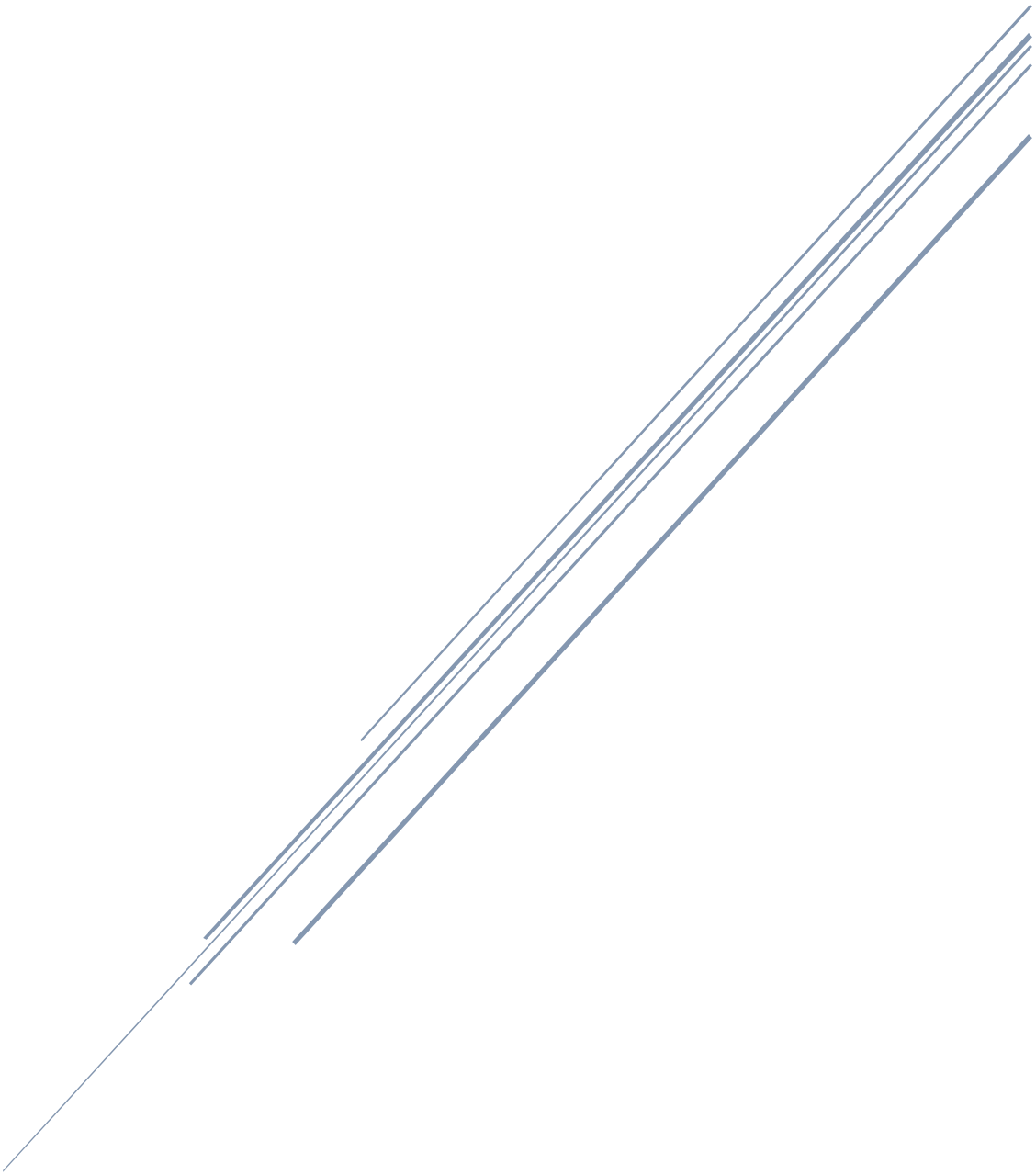
GEORGIA HIV/AIDS NATIONAL STRATEGIC PLAN

2019 - 2022



List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BDD	Basic Data and Directions
Bio BSS	Bio-Behavioral Surveillance Survey
CBO	Community Based Organization
CI	Confidence Interval
CSO	Civil Society Organization
EECA	Eastern Europe and Central Asia
EMTCT	Elimination of Mother to Child Transmission
EU	European Union
FSW	Female Sex Worker
GEL	Georgian Lari
GHRN	Georgia Harm Reduction Network
GoG	Government of Georgia
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
KP	Key Population
LIMS	Laboratory Management Information System
M&E	Monitoring and Evaluation
MoLHSA	Ministry of Labor, Health and Social Affairs
MSM	Men who have sex with men
NGO	Non-Governmental Organization
NSP	Needle and Syringe Program
NSWP	Network of Sex Work Projects
Ob/Gyn	Obstetrics and Gynecologist
OST	Opioid Substitution Therapy
PIT	Provider Initiated Testing
PLHIV	People Leaving with HIV
PMTCT	Prevention of mother-to-child transmission
PSE	Population Size Estimation
PWID	People who inject drugs
RITA	Recent Infection Testing Algorithm
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infections
SVM	Syringe Vending Machines
SW	Sex Worker
TB	Tuberculosis
TGF	The Global Fund
TP	Transition Plan
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund

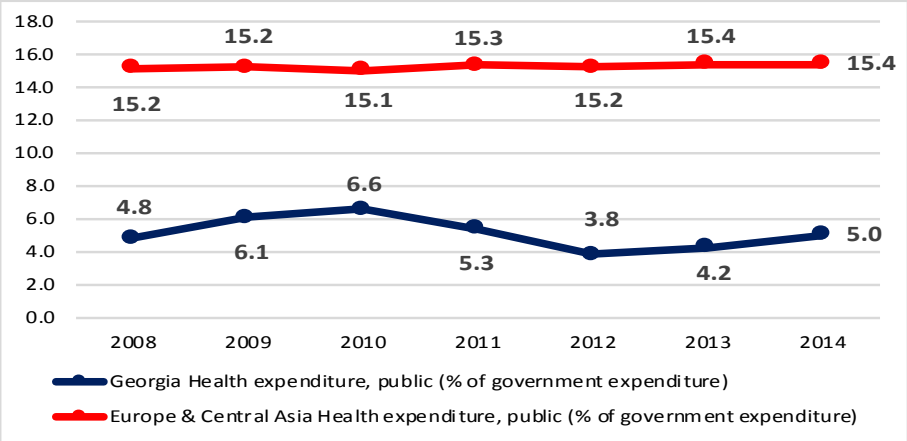
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YKP	Young Key Population

Background

The government of Georgia has declared health of country's population as the priority when announced Universal Health Program in 2013[1] and approved 2014-2020 State Concept of Health Care System of Georgia for Universal Health Care and Quality Control for the Protection of Patient's Rights in 2014[2]. HIV/AIDS is acknowledged as one of the priority communicable diseases along with Hepatitis C, Tuberculosis, and other vaccine-preventable diseases. With the introduction of Hep C elimination program in 2015, Georgia became the first country in WHO European Region to provide universal coverage with Hepatitis C treatment for the entire population.

The spending on health in the general government budget varied between 4% and 7% during 2008 – 2014 (see Figure 1**Error! Reference source not found.**). However, with the introduction of the Universal Health Care program, the state budget allocations have increased, and the share of health spending in the general government budget has reached 8.8% in 2016[3]. Nevertheless, this indicator can be used to indicate the government commitment to distribute the fair share of the government budget to the health system, which is still relatively low compared with other countries in the European region. The fragile economic situation in the country may limit government's ability to increase further its investments in health, which will be required to meet the increased domestic commitments as the international financing for the health sector of Georgia shrinks. The recently manifested trend in the devaluation of the national currency and increased external debt (19 billion GeL[4] as of December 31, 2017) may also present a further challenge.

Figure 1 Health Expenditure as % of total government expenditure (Georgia VS Europe & Central Asia Regional Average)[5]



According to the Global Fund 2018 eligibility criteria, Georgia is still eligible for funding for the 2020-2022 funding cycle[6], but based on the TGF eligibility criteria[7] and understanding the economic fluctuations and possible challenges with taking over funding from external sources, Georgia was among the first few countries in Eastern European and Central Asia region that has developed Transition and Sustainability Plan in 2016[8]. The plan covers the period of 2017-2021 and aims at

[1] Government of Georgia. Ordinance No 36. February 2013 http://ssa.gov.ge/files/01_GEO/KANONMDEBLOBA/Kanon%20Qvemdebare/92.pdf
[2] Government of Georgia. Ordinance No 724. December 2014. https://matsne.gov.ge/en/document/view/2657250
[3] The Georgia Law on the State Budget of Georgia, MoF, 2016.
[4] National Bank of Georgia; https://www.nbg.gov.ge/index.php?m=340&newsid=3320 Accessed on April 10, 2018
[5] http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators#
[6] https://www.theglobalfund.org/media/5641/core_projectedtransitionsby2025_list_en.pdf?u=636570636710000000020
[7] https://www.theglobalfund.org/media/7443/core_eligibility_policy_en.pdf?u=636679305120000000
[8] Georgia Transition Plan. Curatio International Foundation. 2016

ensuring the smooth transition from TGF funding towards fully national funding of HIV and TB national responses by the Year 2022.

The presented document is the fifth National Strategic Plan for HIV/AIDS since the 2003 and beyond analyses of achievements and challenges of the national response, covers transition activities as well.

1. Situation Analysis

1.1 Legal Framework

Georgian citizens are entitled to equal and unlimited access to quality HIV preventive and treatment services. The following legal acts pursue the right to access the adequate health services with full respect for human rights and patient dignity:

1. Constitution of Georgia;
2. Georgia Law on Health Care - 2002;
3. Georgia Law on Medical Activities - 2008;
4. Georgia Law on Patients' Rights - 2000.

The Georgia Law on HIV defines the responsibility of the GoG to ensure the implementation of effective interventions for HIV prevention and treatment. The Law determines the basic principles of HIV/AIDS response in Georgia, the rights and responsibilities of HIV/AIDS patients and health workers, defines the State's responsibility to ensure unrestricted equal access to quality HIV services for all citizens of Georgia.

The existing legislative framework provides protection of health, as well as state and public safety and the fulfillment of the requirements of the international treaties and agreements of Georgia in controlling the infectious diseases.

The Georgia Law on Public Health[9] further emphasizes the role the GoG should play in creating a robust strategic framework for HIV national response and supporting its implementation.

The Georgia Law on State Budget[10] defines annual allocative amount for HIV programs. These allocations cover HIV service delivery costs.

Article 356 of the EU Georgia Association Agreement[11] issued in June 2014 stipulates the commitment of Georgia to strengthen "epidemiological surveillance and control of communicable diseases, such as HIV/AIDS, viral hepatitis, tuberculosis as well as antimicrobial resistance, as well as increased preparedness for public health threats and emergencies."

1.2 Global Strategies and Regional Strategies

Main directions and activities proposed in new strategy are fully aligned with UNAIDS 90-90-90 Strategy[12], Action Plan for the health sector response to HIV in the WHO European Region[13], Dublin

[9] Law on Public Health https://matsne.gov.ge/en/document/view/2805785
[10] Georgia Law on State Budget https://matsne.gov.ge/ka/document/view/3938064
[11] Article 356 of the EU Georgia Association Agreement
[12] 90–90–90 - An ambitious treatment target to help end the AIDS epidemic. http://www.unaids.org/en/resources/documents/2017/90-90-90

Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia[14] and UN Sustainable Development Goal 3[15].

According to the UNAIDS 90-90-90 strategy, by 2020 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression. Georgia strives to achieve those targets.

The Action Plan for the health sector response to HIV in the WHO European Region is a continuation of the work begun by and lessons learnt from the European Action Plan for HIV/AIDS 2012–2015. This Action Plan promotes a public health approach, comprehensive combination of HIV prevention, access to HIV testing and offering treatment to all people living with HIV, including children, adolescents, adults, pregnant and breastfeeding women, and people with coinfections. It guides Member States to ensure implementation of an essential package of HIV services that are people cantered, accessible and appropriate to the national context, with a particular focus on key populations. The plan was finalized following the guidance from the Twenty-third Standing Committee for the Regional Committee for Europe, and endorsed at the 66th session of the WHO Regional Committee for Europe, along with Regional Committee resolution EUR/RC66/R9.

Georgia has undertaken active measures to adjust SDG agenda and its targets to the national circumstances and to advance their implementation. Localization of the SDGs has been done according to the national context, challenges and opportunities. In 2015, Georgia prioritized set of 14 goals out of the total 17, as well as 88 global targets.

The adjusted version of goals and targets covers preferences of economic growth and addresses a range of social needs including education, health, social protection, and job opportunities, climate change and environmental protection, inequality, energy and consumption[16].

As a signatory to many international human rights instruments, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Georgia is required to ensure de facto equality between men and women. Article 2 of CEDAW directly prohibits discrimination against women and obligates States to agree to pursue a policy of eliminating discrimination against women by all appropriate means, and to undertake concrete steps to eliminate discriminatory laws, policies and practices in the national legal framework. The 2014 Association Agreement between Georgia and the EU also requires Georgia to bring national legislation into conformance with international standards[17].

1.3 HIV/AIDS Epidemiological Update

Georgia remains to be a low prevalence country with concentrated epidemics among MSM. Even though the prevalence remains low in general population, there is a risk that epidemic could worsen because of growing number of new cases among key populations, especially PWIDs and MSM, including young key populations (YKPs). According to the National AIDS center, in recent years heterosexual and homo/bisexual contacts together are responsible for majority of cases, followed by

[13] Action plan for the health sector response to HIV in the WHO European Region. WHO Regional Office for Europe. 2017 http://www.euro.who.int/__data/assets/pdf_file/0007/357478/HIV-action-plan-en.pdf?ua=1

[14] Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia. https://www.osce.org/secretariat/29873?download=true

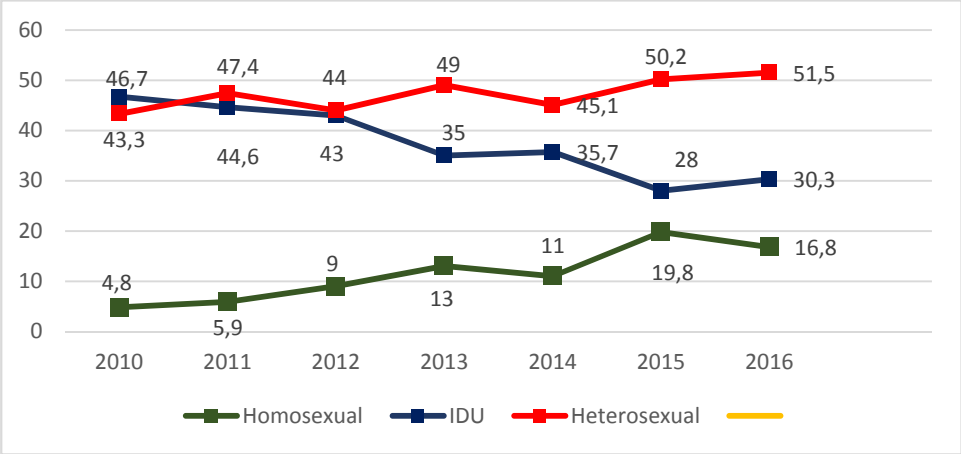
[15] https://www.un.org/sustainabledevelopment/sustainable-development-goals/

[16] https://sustainabledevelopment.un.org/memberstates/georgia

[17] Gender Equality in Georgia: Barriers and Recommendations http://www.ge.undp.org/content/georgia/en/home/library/democratic_governance/gender-equality-in-georgia.html

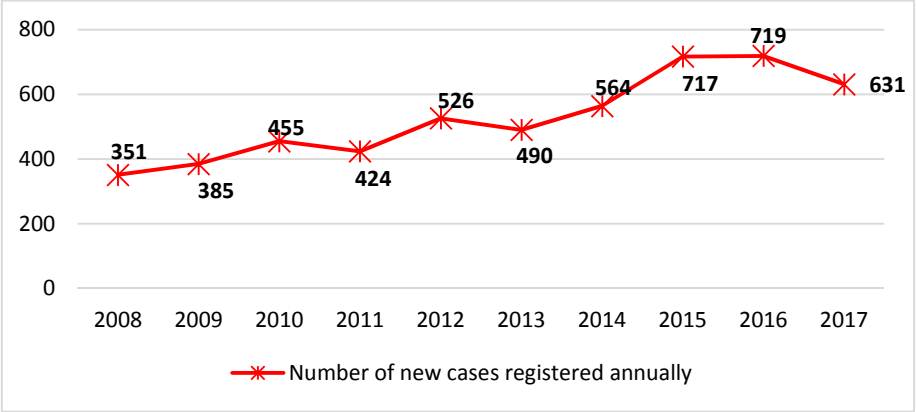
injecting drug use (see Figure 2). This is somewhat alarming, especially knowing that HIV prevalence among MSM is rapidly growing, and according to Bio BSS studies, majority of them have sexual contacts with female partners as well. Due to high stigma some MSM and bisexual men prefer not to disclose their sexual orientation and are registered as heterosexual men. As AIDS Center reports many of them have families and their female partners don't have HIV.

