DRG's) and

integration of vertical state programs (such as disease oriented programs: Diabetes, TB, HIV etc.) into the Universal Health Program.

The government is committed to balanced allocation of funding to support all branches of comprehensive response to HIV.

Adequate funding of care and treatment services including laboratory monitoring of treatment will ensure optimal treatment outcomes, prevent the development of resistance to HIV medication, reduce mortality and strengthen the capacity of health care specialists and facilities. Uninterrupted funding of community-based outreach and prevention services for KAPs will prevent the increase in the number of new HIV cases, transmission of HIV to sexual partners of KAPs and further to the general population, reduce pressure on the clinical and social care system, as well as the future health care expenditure for treatment of HIV infection. Taking into account the expected significant decrease in funding available from external sources, the government of Georgia is planning to increase state budget allocations for HIV prevention and treatment to the level required to sustain and scale-up the country response to HIV and start reversing the HIV epidemic.

Adequate budget planning for the HIV national response will be achieved through the following:

i. Specific guidance and recommendations on the required budget allocations will be prepared on annual basis by the relevant specialists in the MoLHSA and other government departments involved in the response to HIV. These recommendations will be based on continuous monitoring of HIV related expenditures as well as detailed projections of expected funding needs based on epidemics dynamics, key parameters of interventions and identification of gaps in the current response to HIV epidemic.
ii. MoLHSA will create and lead a working group of stakeholders through the assessment, planning and implementation of a phased transition to governmental funding of activities currently supported from external sources. The group will oversee the required adjustments in procurement mechanisms, registration and patent status of essential health products, and other activities required to ensure smooth transition.

Strategic Intervention3.2. Improve policy environment and stakeholder coordination

In order to ensure alignment of legislative and regulatory environment with HIV prevention and care objectives the following activities are envisioned:

i. The required policy reviews and analyses will be conducted on a regular basis with the aim of bringing the legislation related to HIV and drug use with the practical tasks of HIV response, human right imperatives, and regulations related to EU accession. Findings will inform legislative revisions as well as the development and endorsement of operational policies, regulations and guidelines addressing issues affecting access to the essential HIV services. Improvements may relate to operation of service providers including civil society providers and health care facilities, as well as law enforcement agencies and other stakeholders who can influence the delivery of HIV related services.
ii. Concrete steps will be implemented to increase the involvement of PLHIV and KAPs, as well as civil society organizations and networks in the development and delivery of

essential HIV services. The role of these entities is envisaged to increase in community-based outreach and detection of HIV, facilitation of timely progression to care and treatment, delivery of adherence and other support required to ensure the effectiveness of treatment and care, participation in service quality monitoring and assurance, as well as contributing to the elimination of HIV related stigma and discrimination.

iii. PLHIV and KAP networks and associations will be involved in the oversight of the national response to HIV with focus on the most critical areas such as community control by PLHIV and KAP representatives over the development and application of procurement and supply regulations related to essential medicines and other health products used in HIV prevention and treatment.

iv. Georgian PLHIV organizations will continue performing a range of important functions related to ensuring the quality of care and treatment for PLHIV, including necessary psychosocial support to patients and their relatives, advice on complex matters related to status disclosure, challenges faced by children and adolescents living with HIV, and participation in supply of ARV medicines to patients residing in remote areas of the country. Community-based organizations of PLHIV will further engage in facilitating timely progression of PLHIV to community-based support and clinical care. The role of community-based organizations in service development and delivery, quality assurance, and patients' monitoring will be formalized, and the delivery of social support and other essential services will be included in the revised official treatment protocols.

v. Addressing stigma and discrimination in the general population, among health care workers, law enforcement personnel and other groups will be implemented through stronger engagement of the PLHIV support groups in the activities targeting stigma among health care workers (with a particular focus on primary care providers) and other population groups, collaboration of PLHIV and KAP organizations with professional associations of lawyers and human rights protection organizations on addressing discrimination cases, utilization of mass media for social advertising targeting stigma and discrimination, promotion of VCT, other services, and general awareness.

vi. The role of Country Coordinating Mechanism in coordination and support of the national response to HIV will be further strengthened through engagement of essential stakeholders and technical experts. CCM's mandate, bylaws and composition will be revised to enable its effective functioning after the completion of programs funded by the Global Fund.

vii. The relevant governmental departments including the Ministry of Education, the Ministry of Youth and Sports, and the Ministry of Interiors will continue monitoring other populations at increased risk including street children and other vulnerable youth, labour migrants. Relevant interventions will be developed and implemented according to identified needs.

viii. The government will support specific policy development efforts and advisory initiatives implemented by national key population networks and professional NGOs representing their interests. Examples include involvement of Georgian Harm Reduction service providers and other stakeholders in the analysis and revision of outdated clauses of drug related legislation negatively affecting access to essential prevention and care services.

Strategic intervention 3.3. Generate evidence for informed decision-making

Timely access to strategic information, including surveillance and monitoring data is essential for planning and implementation of effective responses and timely adjustments in line with the changing contextual factors. The NSP envisages:

i. Further strengthening of surveillance and program monitoring and evaluation systems. The envisions improvements related to more consistent utilization of Unique Identification Codes; revision and adjustments in the essential monitoring and evaluation definition; better triangulation of available sources of data including program monitoring and periodic surveillance data; as well as disaggregation of program monitoring data by the most epidemiologically significant segments of KAPs. Collection and analysis of regional level data will allow for setting appropriate targets at the regional/municipal level. Participatory quality assessments of the drug scene and other essential contextual characteristics will allow for better understanding of changes affecting KAPs and the risk of HIV transmission, and for timely adjustment of the interventions.

ii. Conducting operation studies and surveillance activities to inform decision making on HIV related issues. The following surveillance activities and studies will be implemented under NSP 2016-2018:
   - Thorough epidemiological analysis based on routine surveillance data and complementary data sources (e.g. safe blood database etc.) to derive conclusive evidence about the HIV epidemic and its drivers. Wherever possible HIV surveillance will be linked with HCV, TB and other relevant surveillance efforts;
   - Continued integrated bio-behavioral surveillance studies (IBBSS) among the key affected populations in accordance with the schedules of the national surveillance plan. IBBSS will cover all parts of the country with significant concentration of KAPs, incorporate population size estimates and will be conducted among PWID, FSW, MSM, and prisoners;
   - Qualitative studies to inform the design of interventions targeting sexual partners of PWID, female sexual partners of MSM, clients and regular sexual partners of SW;
   - Qualitative assessments to identify contextual changes affecting KAPs and the risk of HIV transmission;
   - HIV incidence estimation using recent infection testing algorithm (RITA);
   - Operational research to evaluate patient engagement in HIV care, including evaluation of factors associated with disengagement from care;
   - Operational research to evaluate PMTCT program implementation;
   - Operational research to identify the barriers for PWID (including women who inject drugs) in accessing VCT and OST services;
   - Operational research to identify the barriers for MSM in accessing VCT services;
   - Evaluation of effectiveness of (BCC) interventions targeting KAPs in Georgia;
   - Operational research at Health Care Settings to identify key factors related to stigma and develop recommendations for evidence-based interventions;
   - Economic evaluation of selected prevention and treatment interventions (e.g. economic evaluation of regional level laboratory staff performance under the treatment program; peer-driven interventions among PWID);
   - National AIDS spending assessment and financial gap analyses to inform policy decisions;
   - Study on size estimation and risk behaviors (IBBSS) among street children and other vulnerable youth;
   - HIV vulnerability baseline study among labor migrants;
   - Assessment of HIV/AIDS care and support services.