Figure 2 Main routes of transmission (2010 - 2016[18,19])



The first case of HIV in Georgia was detected in 1989. Since then the country has been actively monitoring the epidemic and has reached significant achievements, but HIV/AIDS remains a significant public health issue. According to the National AIDS center, as of May 2018 in total7012[20] HIV cases are registered. Majority of infected persons are males (5248), within the age group of 29 – 40 at the time of diagnosis; 3772 patients have developed AIDS, 1440 have died. In 2017, in total 631 new cases were registered. The highest annual number of new HIV cases was observed in 2016 – 719 (see Figure 3**Error! Reference source not found.**).

Figure 3 Number of new HIV cases registered annually (2008 - 2017)[21]



[18] Global AIDS Response Progress Report GEORGIA Country Progress Report Reporting Period January – December, 2014 http://www.unaids.org/sites/default/files/country/documents/GEO_narrative_report_2015.pdf

[19] Health Care Statistical Yearbook 2016. Ministry of Labor, Health and Social Affairs of Georgia. National Center for Disease Control and Public Health. 2017. http://ncdc.ge/Handlers/GetFile.ashx?ID=31eee2a3-9bf5-4558-959b-a4b92f600555

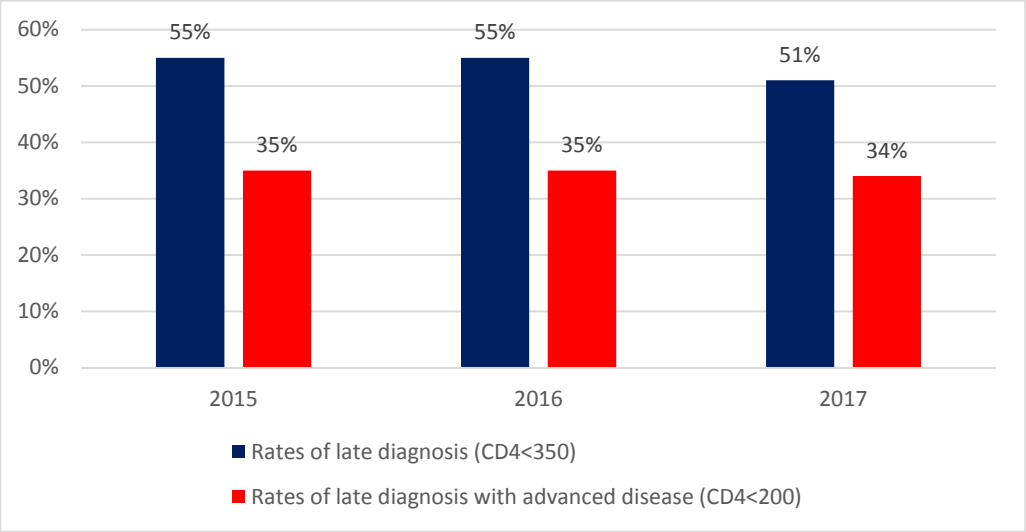
[20] https://aidscenter.ge/epidsituation_eng.html

[21] National AIDS Center. https://aidscenter.ge/epidsituation_eng.html

During the recent communications with UNAIDS, in the process of updating the SPECTRUM, the estimated number of PLHIV in Georgia was set at 10,500 and this estimate has been used in the process of Strategy development.

Late diagnosis remains significant challenge in Georgia. Over the last three years more than half (51 to 55%) of newly diagnosed persons were presented to care late (CD4 cell count <350), while up to 35% already have advanced disease (CD4 cell count <200). Individuals not aware of their HIV status continue to engage in high risk behaviors and unknowingly transmit the virus fueling the growth of the epidemic. Late diagnosis is the leading cause of death in Georgia and also requires additional resources to treat advanced disease otherwise preventable with timely diagnosis[22,23,24].

Figure 4 Late HIV diagnosis in Georgia



In general testing uptake in Georgia is low both in KP's and general population. With introduction of State Hep C program, there is a chance to integrate HIV testing and increase testing coverage, that supposedly will contribute to improved case detection. Analysis of surveillance data from National Center for Disease Control and Public Health (NCDC) shows that in 2017 in total 19,109 individuals were tested for HIV in the country. Out of 631 positive cases majority were detected in medical facilities. Presumably, due to stigma representatives of KP's are reluctant to self-identify themselves as drug users or MSM, and prefer seeking HIV testing in general medical facilities rather than MSM/PWID's focused testing facilities. Thus, it is highly recommended that Provider Initiated Testing (PIT), which has been successfully piloted in the capital city – Tbilisi, be expanded nationwide to upscale HIV testing and improve case detection.

People Who Inject Drugs (PWID)

Based on the latest population size estimation (PSE) survey conducted among PWIDs in 7 cities of Georgia (2016-2017) the national prevalence estimates for problem drug use in adult population is

[22] Chkhartishvili N, Sharvadze L, Chokoshvili O et al. Mortality and causes of death among HIV-infected individuals in the country of Georgia: 1989-2012. AIDS Res Hum Retroviruses. 2014;30:560-6.
[23] Chkhartishvili N, Sharvadze L, Gabunia P, Abutidze A, Nikolaishvili M, Tsertsvadze T. Late HIV diagnosis in Georgia: public health and economic implications. Translational and Clinical Medicine-Georgian Medical Journal. 2016;1:11-14.
[24] Chkhartishvili N, Chokoshvili O, Bolokadze N et al. Late presentation of HIV infection in the country of Georgia: 2012-2015. PLoS One. 2017;12:e0186835.

2.24% (2.13-2.39)[25] which is the third highest estimate in the world and the second in EECA region (see Figure 15 in Annex 1). The PSE used Network Scale-Up (NSU) and Multiplier-Benchmark methods to estimate number of PWID in Georgia. Those methods utilized data from different national databases, including the Ministry of Internal Affairs. Couple scenarios, that were developed based on data triangulation and extrapolation were presented at national consensus building workshop. Based on the National Experts' consensus, the estimated size of the PWID population was set at 52,500 (50,000-56,000) which indicates 5% increase of the population size since 2014 (see

Figure 16). HIV prevalence in PWID has not changed since 2009, and it varies between 2.4% and 2.3% (Figure 17); however it has to be noted that there are regional variations in HIV prevalence with steady high prevalence in Batumi (4.5% in 2009, 5.6% in 2013, 4.4% in 2015, 5.1% in 2017). The highest prevalence since 2008 was found in Zugdidi in 2013 -9.1%, but in 2017 it has the second lowest prevalence after Tbilisi – 1.8%.

Men Who Have Sex with Men (MSM)

Most recent Population Size Estimation (PSE) survey defined the size of MSM population as 17 200[26]. HIV prevalence in this group has increased dramatically over the last couple of years: from 3.7% in 2007 up to 20.7%[27] in 2015 (Figure 14). The recent MSM cohort study, conducted by National AIDS Center showed the very high incidence of HIV infection in this population: up to 6 new infections per 100 person-years of observation. This pretty much explains rising prevalence of HIV[28] in this particular group.

Sex Workers (SWs)

HIV infection prevalence among Female Sex Workers (FSWs) has remained low - less than 2% during the last 15 years (see Figure 18, Annex 1). The latest PSE survey conducted in 2014, and the latest Bio BSS – in 2017 and provided some corrections of PSE for Tbilisi and Batumi. The estimated size of sex workers population for Georgia is 6525[29]; for Tbilisi the estimated size is 600 and for Batumi - 700[30]. Majority of the sex workers surveyed represent the age group 40+.

In contrast to other post-soviet countries, the peculiarity of commercial sex in Georgia, , has been stable over the last 15 years - sex work, at least, the street and facility-based sex work - do not overlap with injecting drug use. However, an alarming new trend indicates about increased use of non-injecting drugs among FSWs in both cities (sedatives/sleeping pills in Tbilisi, and marijuana – in Batumi). More significant proportions reported having used the non-injecting drug during the last 12

[25] Population Size Estimation of People Who Inject Drugs in Seven Cities of Georgia, 2016-2017, Bemoni Public Union(BPU); Curatio International Foundation (CIF)

[26] Population Size Estimation of Men Who Have Sex with Men in Georgia, 2014; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://www.georgia-ccm.ge/wp-content/uploads/MSM-PSE-09.12.2014_Geo.pdf

[27] http://www.unaids.org/en/regionscountries/countries/georgia

[28] Chokoshvili O, Kepuladze K, Tsintsadze M et al. High prevalence and incidence of HIV, syphilis and viral hepatitis among men who have sex with men in Georgia: Findings of the Georgian MSM Cohort. 16th European AIDS Conference. Milan, Italy; 2017.

[29] Population Size Estimation of Female Sex Workers In Tbilisi and Batumi, Georgia 2014; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/150.pdf

[30] Integrated Bio-behavioral surveillance and population size estimation survey among Female Sex Workers in Tbilisi and Batumi, Georgia; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/167.pdf

months in both cities, compared to 2014 survey (Tbilisi: 11% (2017) vs. 6.3% (2014) and Batumi: 20% (2017) vs. 5.8% (2014)). This increase is statistically significant.

Prisoners

The latest Bio BSS among prisoners was conducted in 2015. By then, there were 10,201 (9876 males, 325 - females) prisoners in Georgian penitentiary system, which included 15 establishments. The HIV prevalence found by the survey was 1.4%[31]. In the previous survey of 2012, the prevalence was 0.3% (Figure 19, Annex 1). The increase is not statistically significant.

Knowledge about HIV among prisoners is low (23.3% could correctly answer relevant questions). However, level of stigma towards HIV positive prisoners is not high.

About one third of the prisoners were tested on HIV during the last 12 months and had received test results. Majority of the prisoners reported they were offered testing in prison (77.4%), which demonstrates effectiveness of the HTC cabinets established by the prevention programs within the penitentiary system.

Record of sexual practices among prisoners is not high, and mostly heterosexual contacts are reported. Homosexual contacts are underreported, largely due to high stigma connected to same sex relationship. Condoms (but not lubricants) are available in prisons from the medical points in each establishment.

Although the Bio BSS among prisoners revealed statistically significant increase in the share of those respondents who were covered by preventive program (25.2% in 2015 vs 18.3% in 2012, $p<0.05$), coverage with HIV-services is still up to 25%.

General Population

HIV prevalence in general population is low 0.4%[32] (400 per 100 000 population), and AIDS related mortality is 1.9 per 100 000 population, but Georgia still faces a significant risk of expanding epidemic due to several factors: widespread high-risk practices, growing HIV prevalence among MSM, significant risk of sexual transmission of HIV through bridging populations, and patterns of high mobility specific to key populations. The Strategy proposes to conduct several studies to generate research-based evidences for assessing HIV vulnerability among migrants and street children, as well as population size estimation studies for street children and Bio-BSS among youth.

Progress towards 90-90-90

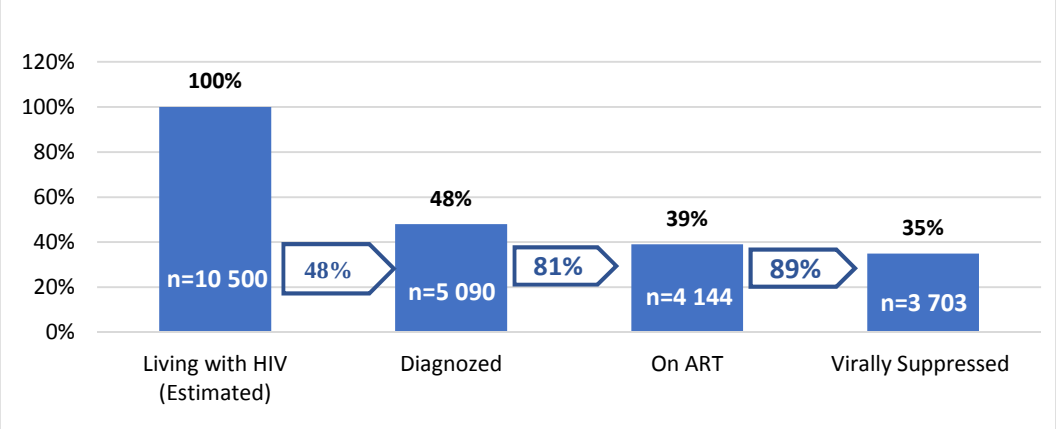
Analysis of national data on fast-track 90-90-90 targets shows that the significant gap in the cascade of HIV care continuum is at the stage of HIV diagnosis with only 48% of the estimated number of people living with HIV aware of their status

Figure 5**Error! Reference source not found.**).

[31] HIV risk and prevention behaviors among Prison Inmates in Georgia; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/157.pdf

[32] National AIDS Center

Figure 5 Progress towards 90-90-90 in Georgia, 2017[33]



While diagnosis remains the primary challenge, the country has made remarkable progress on the right side of the cascade from diagnosis through viral suppression. Georgia started implementation of 'treat all' policy in 2015, and since then all HIV positive persons have been offered antiretroviral therapy (ART) regardless of immune status or disease stage. The country is approaching fast-track targets for ART and viral suppression. Among diagnosed persons ART coverage increased from 62% in 2015 to 81% in 2017; viral suppression rates among those on treatment increased from 84% in 2015 to 89% in 2017.

Excellent results are achieved among children, but it also should be mentioned number of children living with HIV is very low in Georgia (estimated 45 children <15 years), indicating the effectiveness of national effort towards elimination of mother to child transmission of HIV.

Table 1 PMTCT Data

	2015	2016	2017
Number of HIV positive pregnant women on ART	39	45	55
Number of infants who received an HIV test within two months of birth	40	45	51
Number of infants, who tested positive for HIV	1	0	0

Source: National AIDS Center

Nevertheless, the significant gap in HIV case detection undermines accomplishments in treatment provision and on a population level only 35% of PLHIV are virally suppressed, which is not sufficient to derive maximum individual and public health benefits of ART.

Management of co-infections

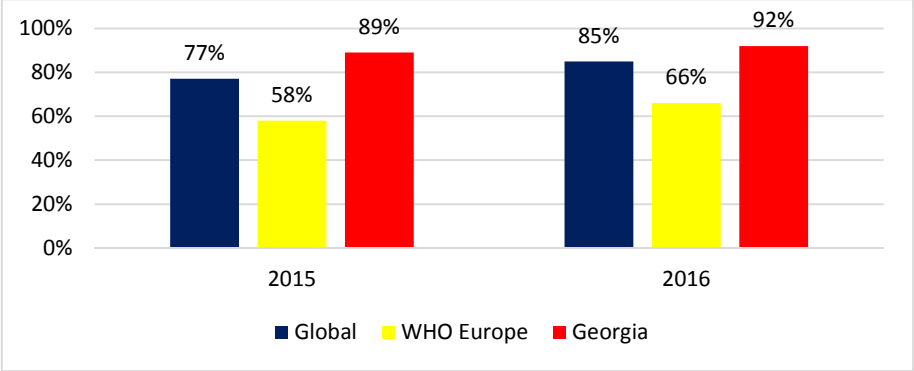
Tuberculosis

[33] Estimated number of PLWH was recently validated by UNAIDS in the process of SPECTRUM update.