Taking into account the limitations of prevalence indicator in the context of effective prevention and care interventions leading to decreasing incidence of HIV transmission and

decreasing mortality, it is important to collect data that may serve as proxy indication of incidence. This will be achieved through disaggregation of prevalence data by age (below 25 and 25 and more), as well as the length of injecting career (less than 3 years and 3 years and more). Combined and triangulated with the SPECTRUM estimates as well as with planned HIV incidence estimation study using recent infection testing algorithm (RITA), these disaggregated prevalence indicators will allow for establishing whether the expected reversal of the HIV epidemic is being achieved.

Regional statistics at least for the regions with high prevalence of key populations will be monitored.

STRATEGIC AREA 3 LEADERSHIP AND POLICY DEVELOPMENT

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.

3 IMPLEMENTATION TIMELINES AND RESPONSIBLE INSTITUTIONS

The list of activities proposed for each objective and strategic intervention is provided in the Annex3. It also includes information about the responsible institutions and collaborating partners.

The responsibility for providing an effective HIV response will be divided between various state institutions and agencies in line with their regular mandate and competencies. The key entities which will lead, coordinate and oversee the strategy implementation are as follow:

- The Country Coordinating Mechanism which encompasses the function of the AIDS National Coordinating Authority assumes the responsibility of leading and coordinating the national response on a strategic level;

- The Ministry of Labour, Health and Social Affairs, which oversees the deliveryofhealthcareservicesanddevelopmentandimplementationofnationalpolicies and regulations;

- The National Centre for Disease Control and Public Health(NCDCPH), which manages funds from the Global Fund and projects funded from these resources, and has primary responsibility for HIV surveillance; and

- The Infectious Diseases, AIDS and Clinical Immunology Research Centre, which is the sole provider of HIV treatment services and coordinator for care and support services.

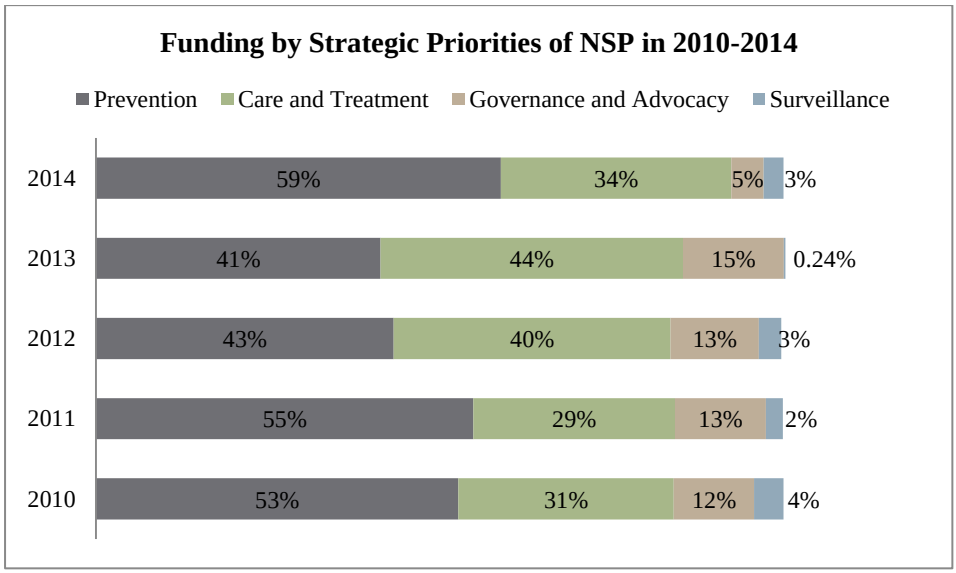
One of the key principles for NSP implementation is close collaboration between government, nongovernment and private sector. The role of civil society played thus far in outreach and delivery of services to PLHIV and key affected populations, in policy dialogue and advocacy will be further expanded. The Government of Georgia recognises that without effective engagement of civil society and without broadening their role, state response to the epidemic will be inadequate.

4 FUNDING THE NATIONAL RESPONSE

The overall funding need for the HIV response has been and will continue to grow steadily due to the scale-up of various prevention and care interventions. The annual cost of the national response to HIV increased from $5.2 million in 2006 to $8 million in 2008 and further to $14.76 million in 2014. A further increase is expected to support the planned expansion in coverage and improvements in service quality. An expected increase in ART coverage will not be associated with a significant increase in funding due to the ongoing optimization of the treatment schemes.

Analysis of NSP spending by strategic priorities showed that the share of funds spent on treatment and surveillance are increasing with a concomitant declining share for prevention (see figure 4.2). However, this tendency changed in 2014 with an increased allocation to prevention.

Figure 4.2. Funding by Strategic Priorities of NSP



The HIV spending dynamics for the next three years is defined by the decreasing share of external contributions and the increasing share of state funding required to ensure a sustainable response to HIV epidemic. In particular, in 2016-2018 the government will fully fund procurement of first-line ARV medicines, laboratory monitoring of treatment quality, and opioid substitution therapy. The detailed budget presented in Annex 4 provides information on expected funding sources for different components of the national response to HIV.

The tables 4.1.and 4.2. and figures 3 and 4 present the funding dynamics including the actual expenditure in 2010–2014, as well as the required allocations for 2016–2018.

Table 4.1.Funding of HIV response by source (in millions of US dollars)

Source		2010	2011	2012	2013	2014	2015	2016	2017	2018
1.1.State HIV Program	Mln $	4.36	4.56	4.55	4.95	8.17	7.99	6.11	10.50	12.45
	%	34%	32%	28%	32%	48%	39%	30%	57%	62%
1.2.State investment in Infrastructure	Mln $	-	-	-	-	-	-	5	-	-
	%							23%		
2.TOTAL International	Mln $	6.83	8.52	11.06	9.14	7.02	10.54	7.73	5.59	4.98
	%	53%	59%	68%	58%	41%	52%	38%	31%	25%
2.1. Global Fund	Mln $	5.3	5.1	8.8	7.5	5.78	9.95			
	%	41%	36%	54%	48%	34%	49%			
3. Household funds (Private Sources)	Mln $	1.61	1.26	0.78	1.60	1.77	1.77	1.38	2.20	2.55
	%	13%	9%	5%	10%	10%	9%	7%	12%	13%
TOTAL		12.80	14.34	16.39	15.69	16.96	20.30	20.08	18.16	19.99

Figure 3. Spending for HIV by source of funding

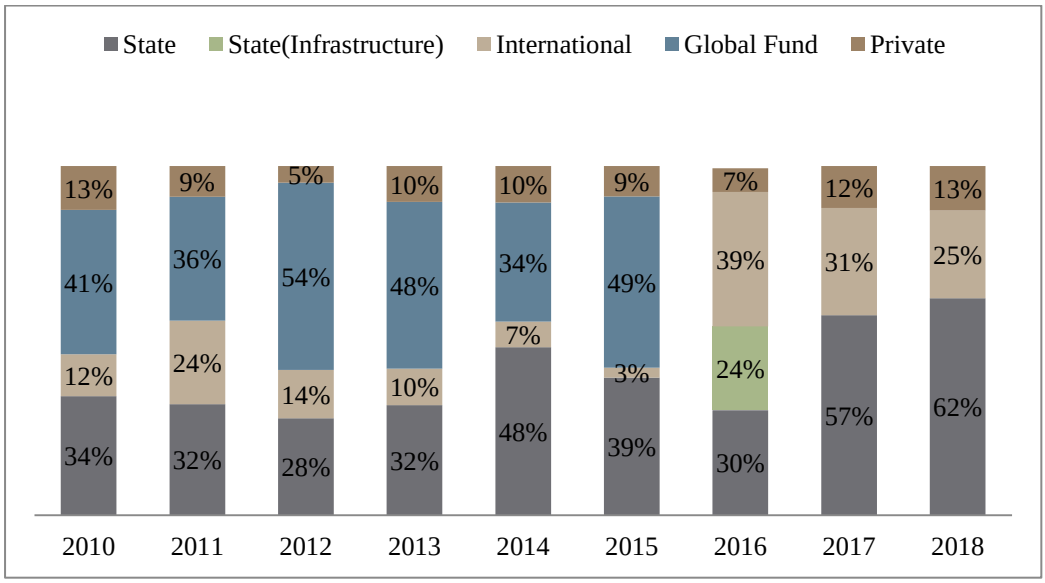
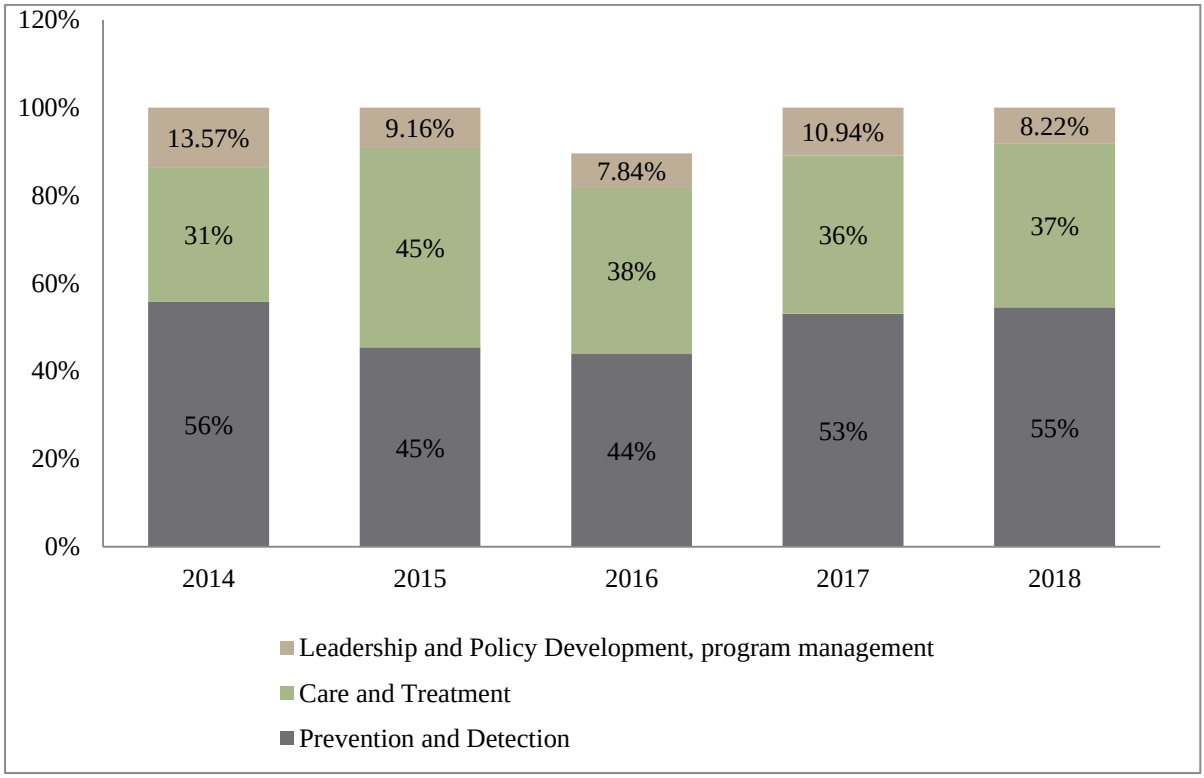


Table 4.2.Funding of HIV response by Intervention area (in millions of US dollars)

Area	2010	2011	2012	2013	2014	2015	2016	2017	2018
Prevention and Detection	7.22	7.87	7.19	6.49	9.46	9.23	8.21	9.64	10.90
Care and Treatment	3.11	3.76	6.20	6.12	5.20	9.22	5.69	6.53	7.45
Leadership and Policy Development, program management	2.47	2.71	3.00	3.08	2.30	1.86	1.18	1.99	1.64
Infrastructure	-	-	-	-	-	-	5.00	-	-
TOTAL	**12.80**	**14.34**	**16.39**	**15.69**	**16.96**	**20.30**	**20.08**	**18.16**	**19.99**

Figure 4.Resource distribution between HIV NSP strategic areas[xiii]



Resource distribution between strategic areas is detailed in figure 4. A significant portion of resources will be allocated to scale up preventive interventions and improve scope and quality (44-55%). One third of the resources will be devoted to maintaining access to ART and achieving better treatment outcomes.

4.1 FINANCIAL GAP ANALYSIS

Over the last several years the share of domestic funding allocated to the HIV response in Georgia has been steadily increasing from 12% in 2008 to 48% in 2014. The Global Fund remained the most significant funding source and provided 34% of the overall funding in 2014. The contribution of other international sources has been decreasing and reached 7% in 2014. The future period will be marked by a further decrease of external contributions, which should be balanced by a significant increase in state budget allocation for HIV. The Global Fund funding that has peaked at 54% of the total HIV spend in 2012 is expected to decrease to 39% in 2016.

For financial gap estimation, NSP budgets were compared with the available resources[xiv] for 2016-2018. The total amount planned by the government for this period will cover from 53% (in 2016) to 62% (in 2018) of the estimated needs.

The state funding will increasingly cover the estimated needs for ARV treatment and care (from 27% of an estimated need in 2016 to more than 90% in 2018) including 31% of ART costs in 2016 and 95% in 2018; for OST (from 49% in 2016 to 57% in 2018); and a

xiii. Five million USD envisioned for AIDS center infrastructure development is not reflected in this figure
xiv. Estimates for domestic spending is based on the Medium Term Expenditures Framework, MoLHSA

significant portion of costs related to program administration. The biggest funding gap is expected in the areas of HIV prevention, policy development, advocacy and operational research. Georgia remains eligibly with the Global Fund new funding model and may receive additional funding to cover the exiting funding gap. Intensive advocacy efforts will be needed to mobilize additional resources from other donors to ensure a full-scale implementation of all planned activities.

The 2016-2018 is a critical transitional period when Georgia has to move from external to domestic funding for HIV National response. In order to guide this process the GoG will elaborate and implement the transition and sustainability plan by 2017. The government in close collaboration with all relevant stakeholders will closely monitor the progress against the strategic objectives. The country dialogue with active engagement of KAPs and PLHIV will continue to timely address the implementation challenges and facilitate introduction of innovative strategies for achieving maximum impact.