The critical part of HIV treatment and care service delivery is the management of co-infections, particularly of tuberculosis and HCV infection, which are two major causes of death among PLHIV in Georgia.[34]

There is active collaboration between TB and HIV services ensuring effective implementation of collaborative HIV/TB activities, including HIV screening of all persons with active TB disease, TB case finding among HIV positive persons and provision of treatment for both diseases. The prevalence of HIV among TB patients remained low – below 5% at all time points over the last decade. Prevalence of TB among newly diagnosed PLHIV is around 5-7%, and in the vast majority of cases TB is diagnosed first, and then HIV positive status is determined. Many of the TB/HIV co-infected patients already have deteriorated immune system, and most likely TB co-infection is the result of late HIV diagnosis. That is why TB is the major cause of death in HIV persons despite the universal availability of treatment for both diseases. Estimates of TB/HIV treatment coverage is over 90% and significantly exceed global and European coverage[35, 36,37].

Figure 6 Proportion of People with TB/HIV Receiving Treatment for Both Diseases



Hepatitis C

Estimated 34% of people living with HIV are co-infected with hepatitis C. It is important to underscore that HCV care is fully integrated within HIV care facilitating high uptake of HCV treatment among HIV/HCV co-infected persons.

Georgia was the first country in the region to ensure universal access to free hepatitis C treatment for HIV/HCV co-infected persons. It started in 2011 within the Global Fund-supported program, and since 2015 has been continued within the national hepatitis C program. From 2011 through 2017, a total of 1104 HIV/HCV co-infected persons were treated for HCV (420 persons with dual therapy in 2011-2015; 684 with direct-acting antivirals in 2015-2017) representing 71% of the co-infected population. Enrollment of PLHIV in HCV treatment program continues with an overall goal of curing HCV in all persons with known HIV/HCV co-infection.

[34] Chkhartishvili N, Sharvadze L, Chokoshvili O et al. Mortality and causes of death among HIV-infected individuals in the country of Georgia: 1989-2012. *AIDS Res Hum Retroviruses*. 2014;30:560-6.
[35] World Health Organization. World Tuberculosis Report 2016. Geneva: WHO; 2016.
[36] World Health Organization. Global Tuberculosis Report 2017. Geneva: WHO; 2017.
[37] World Health Organization. Tuberculosis country profiles (http://www.who.int/tb/country/data/profiles/en/). 2018 vol; 2018

ART treatment, care, retention and mortality

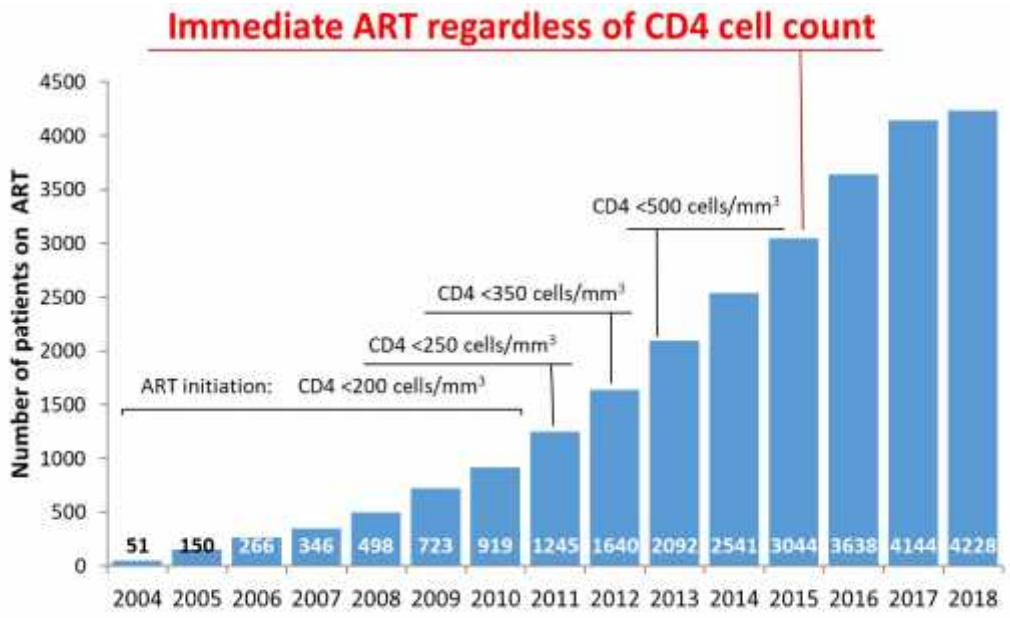
ART treatment and care activities include provision of free outpatient and inpatient services, adherence support and monitoring, palliative care services for chronically ill patients and community-based peer support services. Services are provided at 5 locations countrywide – Tbilisi, Kutaisi, Batumi, Zugdidi and Sokhumi. Infectious diseases, AIDS and Clinical Immunology Research Center (National AIDS Center) provides overall coordination of treatment and care services on national level.

AIDS treatment Center in the capital of occupied region of Abkhazia – Sokhumi has been providing services since 2008 with the active involvement of Zurab Danelia Union "Tanadgoma". Service provision in Abkhazia is supported by the National HIV/AIDS Management Program and the Global Fund project. This support includes provision of antiretroviral drugs, laboratory test-systems for CD4 cell count, and basic program administration costs.

Altogether, these services ensure better quality of life and improved survival of PLHIV. Mortality analysis indicates that among persons with HIV mortality peaked in 2004 with 11 deaths per 100 person-years of observation, which decreased to 2 deaths per 100 person-years in 2017. On a country level AIDS-related mortality was 2.5 deaths per 100,000 population in 2016 and declined to 1.9/100,000 death in 2017. It should be noted that the national census of 2015 resulted in reduction in estimate of the total population of Georgia from 4.4 million to 3.7 million, and this affected calculation of population level mortality.

Number of persons starting ART has been increasing literally on a daily basis. As of end of February 2018 a total of 4228 persons were on treatment (Figure 7), including 482 persons receiving treatment in the occupied region of Abkhazia.

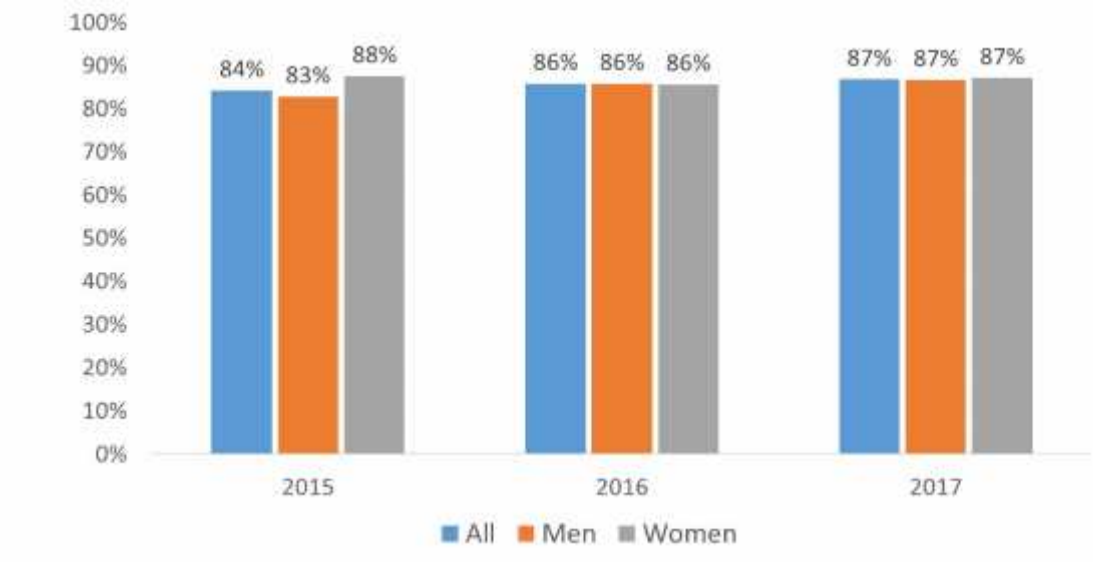
Figure 7 ART initiation criteria and number of persons on treatment



Country is on the path to meet 12-months ART retention target of 90% by 2018. Latest data for 2017 show that 87% of persons on ART have been retained on treatment, with men and women showing virtually identical retention (

Figure 8). More in depth analysis shows that up to 40% of attrition is due to mortality, which primarily occurs within 6 months of diagnosis as a result of late presentation[38].

Figure 8 Retention on ART at 12 months



2. HIV/AIDS National Response – General Approach, Goal, and Strategic Objectives

Georgia has achieved significant progress in several directions in the fight against HIV/AIDS, especially in treatment outcomes, but timely detection and early enrollment in treatment program remain a challenge. It is strategically essential to increase the coverage by preventive services and scale up testing among representatives of key populations and their sexual partners. With decreasing financial support from TGF, it is vital that Government gradually takes financial responsibility to cover activities previously funded by TGF. This will also require close collaboration with non-governmental actors that have been implementing HIV prevention activities for almost two decades.

Despite efforts, coverage with preventive services and testing uptake remains to be a serious challenge for HIV/AIDS National response in Georgia. According to latest epidemiological data, MSM and PWID remain to be the most vulnerable groups with the highest prevalence of HIV. Considering

[38] Chkhartishvili N, Chokoshvili O, Bolokadze N et al. Late presentation of HIV infection in the country of Georgia: 2012-2015. *PLoS One*. 2017;12:e0186835.

the situation with the late diagnosis in Georgia, as well as high HIV prevalence among MSM, testing uptake among these populations shall increase dramatically to improve identification of cases.

HIV prevention among PWIDs is one of the priority objectives of the National HIV Strategy which declares the importance of highly cost-effective evidence-based Harm Reduction (HR) interventions, namely Needle and Syringe Program (NSP)[39] also, Opioid Substitution Treatment (OST) Program, to control HIV epidemic in Georgia. Implementation of harm reduction interventions started in 2005, and since then, despite the strict anti-drug policy, harm reduction services have been expanded considerably in terms of both, the scope and the scale. Since 2016 the Government entirely has taken over the funding for OST program and co-financing requirements for beneficiaries of state program were removed. This has allowed more beneficiaries to access the OST services.

According to the programmatic data, coverage with preventive services among PWID has increased from 17% in 2012 to 57% in 2016. However, program coverage measured through Bio-BSS was considerably lower - 23.3% in 2016. Such difference may be caused by the reporting system that allowed duplication of beneficiaries in the system. The reporting system has changed in 2017, and now clients can only be registered once in the system, using the unique identifier. It is expected that two sources of information will become closer after the change mentioned above, and it will be easier to assess the situation in this group.

NGOs including CBO's are providing preventive services since the first TGF grant was launched in 2002 in Georgia. One of the latest achievements in this term is the introduction of PrEP for MSM, through engagement of community-based organization. However, uptake is still low and substantial work will be needed to increase awareness of PrEP among MSM to generate demand for the service among at-risk groups and increase enrollment in PrEP.

Transition Plan developed and approved by Country Coordination Mechanism in 2016, calls for scaled-up smooth transitioning from the Global Fund financing to full domestic financing of the National HIV/AIDS and TB Programs by 2022. This timing coincides with the timeframe of new National Strategic Plan, which allows the integration of those two documents.

The **overarching goal** of 2019-2022 National Strategic Plan is to reverse HIV epidemic in Georgia, through sustainable, targeted interventions for key populations and their sexual partners, improvement of the quality of the services, and outcomes of the treatment.

To achieve this goal, NSP emphasizes on following three strategic objectives:

1. HIV Prevention and Detection: Scale-up of preventive services to ensure timely detection and progression to care;
2. HIV Treatment and Care: Improve HIV health outcomes through ensuring universal access to quality treatment, care, and support;
3. Governance and Policy development: Ensure sustainability of response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society.

These strategic objectives are the same as in previous National Plan, as well as the majority of activities proposed, as the primary challenge remains the same, timely detection and progression to care. The new activities proposed mainly aim at expanding the coverage of KP's with preventive services and testing, and making services more comprehensive and attractive.

[39] Evaluation cost-effectiveness of needle and syringe program in Georgia, UNAIDS, 2011 http://altgeorgia.ge/2012/myfiles/UNAIDS_reporrt_eng.pdf

Expected significant impact and outcome targets by the end of 2022:

1. Increased funding for HIV response from state budget from 76% in 2018 to 96% by the end of 2022.
2. By the end of 2022, HIV prevalence among the general population is contained under 500 per 100,000 population
3. By the end of 2022, HIV prevalence among MSM is contained under 25%
4. By the end of 2022, HIV prevalence among SWs is contained under 2%
5. By the end of 2022, HIV prevalence among PWIDs is contained under 3%
6. The rate of late HIV detection (<350 cells/mm^3) is reduced from 51% in 2017 to 30% by 2022
7. By the end of 2022 AIDS-related mortality is contained below 2 deaths per 100,000

2.1 HIV Prevention and Detection: Achievements and Remaining Challenges

To increase the coverage with preventive activities, 2019 – 2022 NSP proposes to make them more attractive through expansion of services offered. For instance, adding vaccination/treatment of Hep C and Hep B to HIV case management protocol gives the opportunity to get multiple services at one point, that will decrease the travel time and cost associated to it. As mentioned earlier, Georgia is providing free Hep C treatment program for entire population. This is a great opportunity to integrate HIV testing into existing program and expand HIV testing uptake. Currently, this approach is being tested in several regions of the country. Most likely this model will prove to be effective, and integration will be expanded to the entire country.

Provision of legal and psycho-social assistance, adding vaccination/treatment of Hep C/B to HIV case management protocol, adding HIV testing to Hep C screening standards - all are envisioned to expand the coverage.

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 test 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 the PIT will continue to focus on drug treatment facilities, STI and TB clinics, and antenatal care facilities, with the intention to expand indicator disease-guided HIV testing and counseling in the health sector, including in primary health care. HIV testing efforts will be expanded in people living with HCV through establishing linkages with national hepatitis C program. The developed PIT standards will be refined, endorsed by relevant state authorities and rolled-out through in-service training program involving personnel of the mentioned facilities.

NSP proposes to develop and launch effective behaviour change communication and counselling services for all KP's, including YKP's[40]. Improvement of quality of VCT services provided might also contribute to scaling up testing services. Introduction of self-testing and saliva testing might expand

[40] http://eeca.unfpa.org/en/publications/health-rights-and-well-being

HIV-testing uptake. Georgia has to implement the system of reporting in case of self-testing so that positive cases are not lost to follow up.