ANNEX 1. FIGURES

Figure A.1. HIV testing of PWID as part of the Global Fund Georgia HIV Program

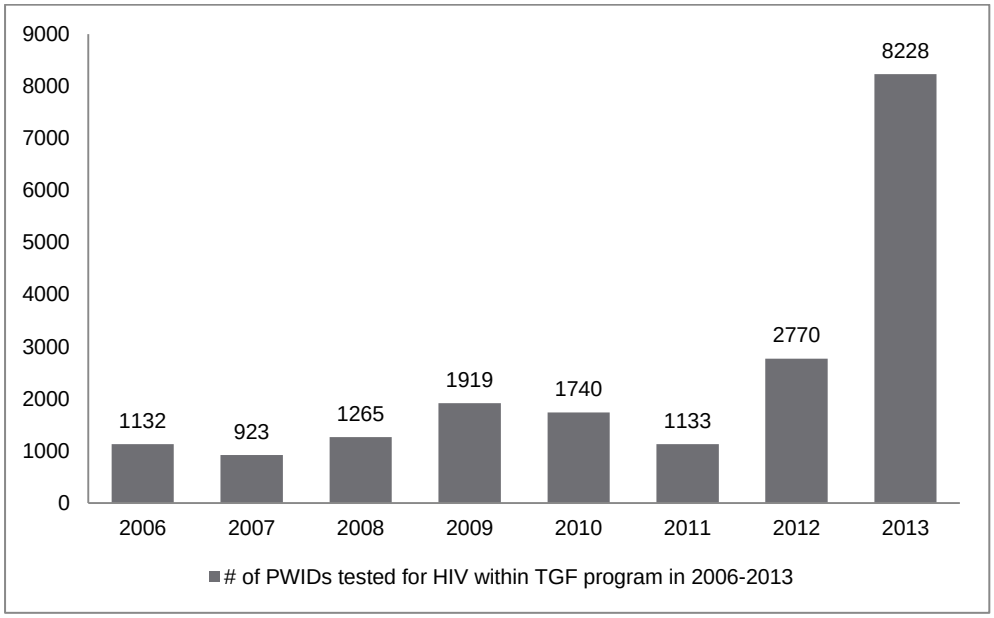


Figure A.2. HIV prevalence rates among MSM in 2007, 2010, 2012 (Tbilisi)

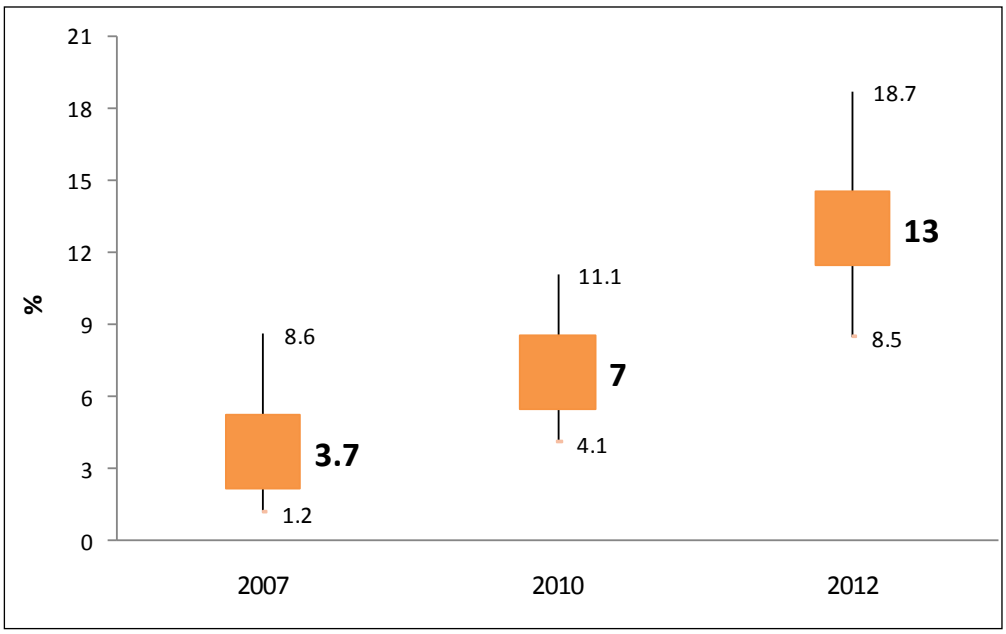


Figure A.3. HIV prevalence among Sex Workers in Tbilisi (2002 - 2014) and Batumi (2004 - 2014)

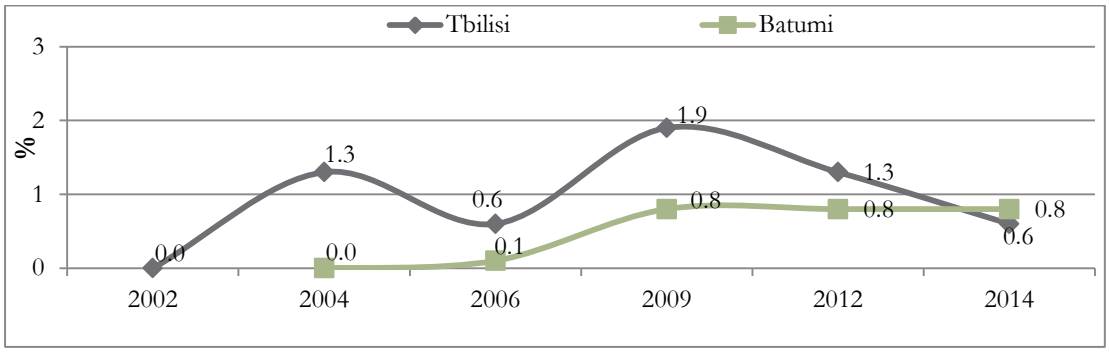


Figure A.4. Evolving ART Initiation Recommendations and Number of Patients on ART

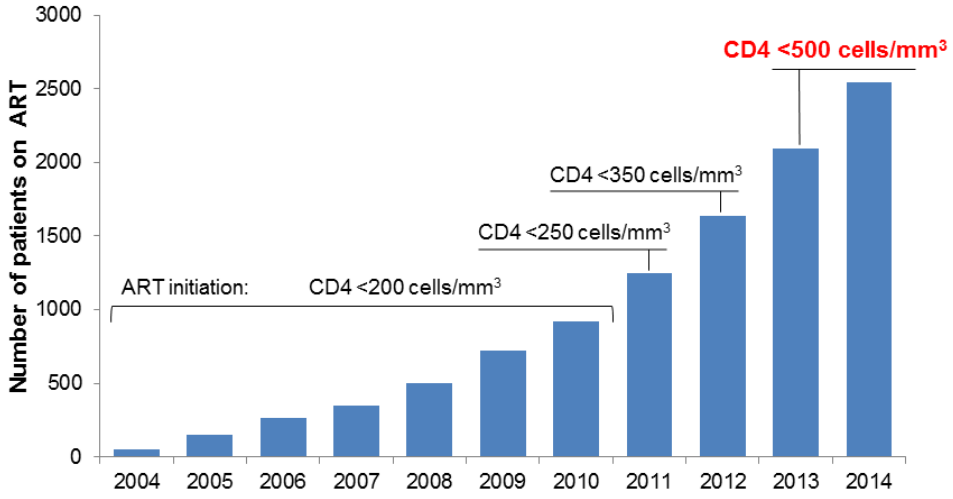


Figure A.5. Mortality Rates among HIV Patients in Georgia

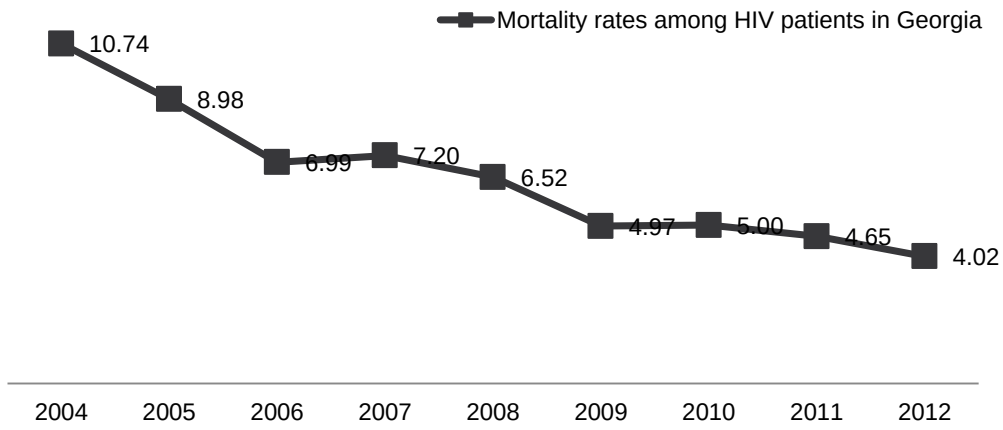
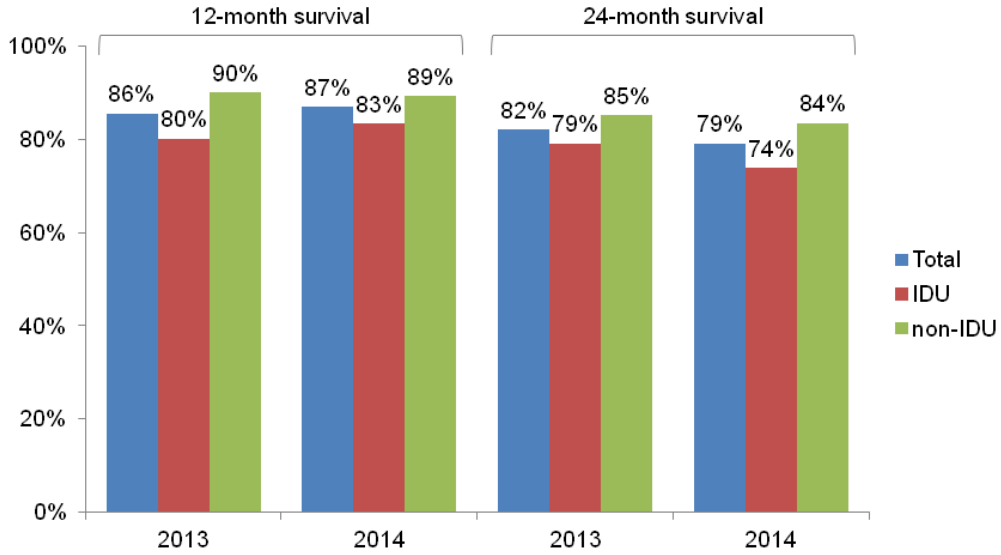


Figure A.6. Survival/retention rates by history of injection drug use



ANNEX 2. INDICATIVE LIST OF PREVENTIVE SERVICE TO BE OFFERED TO SPECIFIC KAPS IN ACCORDANCE WITH IDENTIFIED NEEDS

PEOPLE WHO INJECT DRUGS

- Distribution of injecting instruments and other paraphernalia (alcohol swabs, injecting water, citric acid, and tourniquets);
- Behaviour change communication and counselling;
- Voluntary counselling and testing for HIV;
- Facilitated progression to care and treatment for PLHIV;
- HCV and HBV testing and referrals to vaccination and treatment, inclusion of HCV/HBV treatment/vaccination in case management agenda;
- Overdose prevention and management services (including distribution of Naloxone);
- Distribution of condoms and informational materials;
- STI (testing for syphilis and referrals to treatment, inclusion of STI services in case management agenda);
- Questionnaire-based screening for TB and referrals for further TB diagnostics and treatment;
- OST (includes the delivery of OST as well as referrals to OST and other forms of treatment and rehabilitation as part of case management agenda); Includes collaboration with the IoM funded social entrepreneurship program for PWID.
- Legal aid;
- Psychosocial support including counselling, art-therapy etc.

Interventions targeting PWID will be tailored to attract and retain women who inject drugs, users of various kinds of substances including the new emerging psychoactive drugs, people with the past history of injecting drug use, as well as those at risk of transition to injecting move of administration.

MEN WHO HAVE SEX WITH MEN

- Distribution of condoms and lubricants;
- Behaviour change communication and counselling (including ICT-based);
- Voluntary counselling and testing for HIV, including introduction of saliva tests;
- Facilitated progression to care and treatment for PLHIV;
- STI (inclusion of STI testing and treatment in case management agenda);
- HCV and HBV testing and referrals for treatment, inclusion of HCV treatment and HBV vaccination in case management agenda;
- Questionnaire-based screening for TB and referrals for further TB diagnostics and treatment;
- Legal aid;
- Psychosocial support.

Emphasis is placed on the involvement of peers to explore the social networks of MSM and deliver essential communication.

In addition, exploration of possibility to use PrEP as an additional HIV prevention choice will take place during the impementation of the strategy, aiming at increasing knowledge and acceptibility of ART-based prevention strategies and at demonstration of PrEP feasibility on a small MSM sample selected based on the high risk sexual practices criteria..

SEX WORKERS, INCLUDING TRANSGENDERS

- Distribution of condoms and lubricants;
- Behaviour change communication and counselling (including ICT-based);
- Voluntary counselling and testing for HIV;
- Facilitated progression to care and treatment for PLHIV;
- GBV counselling;

- STI (inclusion of STI testing and treatment in case management agenda);
- HCV testing and referrals for treatment, inclusion of HCV treatment in case management agenda;
- Questionnaire-based screening for TB and referrals for further TB diagnostics and treatment.

Services will be carefully tailored to address significantly varying needs of different segments within the SW population, notably lower income and higher income sex workers. The latter will be offered a lighter service combination predominantly relying on behavior change communication prioritizing new information and communication technology.

PRISONERS

- Access to condoms and lubricants;
- Behaviour change communication and counselling including self-support group counselling;
- Voluntary counselling and testing for HIV;
- Facilitated progression to care and treatment for PLHIV;
- Opioid substitution maintenance.