Service coverage indicators				
Key populations	**2019**	**2020**	**2021**	**2022**
Percentage of People living with HIV who know their status	70%	90%	90%	90%
PWIDs coverage with services	65%	70%	75%	75%
PWIDs testing for HIV	60%	65%	70%	70%
Number of PWIDS receiving OST	9,500	11,000	11,000	11,000
MSM coverage with services	40%	50%	55%	60%
MSM testing for HIV	30%	40%	45%	50%
SWs coverage with services	55%	60%	60%	60%
SWs testing for HIV	45%	50%	55%	60%
Prisoners tested for HIV	65%	70%	75%	75%

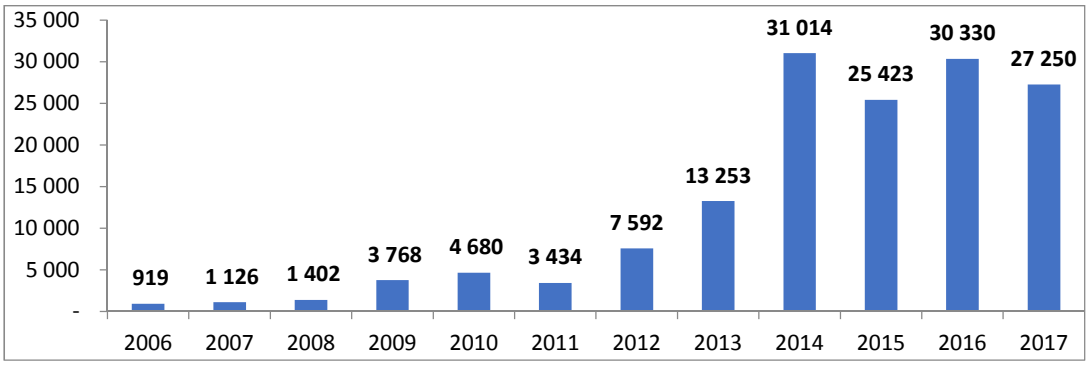
***** *The reason for the downgrade in the coverage indicators is that we corrected the indicator to make it more valid measurement for service coverage and to align the indicator with that commonly used. Namely, through the consultation with stakeholders, it was discovered that coverage indicator in the previous NSP was 'cumulative' for the last three years (meaning all persons covered with services during last three-year period were included in the calculation). Given that we aim at increasing coverage every year, we corrected the method of measurement; recalculated the baselines and set new targets. Measurement frequency for this indicator is yearly. Furthermore, the GAM 2018 indicators suggest having the coverage indicator calculated even for shorter time-period – coverage during last three months vs. last year. Given that we have not had baseline for newly proposed indicator, we decided to have both versions – coverage for last year + coverage for three months. This approach will allow us to monitor the progress against existing baselines, as well as to establish new baseline data for three-month coverage indicator.*

2.1.1. Prevention of HIV transmission, detection of HIV, timely progression to care and treatment among the key affected populations

2.1.1.1 Prevention and detection of HIV among PWID

Since 2013, the coverage of PWID with preventive services has been increasing compeer to previous years, but this increase is not firm, it varied between 25,000 to 31,014. This increase is attributed to four new harm reduction sites that were added in 2013 and peer driven activities initiated and scaled up. The introduction of mobile laboratory services run by Georgia Harm Reduction Network (GHRN) has also contributed to the increase of coverage (Figure 9).

Figure 9 Coverage of PWIDs with preventive services (2006 - 2017)(2 services, among them one is syringe)[41]



According to the GHRN, majority clients visiting service sites are keen to get tested for HIV and/or Hep C. However, coverage of female drug users remains to be most challenging for harm reduction programs. To attract female clients, GHRN is running sewing and knitting courses; in addition, GHRN recruited female outreach workers, and made case management component gender sensitive. It should be noted that once a week, the HR centers located in Tbilisi have introduced a dedicated day for female clients, when beyond the traditional harm reduction services, female drug users are offered reproductive health services and products of hygiene and personal care.

To diversify the service package targeting PWIDs, mental health services will be offered to beneficiaries of harm reduction programs. Substantial efforts will be made to further promote OST program through strengthening psychosocial support for OST clients, accommodating specific needs of women, and introducing long-term OST in penitentiary institutions. For women, adolescents and young people who inject drugs, reproductive health services will be offered at service points.

Peer support programs proved to be effective in reaching out to drug users in Georgia. With the purpose to improve efficacy of peer-driven interventions and optimize HIV case finding, peers will be incentivized for every positive case identified with their support and involvement.

Georgia strives to employ innovative strategies to scale-up coverage of PWIDs and other vulnerable groups with prevention services. One of the innovations might be the introduction of Syringe Vending Machines (SVM) in Georgia that proved to be an effective mode of HR service delivery, which should be a complementary strategy to standard, fixed office-based NSP services. Implementation study about feasibility and operation of SVMs in Tbilisi is being implemented by local NGO – Addiction Research Center Alternative Georgia with financial support from 5% Initiative and in partnership with existing TGF HIV grant. SVMs provide uninterrupted 24/7 access to sterile injection equipment, condoms, and HIV self-test not only those who might be in contact with regular HIV prevention services, but also those who are reluctant to visit such services due to stigma. It is expected that most hidden groups who do not self-identify themselves as injecting drug users or MSM (due to self-denial), or women who suffer double stigma from the society might be attracted to seek HIV prevention materials/commodities in a safe and private environment through accessing vending machines.

Ongoing SVM implementation study in Tbilisi is expected to provide useful data on both - the implementation process and intervention outcomes in Georgian context. Based on favorable results of the study, the country will start scaling up the services to other regions to facilitate early detection and linkage to HIV treatment and care for these groups.

[41] Georgia Harm Reduction Network Programmatic Data

PWID Preventive Services

1. Increase coverage of preventive services
   i. Behavior change communication and counseling services
   ii. VCT
   iii. Introduction of self-testing (Saliva testing)
   iv. TB screening questionnaire for TB diagnostics and referral for treatment
2. Legal Assistance
3. Psycho-social assistance
4. Expansion of OST services
5. Adding vaccination/treatment of Hep C/B to HIV case management protocol
6. Adding HIV testing to Hep C screening standards
7. Peer support programs:
   i. Optimized case finding – incentives provided for every new HIV positive
8. Prevention and treatment of overdose
9. Reproductive health programs, especially programs for adolescent and young people who inject drugs
10. The inclusion of mental health services in prevention/harm reduction programs
11. Introduction of PrEP

2.1.1.2 Prevention and detection of HIV among MSM

Coverage with preventive services and testing has increased among MSM population (see

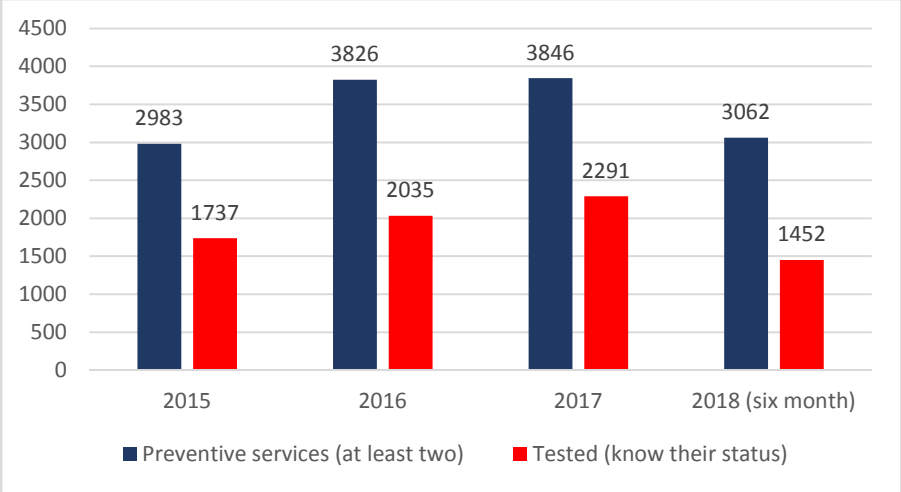
Figure 10). This is the result of substantial changes that prevention package targeting MSM has undergone. First of all, starting from 2016 several interventions were gradually added to the package: Peer Driven Interventions and informational-educational meetings, community mobilization events etc. Outreach activities were conducted in club's as well (in addition to streets and other gathering venues').

During 2017 and 2018 geographical coverage has been expanded through adding new points in the cities were programs were running. This required additional human resources and they were selected from MSM community.

Level of knowledge concerning HIV infection among MSM is high and has further improved over the last years, but this has not influenced personal risk perception among MSM, as well as behaviour trends. As latest IBSS survey revealed[42], MSM population is characterized by risky sexual behavior with a large number of different partners, both male and female. More than half of surveyed MSM reported having a female partner during the last 12 months. They also report the inconsistent use of condoms, especially with permanent partners (both male and female), as well as involvement in group sexual practices often without condoms.

Figure 10 Number of MSM reached by Preventive Services (at least two services) and tested

[42] Population Size Estimation of Men Who Have Sex with Men in Georgia, 2014; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://www.georgia-ccm.ge/wp-content/uploads/MSM-PSE-09.12.2014_Geo.pdf



Introduction of PrEP was piloted for MSM population within the frame of current TGF grant in Georgia. Uptake of services was still low at the moment of NSP development. NSP calls for introduction of PrEP and PEP, not only for MSM but PWID and SW as well. To expand the availability of PrEP and PEP, it is proposed to make them available not only at clinical settings but also at community level and prevention service points.

To design the most effective and comprehensive HIV and STI Programs for MSM, the implementation tool (MSMIT) developed by WHO/UNFPA/ UNAIDS/ NSWP/World Bank/UNDP[43] will be used. Transgender population shall be paid special attention while implementing MSM-targeted prevention information, applying Comprehensive HIV and STI Programs with Transgender People (TRANSIT) tool, developed by WHO/UNFPA/ UNAIDS/ RGT/UNDP/USAID/PEPFAR.[44]

There is no research-based evidence about needs of migrant MSM. However, community and service provider organizations report that the number of migrant MSM referring to the prevention and treatment services is increasing. In some cases migrants do not have access to treatment, especially those not having residence permit – so-called short-term visitors. Considering that some of them are involved in commercial sex and/or have multiple sexual partners, it is important to facilitate their access to HIV prevention, treatment and care services.

Special attention should be paid to stigma and discrimination against MSM and Transgender population in Georgia. Crimes committed based on sexual orientation and gender identity have become systematic driving them underground. Marginalization and discrimination of MSM and transgender individuals have negative impact on their health-seeking behaviors. Advocacy should be strengthened to support conducive legal environment for sexual minority groups.

The crucial factors for increasing coverage include, but are not limited to the following: increasing and strengthening human resources; expansion services to various geographical areas; diversification of the service package to envisage the interventions that meet specific needs of MSM and transgender population; improved coordination and joint efforts of medical service providers and community organizations, piloting of self-testing;

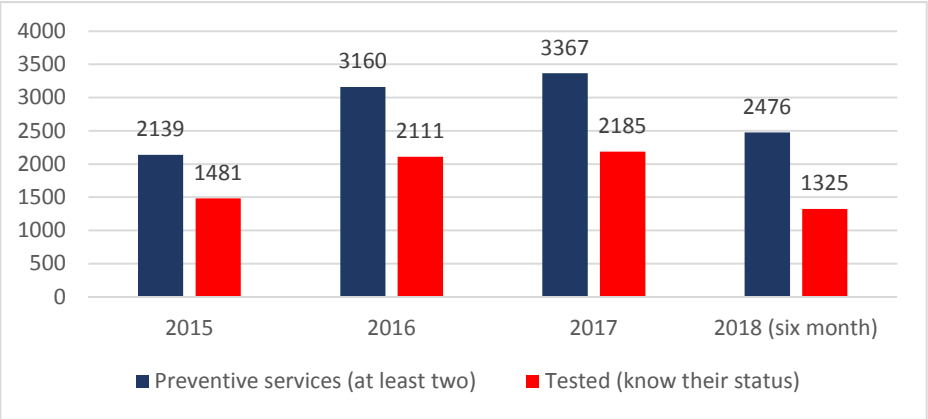
MSM Preventive Services

1. Increase coverage of preventive services
   I. Explore the need for geographical expansion of preventive services
   II. Increase testing coverage
   III. Introduction of self-testing (saliva testing)
   IV. Increase access to condoms and lubricants
   V. Behavior change communication and counseling services (especially for those who are having sexual contact both with men and women, transgender population)
4. Activities against violence and improve referral services
5. Implementation of self-testing based on newly developed protocol according to WHO recommendations
6. Improve access for MSM to Post Exposure Prophylaxis (make PEP available at community level/service points);
7. Improve access to mental health services
8. PrEP expansion

2.1.1.3 Prevention and detection of HIV SW's

Comparing years 2015, 2016, 2017 and 2018, the service packages targeting sex workers have evolved and expanded both in scope as well as in scale. First, in 2016, Peer Driven Interventions were added to the package. Later, in 2017 the approach of these Peer Interventions was modified and adapted to the local context based on the gained experience. Also, in 2017 geographic area of outreach activities was enlarged and, the most important element, number of teams of outreach workers was increased (in 5 cities that the program runs in: from five to nine teams each consisting of 2 social workers). The NGO working on HIV prevention among sex workers deems that increase in the human resources for this component was crucial for increasing coverage (see Figure 11) both programmatically and geographically.

Figure 11 Number of SW reached by preventive services (at least two services) and tested (know their status)



Despite substantial prevention work focusing on sex workers, HIV awareness has remained stably low since the first Bio-BSS was conducted among SWs a decade ago. While they are aware of sexual transmission of HIV, it is challenging to break stereotypes, and debunk the myths and misconceptions about the virus. Efforts will continue to improve HIV awareness and promote safe sex practices with regular partners and clients. This is particularly important as latest Bio-BSS shows that sex workers are more likely to use non-injecting drugs that might adversely influence safe sex practices among SWs.

Prevention service package targeting sex workers will also include counselling on contraception methods, safe abortion, cervical cancer screening, and conception and pregnancy. It is expected that offering additional services will make the package more attractive for beneficiaries, especially for young sex workers (YKPs).

To design the most effective and targeted programs the implementation tool (SWIT) offering practical guidance on effective HIV and STI programs for sex workers will be used[45].

Stigma and discrimination, e.g., verbal assaults and humiliation, are widespread phenomena faced by sex workers. At the same time, trust towards law enforcement is very low, and there is no expectation that police would react adequately to various rights violations of sex workers. This shall also be addressed in combination with the prevention programs, and specific activities, such as sensitization of police personnel shall be conducted throughout the country.

SW's Preventive Services

1. Increase coverage of preventive services
   I. Behavior change communication and counseling services
   II. Increase VCT and introduction of self-testing (saliva testing)
   III. TB screening questionnaire for TB diagnostics and referral for treatment
2. Increase access to condoms and lubricants
3. Add Reproductive health services to existing service package (FP/safe abortion consultation and referral to Ob/Gyn)
4. Sustain STI diagnostic and treatment services
5. Activities against violence and improve referral services
6. Improve access to mental health services
7. Improve access for SW to Post Exposure Prophylaxis (make PEP available at community level/service points);
8. PrEP introduction (make PrEP available at community level/service points);

HIV uptake among prisoners has remained suboptimal over the last 3-4 years.

As for imprisonment related to the drug use, it has also decreased from 4.6% in 2015, to – 0.9% in 2017. Overall, the Penitentiary Department states in its annual report of 2017 that numbers of acquittal sentences have increased by 3.6% compared to 2016. It is obvious that less drug users are imprisoned, especially from 2017. This factor could be somehow linked to decrease in the number of prisoners that are undertaking HIV test.

Prison VCT sites will continue HIV awareness raising individual and group counseling, and will promote HIV testing among prisoners.

Different approaches that can reduce risks of HIV transmission inside penitentiary institutions should be considered and implemented if necessary. First, PrEP will be available for those prisoners who express willingness to start it. After-release programs will continue working with prisoners with the history of illicit drug use to increase their awareness about drug tolerance and overdoses. Besides, psychosocial rehabilitation programs already implemented by the Penitentiary Department will continue referring prisoners to HIV prevention program as appropriate.

Prisoners Preventive Services

1. Increase coverage of preventive services
   a. Behavior change communication and counseling services
2. Increase access to condoms and lubricants
3. Increase access to harm reduction services
4. OST
5. PrEP expansion

[45] http://ww

2.1.2 Prevention and detection of HIV in healthcare settings

HIV indicator condition guided testing is fully covered by the national HIV testing program, which involves 12 healthcare institutions countrywide, including 5 specialty infectious diseases clinics (including national and regional AIDS Centers), 2 general hospitals and 5 primary healthcare clinics. Program provides testing services based on both presence of clinical condition (e.g. viral hepatitis, AIDS defining illnesses, etc.) and risk behavior. The number of people tested within program has been slowly increasing over the last 3 years from 19500 in 2015 to 30275 in 2017. Despite the small scale of the program, it proved highly effective diagnosing 1159 HIV infections in 2015-2017, which is 56% of all new diagnoses made during this period.

Efforts are made to expand PIT. Namely, starting from 2018 all persons diagnosed with hepatitis C, are offered HIV testing at all HCV treatment sites engaged in implementation of national hepatitis C elimination program.

Pilot program of routine HIV screening in 15 primary health care centers of the capital city of Tbilisi is about to launch in the second half of 2018. This pilot program will evaluate feasibility and effectiveness of routine HIV screening in primary care settings, and will identify the most optimal model for service delivery.