ANNEX 3. MONITORING AND EVALUATION FRAMEWORK

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
Impact indicators								
I1	AIDS-related mortality per 100,000 population	2.40	2013	Routine monitoring data	≤2.2	≤2.1	≤2.0	Routine monitoring data
I3	Percentage of men having sex with men (MSM) who are living with HIV	13%	2012	IBBSS		<15%		IBBSS
I4	Percentage of sex workers (SW) who are living with HIV	0.7%	2014	IBBSS	<5%		<5%	IBBSS
I5	Percentage of people who inject drugs (PWID) who are living with HIV	3%	2012	IBBSS		<5%		IBBSS
Outcome indicators								
O1	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	73.2%	2012	IBBSS		80%		IBBSS
O2	Percentage of SW reporting the use of a condom with their most recent client	91%	2012	IBBSS	95%		95%	IBBSS
O3	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	83.5%	2012	IBBSS		87%		IBBSS
O4	Percentage of prisoners who report the use of a condom at last sexual intercourse	n/a	n/a	n/a		76%		IBBSS
O5	Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	87%	2014	Routine monitoring data	88%	89%	90%	Routine monitoring data
O6	Percentage of PLHIV with history of IDU known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	83%	2014	Routine monitoring data	84%	85%	86%	Routine monitoring data

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
Coverage/Output indicators								
1	[HIV Prevention and Detection]							
1.1	Prevent HIV transmission, detect HIV, and ensure timely progression to care and treatment among the key affected populations							
1.1.1	Prevention and detection of HIV among PWID							
C1	Percentage of PWID reached with HIV prevention programs - basic service combination	26%	2014	Routine monitoring data	57%	62%	67%	Routine monitoring data
C2	Percentage of PWID that have received an HIV test during the reporting period and know their results	43%	2014	Routine monitoring data	51%	56%	60%	Routine monitoring data
C3	Number of needles and syringes distributed per PWID per year by needle and syringe programs	45.3	2013	Routine monitoring data	57	78	101	Routine monitoring data
1.1.2	Opioid Substitution Treatment (OST) and other forms of treatment and rehabilitation							
C4	Number of individuals receiving OST	2850	2014	State and GF OST Program Reports	4800	5500	6000	Routine monitoring data
C5	Percentage of individuals receiving OST who received treatment for at least 6 months	TBD	TBD	Routine monitoring data	60%	65%	70%	Routine monitoring data
1.1.3	Prevention and detection of HIV among MSM							
C6	Percentage of MSM reached with HIV prevention programs	10%	2014	Routine monitoring data	25%	35%	50%	Routine monitoring data
C7	Percentage of MSM that have received an HIV test during the reporting period and know their results	8%	2014	Routine monitoring data	18%	25%	40%	Routine monitoring data
1.1.4	HIV Prevention and detection among FSW							
C7	Percentage of sex workers reached with HIV prevention programs	26%	2014	Routine monitoring data	40%	50%	60%	Routine monitoring data

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
C9	Percentage of sex workers that have received an HIV test during the reporting period and know their results	20%	2014	Routine monitoring data	30%	40%	50%	Routine monitoring data
1.1.5	HIV Prevention and Detection among prisoners							
C10	Percentage of prisoners that have received an HIV test during the reporting period and know their results	50%	2014	Routine monitoring data	55%	60%	65%	Routine monitoring data
1.2	Prevention and detection of HIV in healthcare settings							
1.2.1	Enhancing Provider Initiated Testing (PIT) for HIV							
C11	Number of people who received PIT for HIV and know their results	TBD	TBD	Routine monitoring data	23000	25000	28000	Routine monitoring data
1.2.2	Ensuring safety of donor blood							
C12	Number of blood units screened for HIV in a quality assured manner	56456	2014	Routine monitoring data	56500	56500	56500	Routine monitoring data
C13	Percentage of voluntary donors	30.00%	2014	Routine monitoring data	35%	40%	45%	Routine monitoring data
1.2.3	Post-exposure prophylaxis of HIV infection (PEP)							
C14	Percentage of healthcare workers in need of PEP provided with treatment	100%	2014	Routine monitoring data	100%	100%	100%	Routine monitoring data
1.2.4	Prevention of Mother to Child Transmission of HIV (PMTCT)							
C15	Percentage of pregnant women who were tested for HIV and received results	88%	2014	GARP 2014	100%	100%	100%	Routine monitoring data
C16	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	100%	2014	Routine monitoring data	100%	100%	100%	Routine monitoring data
C17	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100%	2014	Routine monitoring data	100%	100%	100%	Routine monitoring data

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
2	[HIV Care and Treatment]							
2.1	Ensure uninterrupted delivery of high quality treatment and care							
2.1.1	Delivery of essential clinical care services to all people living with HIV (PLHIV)							
C18	Percentage of newly diagnosed persons who are enrolled in care	91%	2014	Routine monitoring data	>90%	>90%	>90%	Routine monitoring data
C19	Number of patients receiving out-patient care services	2790	2014	Routine monitoring data	3450	3900	4300	Routine monitoring data
2.1.2	Provision of ART to all PLHIV in need in accordance with existing guidelines, including in the region of Abkhazia							
C20	Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period.	2541	2014	Routine monitoring data	3800	4300	4800	Routine monitoring data
C21	Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period excluding conflict region of Georgia	2228	2014	Routine monitoring data	3300	3700	4100	Routine monitoring data
C22	Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period in the conflict region of Georgia	313	2014	Routine monitoring data	500	600	700	Routine monitoring data
C23	Number of patients receiving clinic based adherence monitoring and support	n/a	n/a	Routine monitoring data	3100	3500	3900	Routine monitoring data
C24	Number of adherence monitoring and support visits performed by mobile units	4228	2014	Routine monitoring data	4200	4400	4600	Routine monitoring data
2.1.3	Effective program administration and quality of service delivery							

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
C25	Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy	82%	2014	Routine monitoring data	83%	84%	85%	Routine monitoring data
C26	Percentage of people with history of IDU on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy	71%	2014	Routine monitoring data	73%	75%	77%	Routine monitoring data
C27	Number of HIV-related hospitalizations	504	2014	Routine monitoring data	522	540	556	Routine monitoring data
C28	Percentage of healthcare facilities reporting no stock-outs of ARV medicines	n/a	n/a	Routine monitoring data	100%	100%	100%	Routine monitoring data
2.2	Reduce morbidity and mortality due to TB and HCV co-infections and injecting drug use							
2.2.1	Intensify HIV/TB collaborative activities							
C29	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	88%	2013	Routine monitoring data	>90%	>90%	>90%	Routine monitoring data
C30	Number of adults and children newly enrolled in HIV care who also start isoniazid preventive therapy treatment during the reporting period	92	2013	Routine monitoring data	150	200	250	Routine monitoring data
2.2.2	Provide treatment and care for viral hepatitis to all PLHIV (funded by HCV program)							
C31	Number of HIV patients receiving treatment for Hepatitis C	136	2014	Routine monitoring data	150	150	150	Routine monitoring data
2.3	Ensure provision of care and support services for PLHIV							
2.3.1	Ensure operation of peer-support services							
C32	Number of PLHIV reached by community-based support services	848	2014	Routine monitoring data	1018	1222	1466	Routine monitoring data
2.3.2	Provide palliative care for chronically ill patients							
C33	Number of visits performed by palliative care mobile units	1461	2014	Routine monitoring data	1500	1500	1500	Routine monitoring data

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
3	[Leadership and Policy Development]							
3.1	Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response							
3.1.2	Development of a national transition plan (transition from external to governmental funding) with ensured participation of key stakeholders, including community representatives and KAPs							
C34	HIV program transition plan from donor to domestic funding	n/a	n/a	n/a		1		Developed document / Endorsement records
3.2	Improved policy environment and stakeholder coordination							
3.2.1	Regular reviews and analyses of HIV related legislation							
C35	Number of legislation review reports	n/a	n/a	Developed document / Endorsement records	1		1	Routine monitoring data
3.2.2	Development of operational policies, regulations and guidelines to support enforcement of revised legislation to address issues affecting access to HIV services							
C36	Number of operational policies, regulations and guidelines developed	TBD	TBD	TBD	TBD	TBD	TBD	Routine monitoring data
3.2.4	Greater utilization of media for stigma elimination, promotion of VCT and other services, and general awareness (media campaigns by CBO/CSO/NSA)							
C37	Number of media campaigns in order to support stigma elimination, promotion of VCT and other services, and general awareness	n/a	n/a	n/a	1	1	1	Routine monitoring data
3.2.5	Development and implementation of stigma reduction activities by PLHIV organizations and KAP networks							

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
C38	Percentage of women and men aged 15-49 expressing accepting attitudes	TBD	TBD	Routine monitoring data	TBD	TBD	TBD	Routine monitoring data
C39	Level of stigma among health care workers	TBD	TBD	Routine monitoring data	TBD	TBD	TBD	Routine monitoring data
3.3	Generate evidence for informed decision making							
3.3.1	Epidemiological analysis based on routine surveillance data and complementary data sources, assessment of HIV/AIDS care and support services, Assessment and revision of the program monitoring system							
C40	Epidemiological analysis based on routine surveillance data and complementary data sources (e.g. safe blood database etc.)	n/a	n/a	Routine monitoring data	1	1	1	Routine monitoring data
C41	Assessment of HIV/AIDS care and support services	n/a	n/a	Routine monitoring data	1	1	1	Routine monitoring data
C42	Assessment and revision of the program monitoring system	n/a	n/a	Routine monitoring data	1	1	1	Routine monitoring data
C43	Establishing linkages between databases to support progression to care	n/a	n/a	Routine monitoring data	1	1	1	Routine monitoring data
C44	Participatory qualitative assessments in KAPs (annually)	n/a	n/a	Routine monitoring data	1	1	1	Routine monitoring data
3.3.2	Integrated bio-behavioral surveillance studies (IBBSS) among KAPs incorporating population size estimates: PWID, FSW, MSM, prisoners, Street Children and risk behavior youth and vulnerability baseline study among labor migrants							
C45	Number of studies implemented (IBBSS among PWIDs)	1	2012	Routine monitoring data		1		Routine monitoring data
C46	Number of studies implemented (IBBSS among FSWs)	1	2014	Routine monitoring data	1		1	Routine monitoring data
C47	Number of studies implemented (IBBSS among MSMs)	1	2014	Routine monitoring data		1		Routine monitoring data
C48	Number of studies implemented (IBBSS among Prisoners)	1	2012	Routine monitoring data		1		Routine monitoring data

SP #	Indicator	Baseline			Timeframe and targets			
		Value	Year	Source of data	2016	2017	2018	Source of data
3.3.3	HIV incidence estimation studies using recent infection testing algorithm (RITA)							
C46	Number of studies implemented (HIV incidence estimation studies using RITA)	n/a	n/a	Routine monitoring data	1	1	1	Routine monitoring data
3.3.4	Operational researches to evaluate patient engagement in HIV care, identify the barriers in accessing VCT (for PWID, MSM) and OST services (for PWID), identify key factors related to stigma at Health Care Settings and develop recommendations for evidence-based interventions, assess health service utilization and patient satisfaction among PLWH							
C47	Number of operational research implemented	n/a	n/a	Routine monitoring data	5	2	1	Routine monitoring data
3.3.5	Economic evaluation of selected prevention and treatment interventions and effectiveness of (BCC) interventions assessment							
C48	Number of studies implemented	n/a	n/a	Routine monitoring data		2		Routine monitoring data

ANNEX 4. NSP 2016-2018 BUDGET

#	Strategic Priority/ Activity area	Total USD				Government				Other			
		2016	2017	2018	Total	2016	2017	2018	Total	2016	2017	2018	Total
1	**[HIV Prevention and Detection]**												
1.1	**Prevent HIV transmission, detect HIV, and ensure timely progression to care and treatment among the key affected populations**	**7,197,121**	**8,530,010**	**9,734,163**	**25,461,295**	**2,190,958**	**3,238,611**	**3,833,859**	**9,263,428**	**5,006,163**	**5,291,400**	**5,900,304**	**16,197,867**
1.1.1	Prevention and detection of HIV among PWID	1,787,056	1,842,815	1,982,072	5,611,944	0	0	56,585	56,585	1,787,056	1,842,815	1,925,487	5,555,359
1.1.2	Opioid Substitution Treatment (OST) and other forms of treatment and rehabilitation	4,450,684	5,604,043	6,558,939	16,613,667	2,190,958	3,230,709	3,763,323	9,184,990	2,259,726	2,373,334	2,795,617	7,428,677
1.1.3	Prevention and detection of HIV among MSM	513,837	653,025	748,216	1,915,077	0	0	5,783	5,783	513,837	653,025	742,433	1,909,294
1.1.4	HIV Prevention and detection among FSW	256,486	278,127	304,850	839,463	0	0	8,169	8,169	256,486	278,127	296,681	831,294
1.1.5	HIV Prevention and Detection among Prisoners	85,269	98,320	89,864	273,453	0	7,902	0	7,902	85,269	90,418	89,864	265,551
1.1.6	Improving quality of services	103,789	53,680	50,222	207,691	0	0	0	0	103,789	53,680	50,222	207,691
1.2	**Prevention and detection of HIV in healthcare settings**	**1,582,077**	**1,671,907**	**1,796,945**	**5,050,930**	**1,524,317**	**1,660,462**	**1,785,042**	**4,969,820**	**57,760**	**11,446**	**11,904**	**81,109**
1.2.1	Enhancing Provider Initiated Testing (PIT) for HIV	370,328	414,317	473,433	1,258,078	349,435	402,871	461,530	1,213,835	20,893	11,446	11,904	44,242
1.2.2	Ensuring safety of donor blood	467,271	490,634	510,260	1,468,165	467,271	490,634	510,260	1,468,165	0	0	0	0
1.2.3	Post-exposure prophylaxis of HIV infection (PEP)	1,753	1,841	1,914	5,509	1,753	1,841	1,914	5,509	0	0	0	0
1.2.4	Prevention of Mother to Child Transmission of HIV (PMTCT)	150,416	169,860	189,054	509,330	113,549	169,860	189,054	472,463	36,867	0	0	36,867
1.2.5	State coordination of component "HIV / AIDS voluntary counseling and testing (VCT) for risk groups" of the National Program on HIV/AIDS	592,309	595,256	622,284	1,809,849	592,309	595,256	622,284	1,809,849	0	0	0	0
2	**[HIV Care and Treatment]**												
2.1	**Ensure uninterrupted delivery of high quality treatment and care**	**10,025,486**	**6,608,851**	**7,221,017**	**23,855,354**	**7,293,582**	**5,498,627**	**6,715,700**	**19,507,908**	**2,731,904**	**1,110,224**	**505,317**	**4,347,446**
2.1.1	Delivery of essential clinical care services to all people living with HIV	3,204,906	3,710,230	4,278,715	11,193,851	2,129,280	3,415,866	4,278,715	9,823,860	1,075,626	294,364	0	1,369,990