The NSP builds upon this experience and plans for expansion of PIT in 3 directions:

1. Enhancing existing design: the program plans for expanding provider initiated testing for self-referred patients, as well patients presented with clinical signs through expanding provider network (e.g. contracting STI clinics);
2. Expanding screening to Primary Care facilities: in order to increase the role of primary healthcare in detection and management of important infection diseases; this will be done jointly with HCV and TB screening offered at PHC level (target population 300 000); individuals will be screened voluntarily;
3. Expanding PIT on hospitalized patients: current national standard practice is to screen surgical patients for HIV (as well as for other blood borne infections). The NSP envisages screening all hospitalized patients for HIV.

In order to accelerate HIV detection in general population some additional novel HIV diagnostic strategies may be tested, including self-testing via pharmacies.

EMTCT

To achieve the elimination of HIV and syphilis transmission from mother to child by 2020, comprehensive set of interventions will be implemented: improvement of coordination among various programs; introduction of integrated approaches; timely detection of HIV and syphilis cases in pregnant women; universal treatment for both diseases; introduction of modern approaches of laboratory diagnostics; strengthened surveillance of elimination processes, development of M&E system for validation of EMTCT by WHO. Throughout September-October, 2017, National Center for Disease Control and Public Health in collaboration with the MoLHSA evaluated the readiness for Elimination of HIV and syphilis transmission from mother to child in Georgia with the means of WHO

validation of elimination questionnaire. According to the National Strategy[46], a National Committee of Elimination of HIV and syphilis transmission from mother to child was established.

Georgia has the ambition to declare the elimination of vertical transmission cases; during 2016 and 2017 no HIV cases have been detected among babies born to HIV positive mothers. MoLHSA has developed and approved the Maternal and Child Care Strategy, which provides details about EMTCT activities and national targets. Thus, EMTCT interventions are not part of the HIV NSP.

Safe Blood

Safe Blood Program was initiated in 1997 in Georgia to ensure the safety of blood and blood components through high-quality testing of donor blood for HCV, HBV, HIV, and syphilis and increasing the proportion of voluntary, non-remunerated donations. Currently, 22 blood establishments are licensed to collect and process blood and blood components in Georgia, but only 15 blood banks participate in the State Safe Blood Program. External laboratory quality control system is in place in all establishments.

Based on screening data of 2015-2017, the number of blood donors has gradually increased; while HIV prevalence among donor population remains low (0.04% in 2015; 0.02% in 2017).

The Blood Safety is one of the priority requirements for Georgia's EU Association Agenda to comply with the regulatory framework of EU (Directive 2002/98/EC). With support of EU, the MoLHSA and NCDC are currently working on elaboration of the new National Blood Safety Strategy, which will be finalized by the end of 2018.

Hepatitis C

In April 2015, Georgia launched hepatitis C elimination program by making the new curative treatment available to people infected with hepatitis C virus (HCV). Georgia has developed Hep C elimination strategy[47]; prepared a comprehensive elimination plan that includes advocacy and communication, surveillance (including high-quality diagnostics) and prevention (e.g., infection control, blood safety, and harm reduction). Additionally, the Ministry has begun broader HCV control activities, including a campaign to raise awareness, provision of free HCV testing, and improve infection control practices. Integration of Hep C testing program with HIV testing is currently being pilot-tested in two regions of Georgia. All persons who test positive on hepatitis are offered HIV testing as well. It is expected, that the pilot will be replicated throughout the country.

The expected outcome of prevention interventions

- By the end of 2020, 90% of people living with HIV know their status
- The number of sterile syringe and needles distributed per PWID per year is increased from 110 to 140 by the end of 2022
- The number of MSM on PrEP is increased from 50 in 2017 to 1,000 MSM
- More than 90% of SWs are reporting the use of a condom with their most recent client
- One hundred percent of blood units are screened for HIV in a quality assured mannered

[46] The Minister of Labour, Health and Social Affairs, The order N 01-137/o, July 7, 2017

[47] STRATEGIC PLAN FOR THE ELIMINATION OF HEPATITIS C VIRUS IN GEORGIA, 2016-2020. http://www.moh.gov.ge/uploads/files/2017/akordeoni/failebi/Georgia_HCV_Elimination_Strategy_2016-2020.pdf

2.2 HIV Treatment and Care: Achievements and Remaining Challenges

While detection remains a challenge, the country has achieved remarkable progress on the right side of cascade: Georgia is approaching fast-track targets for ART and viral suppression. ART coverage among diagnosed persons increased from 62% in 2015 to 81% in 2017. Viral suppression rates among those on treatment increased from 84% in 2015 to 50 89% in 2017. Provider-initiated HIV testing and counseling services cover patients with active TB, and almost 93% of them has been tested for HIV during last two years. The country is on the path to meet 12 month ART retention target of 90% by the end of 2018.

Stratification by age and gender shows that women have better detection rates and have already achieved fast-track targets for ART and viral suppression (93% ART coverage of diagnosed persons, and 91% of those on ART reaching viral suppression). While 89% of men on ART had viral suppression, only 77% of diagnosed men were on treatment.

Georgia was the first country in the region to ensure universal access to free hepatitis C treatment for HIV/HCV co-infected persons. It started in 2011 within the Global Fund-supported program and from 2015 continued within the national hepatitis C program. From 2011 through 2017, a total of 1104 HIV/HCV co-infected persons were treated for HCV (420 persons with dual therapy in 2011-2015; 684 with direct-acting antivirals in 2015-2017) representing 71% of the co-infected population. Enrollment of PLHIV in HCV treatment program continues with an overall goal of curing HCV in all persons with known HIV/HCV co-infection.

Adherence support and promotion include clinic-based services provided to all persons picking-up antiretroviral drugs, as well as out-of-clinic/home support delivered by dedicated adherence mobile units. The latter service was established in 2008, providing services to persons registered with one of the AIDS centers in Tbilisi, Kutaisi, Batumi, and Zugdidi. Mobile units provide adherence monitoring and support on average to 220 persons on a monthly basis.

The palliative care service provision for PLHIV in Georgia was established in 2008 and since then has been led by the Georgian National Association of Palliative Care. The program delivers home-based services through the 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. The program has been providing care to up to 35 patients on a monthly basis.

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. HIV/AIDS Patients Support Foundation implements community services providing up to 10,000 consultations to PLHIV and their family members/caregivers annually.

The primary challenge is that all outpatient care and support activities, that among others, include adherence promotion and support services, home-based palliative care for chronically ill persons and community-based self-support services, are entirely supported by donor funding;

Nevertheless, the significant gap in the diagnosis stage undermines accomplishments in treatment provision, and on a population level, only 35% of PLHIV are virally suppressed, which is not sufficient to derive maximum individual and public health benefits of ART.

Activities suggested for Strategic Objective 2:

1. Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)
    I. Out-patient medical care
    II. In-patient medical care
    III. Laboratory monitoring (CD4 cell count, viral load, drug resistance testing)

Provision of HIV clinical services in Georgia is governed by the national guidelines, which outline key clinical services to be provided to PLHIV, including antiretroviral therapy (ART), treatment monitoring; prevention and treatment of co-infections, AIDS- and non-AIDS related co-morbidities and opportunistic infections. Services are provided through outpatient and inpatient care, and include various laboratory tests, instrumental and imaging examinations, medications, physician's consultations, etc. per the national guidelines.

2. Provide ART to all PLHIV following existing guidelines (including in the region of Abkhazia)
    I. Procure first, second and third-line ARV drugs
    II. Provide clinic based adherence monitoring and support
    III. Provide home-based adherence support

3. Ensure effective program administration and quality of service delivery
    I. Ensure effective program delivery (including in the region of Abkhazia)
    II. Maintain operation of National AIDS Health Information System (HIV/AIDS database) and implement other M&E activities
    III. Implement operational research to inform service delivery
    IV. Ensure quality of service delivery:
        a) Update and develop clinical practice guidelines
        b) Implement quality control/clinical audit for clinical care and ART
        c) Implement quality control for laboratory services
        d) Support human capacity strengthening through continued medical education, including participation in international meetings

4. Ensure necessary investments in the infrastructure
    I. Develop adequate physical infrastructure of the National AIDS Center, including building and equipment

5. Reduce morbidity and mortality due to co-infections with TB and viral hepatitis
    I. Ensure provision of HIV/TB collaborative activities
    II. Provide treatment for hepatitis C
    III. Provide prevention and treatment for hepatitis B

6. Provide care and support services for PLHIV
    I. Ensure operation of peer-support services
    II. Improve access to general health care through community-based case management and education
    III. Provide palliative care for chronically ill patients.

Expected outcomes of effective delivery of HIV treatment and care services:

- By the end of 2020, 90% of adults and children with HIV are receiving ARV
- By the end of 2020, the percentage of people on ART tested for viral load (VL) with VL level <1000 copies/ml is 90%

2.3 Governance and Leadership: Achievements and Remaining Challenges

Population's health is one of the priorities declared by the GoG. This is reflected in the governing documents and supported by the 2.5-time increase in state healthcare budget for the years 2012-2016. The share of the healthcare expenses in the total public expenditures and the total amount of healthcare spending are increasing. Implementation of the Universal Healthcare Program and C Hepatitis Elimination Program and approval of the National HIV/AIDS and TB Strategic Plans are only some of those many activities that demonstrate the GoG commitment towards improving the health status of the population.

It should also be noted that continuation of repressive drug policy can considerably hinder implementation of an effective national HIV/AIDS response. There are no legal documents issued by the Ministry of Health about the needle and syringe programs; therefore, the Georgian Harm Reduction Network (GHRN) implements this program without any legal basis. Despite the process that has started in the country with the establishment of multi-sectoral Government commission chaired by Minister of Justice and active support of drug policy liberalization by Chair of the Parliament Committee on Health and Social Issues, no considerable change has been introduced so far. Besides the barriers to the expansion of preventive programs, this creates additional tensions in society and contributes to further stigmatization of drug users. Therefore, this problem must be addressed through the policy liberalization before the Global Fund financing is halted.

Civil society organizations have specific competences which should be used by the National Programs to combat HIV/AIDS, such as reaching out to vulnerable populations, mobilizing communities, channeling information and framing effective service delivery models. The Government of Georgia also recognizes the need of involvement of non-state actors for the success of the nationwide HIV/AIDS response and strengthening the partnerships with the civil society establishments. Georgia country report on Transition from the Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries [48] identifies that while the general regulation allowing social contracting by the GoG exists in Georgia, yet the detailed rules and procedures for contracting CSOs for health services delivery do not exist. Furthermore, there is an evidence that the GoG already has been contracting NGO's to provide both social and health services using public funds, however it has not been used for HIV prevention.

The 2016 – 2018 HIV/AIDS NSP highlighted the importance of a greater involvement of civil society (NGOs, CBOs, etc.) and key affected populations in the development and delivery of essential HIV services [49] but the NSP has not addressed the policy and regulatory gaps for social contracting that will be essential for channeling state funds to civil society organizations for HIV prevention services. The challenges to social contracting mechanism in Georgia have been identified in the TPA report[50] and addressing these challenges has emerged as one of the recommendations to ensure smooth transition from TGF funding to state ownership. This recommendation has been partially reflected in the TGF HIV grant, which alongside other regulatory changes will implement activities aiming at developing an effective platform for state funding for HIV prevention services among KAPs.

[48] Transition from the Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries. Georgia Country Report. Curatio International Foundation

[49] The Georgian National HIV/AIDS Strategic Plan for 2016-2018. p. 18

[50] Transition from the Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries. Georgia Country Report. Curatio International Foundation

Capacity building of community-based organizations in financial management, procurement rules and regulations still has to be conducted. Current NSP calls for an assessment of feasibility of establishing social contracting mechanism in Georgia. NSP calls for provision of support for NGO advocacy efforts to negotiate with government regarding the issue of social contracting. This is proposed to be done through facilitated discussions and consensus building workshops.

Stigma and discrimination associated with specific behaviors remain to be a challenge for Georgia, despite the anti-discrimination law passed in 2014, which bans all forms of discrimination based on religion, ethnicity, or sexual orientation. The country also has adopted the strategy against violence which focuses mostly on domestic violence, but it contains a section related to discrimination towards people with addictions. Moreover, the powerful Georgian Orthodox Church creates barriers to the application of such documents by direct or indirect opposition via faith community.

1. Create the conducive legal environment to ensure smooth implementation of HIV national response and achieve greater engagement of civil society

    I. Increase Coordination among critical players, relevant government bodies, Parliamentary committees, civil society, the National Platform on Drug Policy Reform
    II. Monitor and foster policy interventions to remove the legislative barriers for access to HIV Prevention and harm reduction services in civil and penitentiary sectors
    III. Support development and enforcement of the Four-pillar Drug Policy, Anti-Drug Strategy, and Action Plan

2. Create enabling environment for CSO engagement in HIV national response

    i. Assess feasibility of establishing a social contracting mechanism in Georgia
    ii. Build Capacity for CSOs/CBOs, their networks, and coalitions – through training and technical assistance in management, resource mobilization for CSOs/CBOs to satisfy the state procurement requirements.

3. Ensure full budgetary commitment and allocative efficiency for national HIV response

    I. Conduct HIV program allocative and technical efficiency study to inform HIV strategic planning during the transition period
    II. Support the Government of Georgia to establish a System of Health Accounts that will regularly monitor HIV expenditure data and generate reports that are public accessible
    III. Provide capacity building and TA to relevant local staff to ensure that the SHA is functioning properly
    IV. Conduct HIV/AIDS Spending data analysis on an annual basis
    V. Allocate commensurate funding for prevention programs targeting KAPs, including low threshold services
    VI. Align state funds allocation to epidemiological priorities for each key population affected to ensure allocative efficiency
    VII. Ensure state funding to support HIV related researches, including second-generation studies (Population Size Estimation studies, IBBSs among KAPs)
    VIII. Engage with relevant ministries and local governments, city mayors and municipalities to encourage their engagement in multi-sectoral HIV response.

4. Ensure Adequate and sustainable staffing in HIV response, especially for outreach/social workers
5. Sustainable development of Health Information System in HIV national response (Bio BSS and PSE funding)
6. Maintain the effective and functional procurement and supply chain for the HIV/AIDS health

Health Information System

Based on the transition assessment study, HIV routine statistical reporting and M&E systems in Georgia are integrated into the national reporting systems; however, challenges remain in the standardization of the data collection and disaggregation.[51] The report emphasizes that analytical capacity of staff is not adequate. The second generation surveillance studies (IBBSSs and Population Size Estimation studies) among key affected populations serve as a major source to monitor epidemiological and behavioral trends among KAPs. In addition, these studies generate most consistent data about the program coverage and service outcomes. Population size estimation studies provide reliable estimates about the number of people needed services and, thus is the key for programming and projection purpose. Currently HIV grant funded by the Global Fund continues financing of IBBSSs combined with population size estimation studies.

During the transition period, advocacy work will take place to ensure that the GoG incrementally increases funding surveillance studies. In a same period capacity of conducting IBBSS studies will be transferred to NCDC. Curatio International Foundation who has been conducting surveillance and PSE studies since 2008, will be providing on-job trainings to NCDC appropriate staff, to make sure that the knowledge of methodology, field planning and implementation, as well as data entry and analytical capacity is fully transferred.

Introducing web-based database for prevention services will enable service providers with tools for data standardization and disaggregation, and therefore is very important step to improve the quality of HIV data. In addition, within the frames of the GF HIV grant, activities are planned to explore the possibility of aligning databases used by both, health care facilities and civil society organizations to support clients' progression along the continuum of services. The GF program supports development of methodology for data triangulation, and synchronization of monitoring systems utilized by health care facilities on one hand, and NGOs on the other hand.