#	Strategic Priority/ Activity area	Total USD				Government				Other			
		2016	2017	2018	Total	2016	2017	2018	Total	2016	2017	2018	Total
	(PLHIV)												
2.1.2	Provision of ART to all PLHIV in need in accordance with existing guidelines, including in the region of Abkhazia	1,876,546	2,183,496	2,503,248	6,563,291	572,371	1,737,344	2,382,427	4,692,141	1,304,176	446,152	120,821	1,871,149
2.1.3	Effective program administration and quality of service delivery	402,064	422,167	439,054	1,263,286	49,962	52,460	54,558	156,980	352,103	369,708	384,496	1,106,306
2.1.4	Necessary investments in the infrastructure	4,541,970	292,957	0	4,834,927	4,541,970	292,957	0	4,834,927	0	0	0	0
2.2	**Reduce morbidity and mortality due to TB and HCV co-infections and injecting drug use**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2.2.1	Intensify HIV/TB collaborative activities (funded from the TB program)	0	0	0	0	0	0	0	0	0	0	0	0
2.2.2	Provide treatment and care for viral hepatitis to all PLHIV (funded from the HVC program)	0	0	0	0	0	0	0	0	0	0	0	0
2.3	**Ensure provision of care and support services for PLHIV**	**221,855**	**227,511**	**241,032**	**690,397**	**0**	**0**	**0**	**0**	**221,855**	**227,511**	**241,032**	**690,397**
2.3.1	Ensure operation of peer-support services	149,767	149,959	158,685	458,410	0	0	0	0	149,767	149,959	158,685	458,410
2.3.2	Provide palliative care for chronically ill patients	69,874	73,367	76,302	219,543	0	0	0	0	69,874	73,367	76,302	219,543
2.3.3	Support effective linkage of PLHIV to HIV and other medical care, as well as supportive services (case-manager)	2,214	4,185	6,045	12,444	0	0	0	0	2,214	4,185	6,045	12,444
3	**[Leadership and Policy Development]**									**0**	**0**	**0**	
3.1	**Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response**	**37,662**	**43,106**	**28,231**	**108,999**	**25,399**	**26,669**	**27,735**	**79,803**	**12,263**	**16,437**	**496**	**29,196**
3.1.1	Continuous monitoring of HIV related expenditures through the national health accounts analysis	25,399	26,669	27,735	79,803	25,399	26,669	27,735	79,803	0	0	0	0
3.1.2	Development of a national transition plan (transition from external to	12,263	16,437	496	29,196	0	0	0	0	12,263	16,437	496	29,196

#	Strategic Priority/ Activity area	Total USD				Government				Other			
		2016	2017	2018	Total	2016	2017	2018	Total	2016	2017	2018	Total
	governmental funding) with ensured participation of key stakeholders, including community representatives and KAPs												
3.2	**Improved policy environment and stakeholder coordination**	**268,796**	**290,820**	**299,973**	**859,589**	**0**	**0**	**0**	**0**	**268,796**	**290,820**	**299,973**	**859,589**
3.2.1	Regular reviews and analyses of HIV related legislation	9,084	9,538	9,920	28,542	0	0	0	0	9,084	9,538	9,920	28,542
3.2.2	Development of operational policies, regulations and guidelines to support enforcement of revised legislation to address issues affecting access to HIV services	4,542	4,769	4,960	14,271	0	0	0	0	4,542	4,769	4,960	14,271
3.2.3	Collaboration of CSOs with associations of lawyers and human rights protection organizations on addressing discrimination: development of joint plans of action and support to legal services providers	454	477	496	1,427	0	0	0	0	454	477	496	1,427
3.2.4	Greater utilization of media for stigma elimination, promotion of VCT and other services, and general awareness (media campaigns by CBO/CSO/NSA)	27,638	45,712	47,540	120,889	0	0	0	0	27,638	45,712	47,540	120,889
3.2.5	Development and implementation of stigma reduction activities by PLHIV organizations and KAP networks	58,144	64,628	67,214	189,986	0	0	0	0	58,144	64,628	67,214	189,986
3.2.6	Further strengthening of CCM role in coordination and support of national response	68,961	72,409	75,305	216,675	0	0	0	0	68,961	72,409	75,305	216,675
3.2.7	Support of thematic policy development, advisory and advocacy activities implemented by national key population networks (Drag policy, LGBT)	95,431	90,902	94,539	280,872	0	0	0	0	95,431	90,902	94,539	280,872
3.2.8	National AIDS Conference	4,542	2,385	0	6,927	0	0	0	0	4,542	2,385	0	6,927
3.3	**Generate evidence for informed decision making**	**435,146**	**448,221**	**297,406**	**1,180,774**	**0**	**0**	**91,613**	**91,613**	**435,146**	**448,221**	**205,793**	**1,089,161**

#	Strategic Priority/ Activity area	Total USD				Government				Other			
		2016	2017	2018	Total	2016	2017	2018	Total	2016	2017	2018	Total
3.3.1	Epidemiological analysis based on routine surveillance data and complementary data sources, assessment of HIV/AIDS care and support services, Assessment and revision of the program monitoring system	89,259	103,641	56,998	249,899	0	0	0	0	89,259	103,641	56,998	249,899
3.3.2	Integrated bio-behavioral surveillance studies (IBBSS) among KAPs incorporating population size estimates: PWID, FSW, MSM, prisoners, Street Children and risk behavior youth and vulnerability baseline study among labor migrants	265,949	293,937	190,810	750,696	0	0	91,613	91,613	265,949	293,937	99,197	659,082
3.3.3	HIV incidence estimation studies using recent infection testing algorithm (RITA)	22,710	0	24,799	47,509	0	0	0	0	22,710	0	24,799	47,509
3.3.4	Operational researches to evaluate patient engagement in HIV care, identify the barriers in accessing VCT (for PWID, MSM) and OST services (for PWID), identify key factors related to stigma at Health Care Settings and develop recommendations for evidence-based interventions, assess health service utilization and patient satisfaction among PLHIV	57,229	14,307	24,799	96,335	0	0	0	0	57,229	14,307	24,799	96,335
3.3.5	Economic evaluation of selected prevention and treatment interventions and effectiveness of (BCC) interventions assessment	0	36,336	0	36,336	0	0	0	0	0	36,336	0	36,336
4	**Management of contribution from international funding mechanism**									**0**	**0**	**0**	
4.1	**Management of contribution from international funding mechanism**	**316,713**	**335,930**	**369,207**	**1,021,851**	**0**	**0**	**0**	**0**	**316,713**	**335,930**	**369,207**	**1,021,851**
	TOTAL	**20,084,857**	**18,156,357**	**19,987,975**	**58,229,189**	**11,034,256**	**10,424,368**	**12,453,949**	**33,912,572**	**9,050,601**	**7,731,989**	**7,534,026**	**24,316,616**

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