Procurement and Supply Chain Management

The procurement and supply of health products for HIV prevention and treatment is managed by NCDC. NCDC uses relevant SOPs for forecasting, development of specifications, market search, procurement and distribution that, per the HIV/AIDS CN, are adequate and ensure continuous supply of these products. The ARV medication are procured through the Global Fund supported Pooled Procurement Mechanism (PPM), which gives access to the most competitive prices on the market and deliveries even for countries with low-volume purchases, such as Georgia. The PPM is used also for the first line ARV medications that are currently procured through the public funds for this purpose, a specific provision is included in the State Budget Law of Georgia to enable NCDC to procure through PPM without using the common state procurement mechanism. The MoLHSA is currently exploring the possibility for procuring the ARV drugs locally through the existing state procurement mechanism. This plan should be carefully considered, and alternative options

[51] Transition from the Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries. Georgia Country Report. Curatio International Foundation; p.62

evaluated to ensure uninterrupted supply of high quality health products at competitive prices as country moves towards full transition of procurement responsibilities from TGF.

Under the GF HIV grant, several initiatives will be carried out to ensure proper functioning of existing procurement and supply chain system being currently utilized by NCDC. The outcome of these initiatives will include setting new warehouse at the Lugar Center, LMIS, etc. Policy dialogue will take place to decide which national agency/structure will assume the responsibility for the procurement and supply of health products for HIV response. If this responsibility is shifted from NCDC and transferred to another structure, such as Social Service Agency, which currently procures health commodities for other State Health Programs, additional capacity building activities will be required.

Human resources

The TPA study report[52] identifies moderate risk in terms of sustainability of interventions aimed at strengthening human resources for quality HIV/AIDS service delivery. There is no policy for production/training of non-medical staff, in particular for CSOs personnel. In addition, transition preparedness report emphasizes that training activities that have been fully covered by the external sources for the last decade have not been institutionalized in the formal education system, which increases sustainability risk.

According to the HIV NSP the Government will invest to provide trainings of health care personnel from institutions that will be involved in the newly initiated PIT; training of medical staff on newly updated PMTCT guidelines; and capacity building of the AIDS Center (in-service trainings and international conferences).[53]

One of the key aspects for smooth transition is institutionalization of training programs previously provided through donor-funding programs into formal education system. Staff training should be regulated through well-established accreditation and/or re-certification system that will encourage employers to allocate funding for staff development.

During the transition period, a comprehensive policy for production/training of qualified HIV professionals and CSO personnel will be developed. The policy will define professional competencies, qualification frameworks for various specialists, and accreditation/certification procedures. It should be acknowledged that professional development of CSO staff, including their training, attendance in conference, presenting research data through oral or poster presentations at local, regional and global conferences have been traditionally supported by donor funds.

HIV related training modules that have been developed and successfully implemented through TGF and other donor-funded programs in Georgia will be institutionalized to become a part of formal curricula in high education institutions. This strategy will ensure long-term sustainability of donor-funded training. For this purpose, thorough assessment (inventory) of available training modules/training materials will be conducted; and a dialogue with university administrations and academia staff will be initiated to present existing materials to potential lecturers and identify professions (faculties, specialties) that can benefit from HIV-related training. Academia staff will be supported to work closely with CSOs trainers to modify training materials (syllabi, curricula, presentations, pre- and post-tests) as needed to be compatible with the university standards. Some examples of training institutionalization are as follows: HIV stigma training for medical students; training for mass media representatives; HIV-research trainings for students of public health

[52] Transition from the Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries. Georgia Country Report. Curatio International Foundation;
[53] The Georgian National HIV/AIDS Strategic Plan for 2016-2018. P. 10; 11; 14

MA/PhD students; motivational interviewing techniques for social workers, psychologists, etc. To ensure sustainability, a cadre of trainers will be established through training of trainers on HIV-related topics.

Expected outcomes from effective implementation of interventions under Strategic Area 3: Leadership and policy development

- Coordination of the national multi-sectoral response is effective and based on the operational and strategic information which is available for informed decision making
- Adequate resources are mobilized and required investment 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, provide the conducive environment for effective HIV national response.

3. Funding Requirements for 2019 – 2022 NSP

This section looks at available sources of funding and funding needs for HIV response in Georgia with the objective to inform allocations for 2019-2022 period.

3.1 Current Funding Landscape

Funding for HIV national response in Georgia has been increasing and is projected to continue rising as the number of diagnosed HIV cases is expected to rise substantially. Also, international and national targets call for increased coverage and access to prevention, treatment and care services.

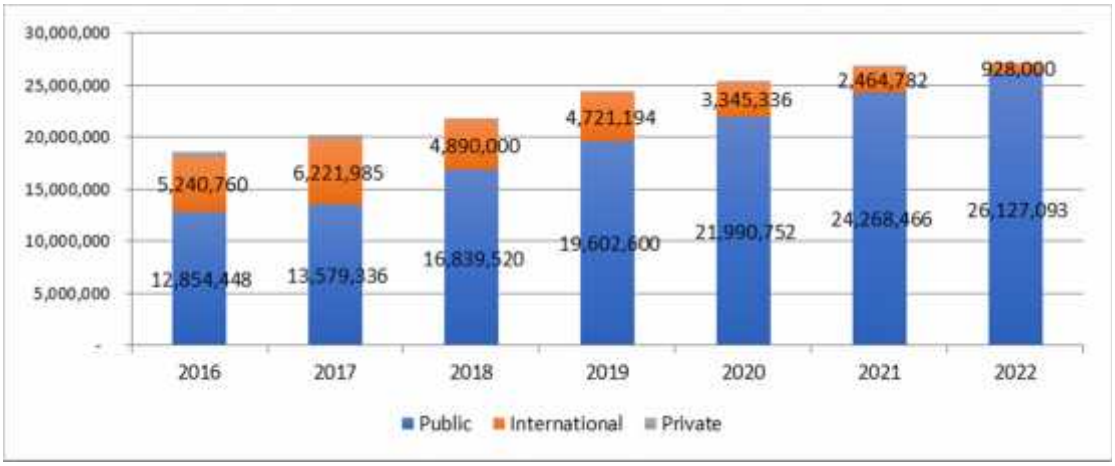
In this section, we look at funding landscape of HIV response in Georgia for past 4 years, as well as projections for the following 4-year period. Information about executed/past funding is derived from Global AIDS Monitoring Reporting, while the current period is estimated based on budgets approved for specific programs and activities. Projections made for the future period are based on the national Medium-Term Expenditure Framework – Basic Data and Directions (BDD).

National Spending Level

For the past period, the national expenditures on HIV/AIDS have been raising. From 2016 to 2018, the total annual expenditure[54] for HIV response has increased by 17% and is planned to remain approximately 26 mln USD per year in the following 4-year period. (Figure 12)

Figure 12: Total HIV Expenditures by source (in US$); (2016-2022)

[54] Expenditures for 2018 are projected



The number of factors had influenced the level of spending for the past, current and future periods. Those factors include the transition from donor funding to domestic funding and increased integration of Hep C elimination and HIV case detection programs.

Georgia has successfully completed the transition of methadone substitution therapy from donor funding to public funding in 2017 and made this service universally free of charge at the point of use.

Sources of funding

Primary sources of funding of HIV response in Georgia are domestic (77% in 2018) and international funds (22% in 2018). Private, out-of-pocket expenditures are the insignificant source of funding (≈1%) and include expenditures related to substitution treatment for substance use for individuals who opt-out from public programs.

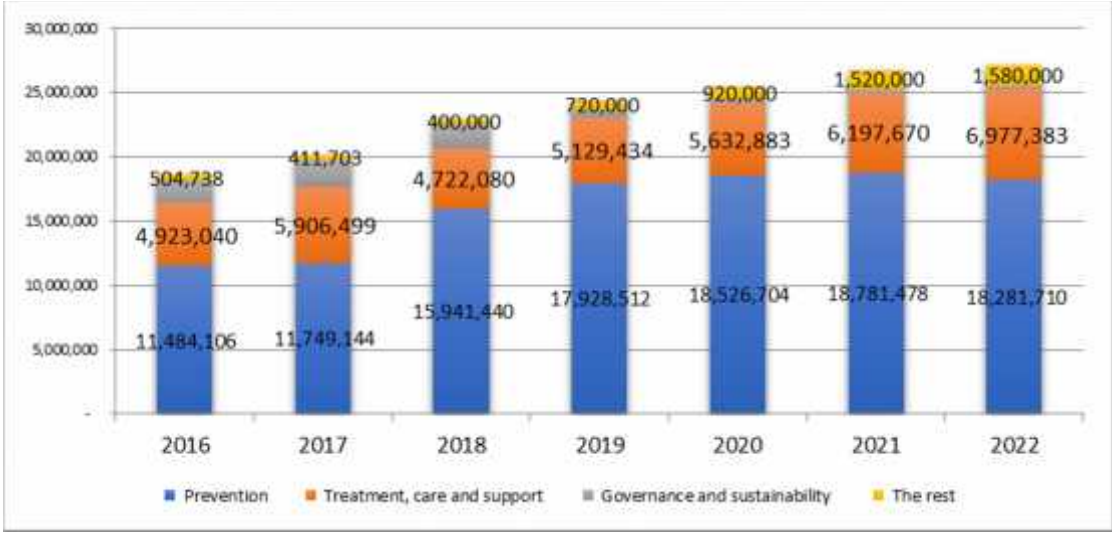
As the transition process from the Global Fund funding to domestic sources intensifies, the national HIV funding undergoes profound transformation concerning sources of funding. Compared with 2016, the annual domestic expenditures are planned to increase by 45% for 2022 and will account for 96% of total projected expenditures for HIV and it will include services currently funded by the Global Fund (including the services for KAPs).

International funding mostly received from the Global Fund is projected to nearly halve from 2016 to 2022 and will account for only 3% of total HIV funding, compared to 28% in 2016.

Funding priorities

During the last few years, funding for the key priorities in HIV response has also changed. While in previous years, significant share of public resources was dedicated to treatment, care, and support services, from 2016 the balance is altered towards more funding for prevention services. In addition, HIV National Response will continue to prioritize funding of prevention services from 2019-2022. Overall, for the following period (2019-2022), annual expenditure for prevention is planned to increase by 15%, compared to 2018 (Figure 13).

Figure 13 Funding by Priority area (USD)



Financing policies

HIV prevention and treatment and care services have been free of charge at the point of care (excluding, co-payments for substitution treatment abolished from 2017). For the period of this NSP (2019-2022), it is declared to maintain universal access for HIV services. Even more, access to several services will be expanded.

Evaluation of HIV Financing Environment

Funding for HIV services in Georgia has been reliable with little to no significant interruptions. However, numbers of macroeconomic and operational factors are to be considered when evaluating financial risks.

Fiscal policy priorities of the country: the national fiscal policy priorities of the country are reflected in the Basic Data and Directions document annually developed by the Ministry of Finance. The current National Basic Data and Directions document for 2019-2022 (noted as draft) [55] outlines that the fiscal policy priorities for 2019-2022 are investments in infrastructure and in creation of employment opportunities. Investments and sustainability of pensions, social and health services, and education are also among the top priorities of the country and protection of the nation's population from HIV and TB is specifically highlighted in the policy.

While outlook for revenues is stable, the BDD projects 3% growth rate of domestic healthcare allocation, which means that HIV expenditures should be prioritized within healthcare budget in order to ensure higher than average rate of increase. Transition from donor funding creates a significant budgetary pressure, which is coupled with a pressure to increase detection and treatment rates in order to achieve 90-90-90 by 2020 and therefore, calls for intensification of resources.

Currency fluctuation is another significant challenge, as the Georgian Lari has devolved against the US Dollar during the implementation period of the last NSP. National Bank of Georgia has been exercising some monetary control measures to offset this devaluation, however, further devaluation will be a challenge for ARV procurement done at international prices.

[55] MoF: https://mof.ge/images/File/mimartulebebi/19-22-BDD-PIRVELADI-04.07.2018.pdf

Operational factors that have a significant potential to influence overall HIV spending includes implementation arrangements of transition from donor funding. Currently, there are number of services still exclusively covered by the donors. During the period of this NSP, the GoG will allocate the funds to substitute donor funding, however, the design of payment and procurement schemes (e.g. for HIV prevention services among KAPs) has a significant potential to influence how those services are delivered in the country.

Financial protection: HIV prevention and treatment services in Georgia are now predominantly funded from public (and international) sources, exerting limited to no financial hardship to individuals and their households.

3.2 Budget Outline and Funding Gap

Activities outlined in the National Strategic Plan for 2019 -2022 are projected to cost 70 mln USD (4-year period[56]).

NSP Budget by Strategic Objectives				
Component	Total	State	GF	Undefined
Prevention	35,814,745.32	27,479,962.62	8,194,853.07	247,929.63
Care & Treatment	31,526,392.98	29,685,233.85	1,756,009.13	85,150.00
Governance, Policy & Evidence generation	1,498,527.00	-	388,449.00	1,284,078.00
Management	1,120,000.00	-	1,120,000.00	-
Total	69,959,665.30	57,165,196.46	11,459,311.20	1,617,157.63

It is projected that country will not face a gap for overall HIV response activities, however, will require alteration of current allocation framework to accommodate scale up of prevention and care activities projected in this NSP.

Activities classified as “undefined” include some of the preventive measures, like HBV vaccination among KAPs, quality assurance activities and evidence generation activities in the amount of 1.6 mln USD.

The key driver for this increase is costs related to significantly higher rates for detection and treatment of HIV, projected as a part of 90-90-90 targets. For example, this called for increased HIV detection activities and for the provision of ARV, hospital and outpatient care services for the increased number of PLHIV. Overall, by the end of 2022, it is projected that the number of individuals on ARV treatment will double.

4. Monitoring and Evaluation framework

The HIV NSP for 2019-2022 is accompanied by the M&E framework (Annex 3) that identifies a set of SMART indicators of different levels: impact, outcome and coverage/output level indicators. In total 80 indicators are proposed to monitor and report on progress toward achieving the NSP goals and strategic objectives. There are 7 impact and 8 outcome indicators that help monitor the signs of evolving HIV epidemics among the key affected population and the general public. Indicators allow assessing the impact of HIV national response on health and well-being of people infected with and

[56] This excludes Hepatitis C Elimination program, which is a part of the National HIV Response, but nonetheless, the country has a separate program and the strategy to address the disease.

affected by HIV in Georgia. Output level indicators include topic-specific measurements for monitoring HIV service coverage, the quality of services, policy development, governance and accountability, HIV-related research, health information system, as well as HIV financing.

Most national indicators are consistent with previous NSPs to allow trend analysis across years and assess if the national HIV response is continuously moving in the right direction to mitigate the impact of HIV epidemics and achieve the ambitious goal of 90-90-90. Some indicators were revised, and few new indicators were added to be aligned with the SDGs, Global Health Indicators, and WHO defined EMTCT goals. Where applicable, changes to Global AIDS Monitoring 2018 requirements[57] have also been considered.

The Framework displays baseline values and sets annual targets. Indicators and targets were defined through the participatory process involving wide-range of critical stakeholders. Consultation meetings were held with national experts, the program implementing partners from government institutions and civil society, including community-based organizations and constituencies.

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, this will require further strengthening of surveillance and program monitoring and evaluation systems.

NSP proposes conducting operation studies and surveillance activities to inform decision making on HIV related issues. The following surveillance activities and studies will be implemented:

1. 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;

2. HIV incidence estimation using recent infection testing algorithm (RITA);

3. Evaluation of effectiveness of (BCC) interventions targeting KAPs in Georgia;

4. National AIDS spending assessment and financial gap analyses to inform policy decisions;

5. Study on size estimation and risk behaviors (IBBSS) among street children and other vulnerable youth;

6. Pre-treatment HIV drug resistance survey;

7. Assessing engagement in HIV care;

8. Survey on health service accessibility;

9. Qualitative survey to look at peculiarities of MSM behavior.

[57] Global AIDS Monitoring 2018. UNAIDS. http://www.unaids.org/sites/default/files/media_asset/2017-Global-AIDS-Monitoring_en.pdf

Annexes

Annex 1 Figures

Figure 14 HIV prevalence among MSM in 2007, 2010, 2012, 2015, Tbilisi based on non-weighted data (sample sizes 136, 271, 216 and 300 respectively)

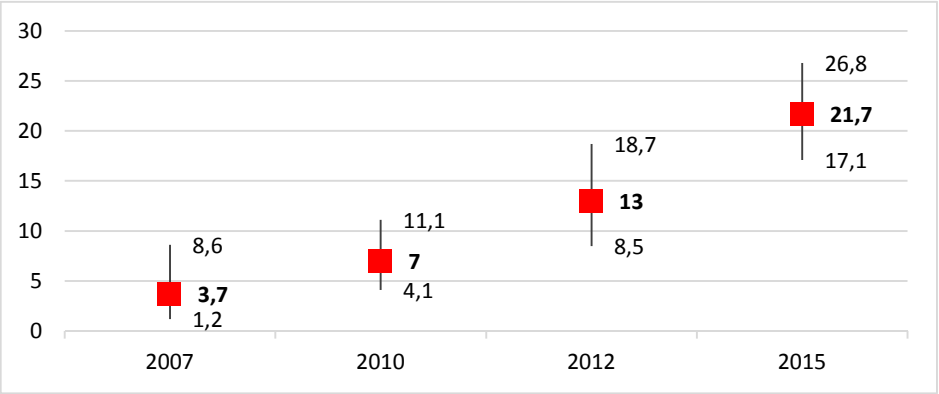


Figure 15 Prevalence of injecting drug use in the adult population in EECA region[58,59]

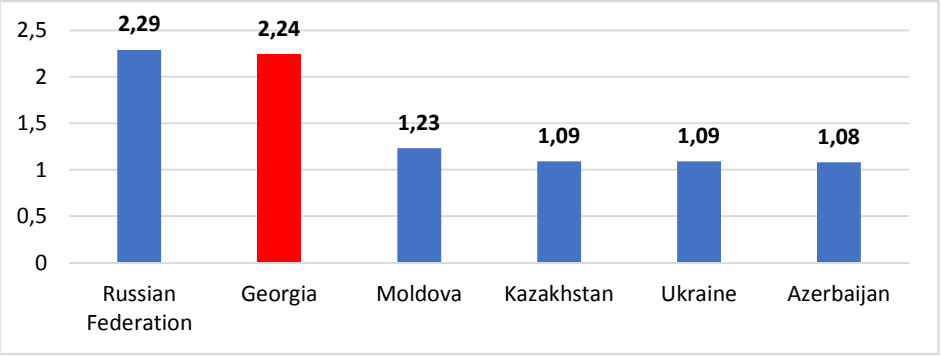


Figure 16 PWID Population Size Estimations during 2011-2017

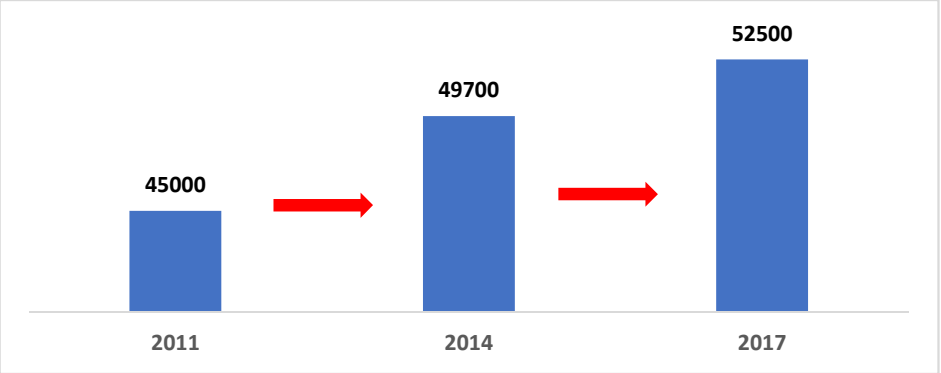


Figure 17 HIV Prevalence among PWID (2009-2017)[60]

[58] World Drug Report 2017
[59] PWID PSE – Curatio International Foundation, 2017

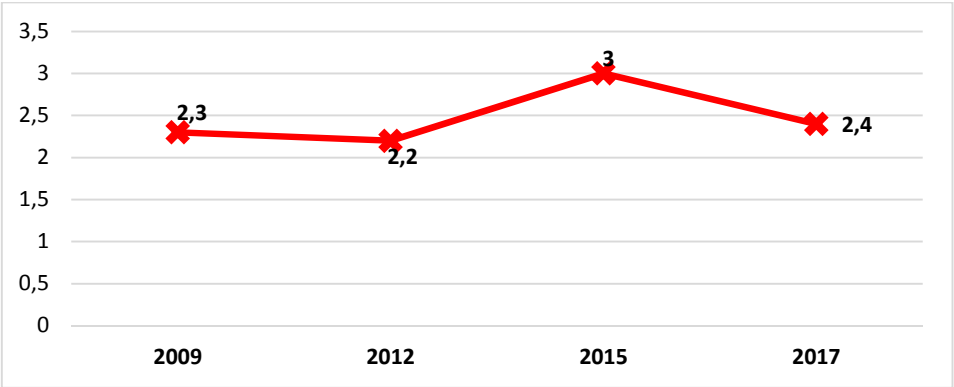


Figure 18 HIV prevalence among Female Sex Workers in Tbilisi and Batumi (2002-2017)

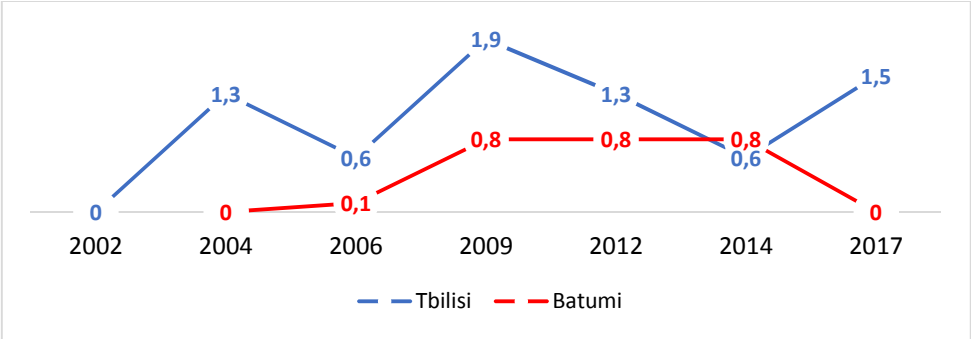
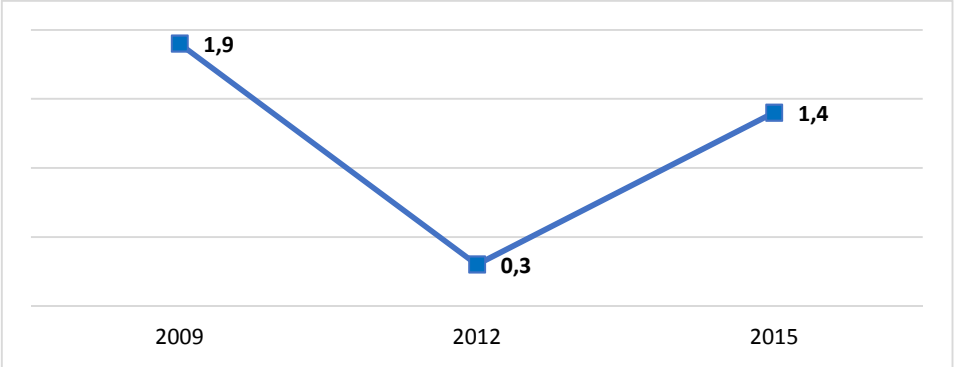


Figure 19 HIV prevalence among prisoners in 2009, 2012, 2015 (sample sizes 211, 286 and 301, respectively)



[60] HIV risk and prevention behaviors among People Who Inject Drugs in seven cities of Georgia, 2016-2017, Bemoni Public Union(BPU); Curatio International Foundation (CIF)

Annex 2 Detailed budget (USD)

#	Strategic Priority/ Activity area	2019	2020	2021	2022	Total
1	**[HIV Prevention and Detection]**	**8,082,959**	**8,888,603**	**9,264,495**	**9,578,688**	**35,814,745**
1.1	**Prevent HIV transmission, detect HIV, and ensure timely progression to care and treatment among the key affected populations**	**6,828,034**	**7,345,299**	**7,759,540**	**8,051,948**	**29,984,821**
1.1.1	Prevention and detection of HIV among PWID	1,956,032	2,002,815	2,049,721	2,091,712	8,100,279
1.1.2	Opioid Substitution Treatment (OST) and other forms of treatment and rehabilitation	3,722,400	3,974,400	4,234,400	4,442,400	16,373,600
1.1.3	Prevention and detection of HIV among MSM	627,240	698,661	734,372	741,002	2,801,276
1.1.4	HIV Prevention and detection among FSW	331,783	350,160	366,327	382,495	1,430,765
1.1.5	HIV Prevention and Detection among Prisoners	80,000	80,000	80,000	80,000	320,000
1.1.6	Hepatitis B Prevention and vaccination among KAPs	18,000	18,000	18,000	18,000	72,000
1.1.7	Special Programs for adolescents and young people who inject drugs	-	12,000	12,000	12,000	36,000
1.1.8	PrEP	92,579	153,174	208,630	228,250	682,632
1.1.9	Mental health services for all KAPs	-	12,000	12,000	12,000	36,000
1.1.10	Improve access to SRH services for all KAPs	-	30,000	30,000	30,000	90,000
1.1.11	Introduction and expansion of HIVST among KAPs and other vulnerable groups	-	14,090	14,090	14,090	42,269
1.2	**Prevention and detection of HIV in healthcare settings**	**1,254,925**	**1,543,304**	**1,504,956**	**1,526,740**	**5,829,925**
1.2.1	Enhancing Provider Initiated Testing (PIT) for HIV, including HIV confirmation	471,581	576,512	488,716	483,308	2,020,117
1.2.2	Provider initiated testing at primary care setting	-	120,000	100,000	50,000	270,000
1.2.3	Provider initiated HIV testing in hospitalized persons	-	-	-	-	-
1.2.4	Ensuring safety of donor blood	630,000	693,000	762,000	838,520	2,923,520
1.2.5	Post-exposure prophylaxis of HIV infection (PEP)	1,344	1,792	2,240	2,912	8,288
1.2.6	Prevention of Mother to Child Transmission of HIV (PMTCT)	152,000	152,000	152,000	152,000	608,000
2	**[HIV Care and Treatment]**	**5,497,924**	**7,895,489**	**8,978,894**	**9,154,086**	**31,526,393**
2.1	**Ensure uninterrupted delivery of high quality treatment and care**	**5,266,840**	**7,664,405**	**8,748,022**	**8,923,014**	**30,602,281**
2.1.1	Delivery of essential clinical care services to all people living with HIV (PLHIV)	4,862,800	7,272,365	8,355,982	8,530,974	29,022,121
2.1.2	Provision of ART to all PLHIV in need in accordance with existing guidelines, including in the region of Abkhazia	66,392	66,392	66,392	66,392	265,568
2.1.3	Effective programme administration and quality of service delivery	337,648	325,648	325,648	325,648	1,314,592
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 (funded from the TB program)	-	-	-	-	-
2.2.2	Provide treatment and care for viral hepatitis (funded from the HVC program)	-	-	-	-	-
2.3	**Ensure provision of care and support services for PLHIV**	**231,084**	**231,084**	**230,872**	**231,072**	**924,112**
2.3.1	Ensure operation of peer-support services	148,612	148,612	148,400	148,600	594,224

2.3.2	Provide palliative care for chronically ill patients	57,832	57,832	57,832	57,832	231,328
2.3.3	Support effective linkage of PLHIV to HIV and other medical care, as well as supportive services (case-manager)	24,640	24,640	24,640	24,640	98,560
3	**[Leadership and policy development and transition-related activities]**	**437,833**	**279,638**	**371,628**	**409,428**	**1,498,527**
3.1	**Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response**	**88,600**	**73,600**	**73,600**	**73,400**	**309,200**
3.1.1	Continuous monitoring of HIV related expenditures through the national health accounts analysis	25,000	25,000	25,000	25,000	100,000
3.1.2	Support implementation of transition plan through establishing a dedicated M&E function (FIN.57-64)	36,200	36,200	36,200	36,000	144,600
3.1.3	Ensure full budgetary commitment and allocative efficiency for national HIV response (FIN.57-64)	27,400	12,400	12,400	12,400	64,600
3.2	**Improved policy environment and stakeholder coordination**	**13,084**	**68,538**	**68,920**	**68,920**	**219,462**
3.2.1	Regular reviews and analyses of HIV related legislation	9,084	9,538	9,920	9,920	38,462
3.2.2	Development and implementation of stigma reduction activities by PLHIV organisations and KAP networks	-	55,000	55,000	55,000	165,000
3.2.3	National AIDS Conference	4,000	4,000	4,000	4,000	16,000
3.3	**Generate evidence for informed decision making**	**336,149**	**137,500**	**229,108**	**267,108**	**969,865**
3.3.1	Review State Procurement Law and relevant regulations to identify potential barriers for non-state actors, including community-based organizations to deliver HIV services under the state funding/Create enabling environment for CSO and community-based organizations engagement in HIV & TB national response (G&P.54 and 55)	12,000	-	-	-	12,000
3.3.2	Improve HIV program's accountability to disseminate programmatic and financial data to key actors and wider public.	5,000	5,000	5,000	5,000	20,000
3.3.3	Develop costed HIV/AIDS National Strategy for 2023-2027 and Action Plan	-	-	-	16,000	16,000
3.3.4	Sustainable development of Health Information System in HIV national response	8,400	8,400	-	-	16,800
3.3.5	Develop policy for production and continuous professional development of human resources for HIV/AIDS programs, including CSO personnel	4,200	-	-	-	4,200
3.3.6	Integrate HIV training modules in the undergraduate and postgraduate education system	2,100	2,100	2,100	2,100	8,400
3.3.7	Training of trainers, including that for academia staff on HIV related topics	18,500	22,000	8,008	8,008	56,516
3.3.8	Integrated bio-behavioural surveillance studies (IBBSS) among KAPs incorporating population size estimates: PWID, FSW, MSM, prisoners, Street Children and risk behaviour youth and vulnerability baseline study among labour migrants	265,949	-	180,000	140,000	585,949
3.3.9	Pre-treatment HIV drug resistance survey (2019, 2021)	-	64,000	-	64,000	128,000
3.3.10	Monitoring recent HIV infections (2019, 2020,2021,2022)	20,000	20,000	20,000	20,000	80,000

3.3.11	Assessing engagement in HIV care (2019, 2021)	-	10,000	-	10,000	20,000
3.3.12	Survey on health service accessibility (2020, 2022)	-	-	10,000	-	10,000
3.3.13	Updating public health and clinical guidelines and national standards	-	6,000	4,000	2,000	12,000
4	**Management of contribution from international funding mechanism**	**320,000**	**320,000**	**320,000**	**160,000**	**1,120,000**
	TOTAL	**14,338,716**	**17,383,731**	**18,935,017**	**19,302,201**	**69,959,665**

Annex 3 2019 – 2022 NSP M&E Framework

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
	Impact indicators								
Imp.1	HIV prevalence rate per 100,000 population)	400 per 100,000 (0.40%)	2017	SPECTRUM	<500	<500	<500	<500	SPECTRUM
Imp.2	AIDS-related mortality per 100,000 population	1.9/100,000	2017	Routine monitoring data	≤2.0	≤2.0	≤2.0	≤2.0	Routine monitoring data/Civil registration/SPECTRUM
Imp.3	Percentage of men having sex with men (MSM) who are living with HIV	21% (Tbilisi)	2015	IBBSS	<25%	<25%	<25%	<25%	IBBSS
Imp.4	Percentage of sex workers (SW) who are living with HIV	<2%	2017	IBBSS	<2%	<2%	<2%	<2%	IBBSS
Imp.5	Percentage of people who inject drugs (PWID) who are living with HIV	2.30%	2017	IBBSS	<3%	<3%	<3%	<3%	IBBSS
Imp.6	HIV Incidence rate (per 1,000 population)	0.22	2017	Monitoring data/SPECTRUM	0.19	0.16	0.13	0.1	SPECTRUM
Imp.7	Congenital syphilis rate (per 100,000 live births)	15.2 (N=8)	2017	Routine HIS	<50	<50	<50	<50	Routine HIS
	Outcome indicators								
O.8	Percentage of people living with HIV who know their status	48%	2017	Monitoring data/SPECTRUM	70%	90%	90%	90%	SPECTRUM/ monitoring data
		51.4% (<350 cells/mm^3);	2017	Monitoring data	45%	40%	35%	30%	Monitoring data
O.9	Late HIV diagnosis	33.7% (<200 cells/mm^3)	2017	Monitoring data	30%	25%	20%	20%	Monitoring data
O.10	ART coverage: Percentage of people living with HIV currently receiving ART among the estimated number of adults and children living with HIV	39%	2017	Monitoring data/SPECTRUM	63%	81%	81%	81%	SPECTRUM

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
O.11	Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	87%	2017	Routine HIS	90%	90%	90%	90%	Routine HIS
O.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	63.2% in Tbilisi	2015	IBBSS	70%		80%		IBBSS
		78.8% in Batumi	2015	IBBSS	80%		85%		IBBSS
O.13	Percentage of SW reporting the use of a condom with their most recent client	96% in Tbilisi; 90% in Batumi	2017	IBBSS		>90%			IBBSS
O.14	Number of needles and syringes distributed per PWID per year	73 syringes per PWID per year	2017	Program data	110	120	130	140	Program data
O.15	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	81%	2017	IBBSS		>90%			IBBSS
	Coverage/Output indicators								
SO 1	**HIV Prevention and Detection: Scale-up of preventive services to ensure timely detection and progression to care**								
	HIV Prevention among PWID								
Cov.16	Percentage of PWIDs reporting having received a combined set of HIV prevention interventions (last year)	23%	2017	IBBS		60%			IBBSS
		52%	2017	Program data	65%	70%	75%	75%	Routine monitoring data
Cov.17	Percentage of PWIDs reporting having received a combined set of HIV prevention interventions (past three months)	NA		IBBSS		TBD			IBBSS
Cov.18	Percentage of PWIDs who tested for HIV in the past 12 months, or who know their current HIV status	36%	2017	IBBSS		50%			IBBSS
		50%	2017	Program data	60%	65%	70%	70%	Routine monitoring data
	Opioid Substitution Treatment (OST)								
Cov.19	Number of individuals receiving OST	8038	2017	Program data	9,500	11,000	11,000	11,000	Program data
Cov.20	Percentage of people who inject drugs (PWID)receiving OST	49%	2017	Program data	58%	68%	68%	68%	Program data

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
Cov.21	Percentage of individuals receiving OST who received treatment for at least 6 months	47%	2017	Program data	65%	70%	70%	70%	Program data
Cov.22	Number of prisoners who received detox/OST in penitentiary system	533	2017	Program data	NA	NA	NA	NA	Program data
	HIV Prevention among MSM								
Cov.23	Percentage of MSM reporting having received a combined set of HIV prevention interventions (last year)	43.5% in Tbilisi; 40% in Batumi	2015	IBBSS	50%		60%		IBBS
		22% in Tbilisi, Batumi, Kutaisi	2017	Program data	40	50%	55%	60%	Program data
Cov.24	Percentage of MSM reporting having received a combined set of HIV prevention interventions (past three months)	NA		IBBS	TBD		TBD		IBBS
Cov.25	Percentage of MSM who tested for HIV in the past 12 months, or who know their current HIV status	(proxy)38.4% in Tbilisi; 43% in Batumi	2015	IBBS	45%		60%		IBBS
		13% in Tbilisi, Batumi, Kutaisi	2017	Program data	30%	40%	45%	50%	Program data
Cov.26	People receiving pre-exposure prophylaxis	50	2017	Program data	250	500	750	1000	Program data
	HIV Prevention among FSW								
Cov.27	Percentage of SWs reporting having received a combined set of HIV prevention interventions (last year)	63% in Tbilisi;	2017	IBBS		70%			IBBS
		77% in Batumi	2017	IBBS		80%			IBBS
		52% in Tbilisi, Kutaisi, Batumi, Zugdidi, Telavi	2017	Program data	55%	60%	60%	60%	Program data
Cov.28	Percentage of SWs reporting having received a combined set of HIV prevention interventions (past three months)	NA		IBBS		TBD			IBBS
Cov.29	Percentage of SWs who tested for HIV in the past 12 months, or who know their current	31% in Tbilisi	2017	IBBS		50%			IBBS
		58% in Batumi	2017	IBBS		60%			IBBS

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
	HIV status	33% in Tbilisi, Kutaisi, Batumi, Zugdidi, Telavi	2017	Program data	45%	50%	55%	60%	Program data
	HIV Prevention among prisoners								
Cov.30	Percentage of prisoners that have received an HIV test during the reporting period and knew their HIV test results	60%	2017	Routine monitoring data	65%	70%	75%	75%	Routine monitoring data
	Improve HIV case detection through targeted HTC in specialty clinics, and expanding PIT in healthcare settings								
Cov.31	Number of people who received HTC for HIV in specialty clinics and know their HIV test result	30,275	2017	Routine monitoring data	43,250	51,400	52,000	52,000	Surveillance/National AIDS HIS
Cov.32	Number of hospitalized patients who received PIT and know their HIV test results	NA	2017	Routine monitoring data	300,000	300,000	300,000	300,000	Surveillance/National AIDS HIS
Cov.33	Number of patients visiting primary health care who received PIT and know their HIV test results	NA	2017	Routine monitoring data	120,000	150,000	100000	50,000	Surveillance/National AIDS HIS
Cov.34	Sero-positivity rate among persons tested through the PIT	NA	NA	Routine monitoring data	NA	NA	NA	NA	Surveillance/National AIDS HIS
	Ensuring safety of donor blood								
Cov.35	Percentage of blood units screened for HIV in a quality assured manner	100%	2017	Routine monitoring data	100%	100%	100%	100%	Routine monitoring data
Cov.36	Percentage of voluntary donors	28%	2018	Routine monitoring data	30%	35%	40%	45%	Routine monitoring data
	Elimination of Mother to Child Transmission of HIV (EMTCT)								
Cov.37	Percentage of pregnant women who were tested for HIV and received results	94%	2017	Routine Monitoring data	>=95%	>=95%	>=95%	>=95%	Routine monitoring data

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
Cov.38	Percentage of HIV-positive pregnant women who received ARV to reduce the risk of mother-to-child transmission	85%	2017	SPECTRUM	>= 95%	>= 95%	>= 95%	>= 95%	Routine monitoring data
Cov.39	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100% (actual N=51)	2017	Routine Monitoring data	>= 95%	>= 95%	>= 95%	>= 95%	Routine monitoring data
Cov.40	HIV prevalence among pregnant women (%)	0.10%	2017	Routine Monitoring data (MCH Strategy)	<0.05%	<0.05%	<0.05%	<0.05%	Routine monitoring data
Cov.41	Coverage of syphilis testing in women attending antenatal care services: Percentage of pregnant women who were tested for syphilis (at least once during pregnancy)	92% (52,938/57,428)	2017	Routine Monitoring data	>= 95%	>= 95%	>= 95%	>= 95%	Routine monitoring data
Cov.4342	Percentage of pregnant women attending antenatal clinics with a positive (reactive) syphilis serology	0.3% (176/52,938)	2017	Routine Monitoring data	0.10%	<0.1%	<0.1%	<0.1%	Routine monitoring data
Cov.43	Percentage of antenatal care attendees during a specified period with a positive syphilis serology who were treated adequately	NA	NA	NA	>95%	>95%	>95%	>95%	Routine monitoring data
SO 2	**HIV Treatment and Care: Improve HIV health outcomes through ensuring universal access to quality treatment, care and support**								
	Ensure uninterrupted delivery of high-quality treatment and care								
Cov.44	Percentage of adults and children diagnosed with HIV receiving antiretroviral therapy at the end of the reporting period.	81%	2017	Routine monitoring data/ National AIDS HIS	90%	90%	90%	90%	National AIDS Health Information System Routine monitoring data
Cov.45	Percentage of people on ART who are virologically suppressed (VL) with VL level ≤ 1000 copies/ml	89%	2017	Routine monitoring data/ National AIDS HIS	90%	90%	90%	90%	Routine monitoring data/ National AIDS HIS
Cov.46	Percentage of healthcare facilities reporting no stock-outs of ARV medicines	100%	2017	Routine monitoring data	100%	100%	100%	100%	Routine monitoring data

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
	Reduce morbidity and mortality due to TB and HCV co-infections and injecting drug use								
Cov.47	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	92%	2016	Routine monitoring data	>90%	>90%	>90%	>90%	Routine monitoring data
	Ensure provision of care and support services for PLHIV								
Cov.48	Number of People living with or affected by HIV reached with community care and support services in community settings	1,578	2017	Program data	1,700	1,900	2,100	2,300	Program data
SO 3	**Governance and Policy development: Ensure sustainability of response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society.**								
	Create Conducive legal environment for HIV response								
G&P.49	Georgian Criminal Code and Administrative Offences Code, Georgia Framework Law on Drugs, Psychotropic Substances, Precursors and Narcological Aids - revised; amendments adopted to remove barriers to HIV& harm reduction services	NA			X				Matsne.gov.ge
G&P.50	The 4-pillar Drug Policy, Anti-drug strategy and 3-year Action Plan developed and approved by the Government	NA			X				Drug Policy; Anti-drug Strategy; Action Plan; Government resolution
G&P.51	Review HIV/AIDS State Law; development and adoption of corresponding bylaws	NA			X				Matsne.gov.ge
	Review State Procurement Law and relevant regulations to identify potential barriers for non-state actors, including community-based organizations to deliver HIV services under the state funding								

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
G&P.52	Barriers and opportunities for CSOs/CBOs to satisfy the state procurement requirements identified	NA	NA		X				Report outlining barriers and capacity of CSOs for participating in state tenders
G&P.53	Detailed operational manual to support CSOs participation in state tendering developed	NA	NA		X				Operational manual
	Development and implementation of stigma reduction activities by PLHIV organizations and KAP networks								
G&P.54	Percentage of women and men aged 15-49 expressing accepting attitudes	TBD	NA	MICS	TBD			TBD	MICS report
	Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response								
Fin.55	The share of public spending out of the total spending for HIV national response	76%	2018	NSP Budget	79%	85%	87%	96%	HIV/AIDS Spending data
Fin.56	% of public spending on HIV targeting KAPs	1,900,000					10%		
Fin.57	The total allocation of public funding through contracting non-sate actors to deliver HIV prevention services, including low threshold harm reduction (excluding OST) and community support services				TBD	TBD	TBD	TBD	Program Budgets; AIDS spending data ; Global AIDS Monitoring reports/Funding Matrix
Fin.58	The share of public spending out of the total spending on IBBSs & PSE among KAPs (%)					50%		70%	
Fin.59	Analyzing data on AIDS spending by each KAP to assess the allocative efficiency	NA	NA		X	X	X	X	AIDS spending annual report, which includes the section on allocative efficiency
	Generate evidence for informed decision making								
	Integrated bio-behavioral surveillance studies (IBBSS) among KAPs incorporating population size estimates								

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
HIS.60	IBBSS and PSE among PWIDs	NA				X			Research reports
HIS.61	IBBSS and PSE for FSWs	NA				X			Research reports
HIS.63	IBBS and PSE among MSM	NA					X		Research reports
HIS.64	IBBS among prisoners	NA				X			Research reports
HIS.65	HIV vulnerability and size estimation study among street children	NA			X				Research reports
HIS.66	HIV vulnerability among the migrant population	NA				X			Research reports
HIS.67	IBBSS among youth	NA			X				Research reports
	Operational research								
Res.68	Pre-treatment HIV drug resistance survey	NA			X		X		Research reports
Res.69	Monitoring recent HIV infections using recent infection testing algorithm (RITA)	NA			X	X	X	X	Research reports
Res.70	Assessing engagement in HIV care	NA			X		X		Research reports
Res.71	Survey on health service accessibility	NA				X		X	Research reports
	Improve the quality of HIV service delivery (SD)								
SD.72	Revision of national standard on HIV prevention among MSM, and men who have sex with men and women	NA				X			Updated/approved the standard
SD.73	Revision of national standard on HIV prevention among sex workers	NA				X			Updated/approved the standard
SD.74	Revision of harm reduction national standard for PWIDs	NA					X		Updated/approved the standard
SD.75	Revision of national standard on HIV prevention targeting youth	NA					X		Updated/approved the standard
SD.76	Revision of clinical guidelines	NA							Updated/approved guideline.
	Accountability								
Acc.77	Publishing HIV programmatic and financial reports to make them accessible on public domains	NA			X	X	X	X	Programmatic/financial reports; websites.

		Baseline			Timeframe and targets				
Ind type	**Indicator name**	**Value**	**Year**	**Source**	**2019**	**2020**	**2021**	**2022**	**Source of data**
	Monitoring and Evaluation								
Mon.78	Operational manual (including indicators' reference sheets) for the NSP Monitoring and Evaluation framework developed	NA	NA		X				Operational Manual
Mon.79	Monitoring the progress towards implementation of NSP by external monitoring committee/community monitors	NA			X	X	X	X	Monitoring reports/meeting minutes
Mon. 80	M&E reports about achievements against the NSP indicators produced annually and are accessible to the public	NA	NA		X	X	X	X	Annual M&E reports uploaded on the NCDC, MOH, CCM websites

References

1. 90–90–90 - An ambitious treatment target to help end the AIDS epidemic. http://www.unaids.org/en/resources/documents/2017/90-90-90
2. Action plan for the health sector response to HIV in the WHO European Region. WHO Regional Office for Europe. 2017
3. Article 356 of the EU Georgia Association Agreement
4. Chkhartishvili N, Chokoshvili O, Bolokadze N et al. Late presentation of HIV infection in the country of Georgia: 2012-2015. *PLoS One*. 2017;12:e0186835.
5. Chkhartishvili N, Sharvadze L, Chokoshvili O et al. Mortality and causes of death among HIV-infected individuals in the country of Georgia: 1989-2012. AIDS Res Hum Retroviruses. 2014;30:560-6.
6. Chkhartishvili N, Sharvadze L, Gabunia P, Abutidze A, Nikolaishvili M, Tsertsvadze T. Late HIV diagnosis in Georgia: public health and economic implications. Translational and Clinical Medicine-Georgian Medical Journal. 2016;1:11-14.
7. Chokoshvili O, Kepuladze K, Tsintsadze M et al. High prevalence and incidence of HIV, syphilis and viral hepatitis among men who have sex with men in Georgia: Findings of the Georgian MSM Cohort. 16th European AIDS Conference. Milan, Italy; 2017.
8. Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia. https://www.osce.org/secretariat/29873?download=true
9. Evaluation cost-effectiveness of needle and syringe program in Georgia, UNAIDS, 2011 http://altgeorgia.ge/2012/myfiles/UNAIDS_reporrt_eng.pdf
10. Gender Equality in Georgia: Barriers and Recommendations
11. Georgia Law on State Budget https://matsne.gov.ge/ka/document/view/3938064
12. Georgia Transition Plan. Curatio International Foundation. 2016
13. Global AIDS Monitoring 2018. UNAIDS. http://www.unaids.org/sites/default/files/media_asset/2017-Global-AIDS-Monitoring_en.pdf
14. Global AIDS Response Progress Report GEORGIA Country Progress Report Reporting Period January – December, 2014
15. Government of Georgia. Ordinance No 36. February 2013 http://ssa.gov.ge/files/01_GEO/KANONMDEBLOBA/Kanon%20Qvemdebare/92.pdf
16. Government of Georgia. Ordinance No 724. December 2014. https://matsne.gov.ge/en/document/view/2657250
17. Health Care Statistical Yearbook 2016. Ministry of Labor, Health and Social Affairs of Georgia. National Center for Disease Control and Public Health. 2017. http://ncdc.ge/Handlers/GetFile.ashx?ID=31eee2a3-9bf5-4558-959b-a4b92f600555
18. HIV risk and prevention behaviors among People Who Inject Drugs in seven cities of Georgia, 2016-2017, Bemoni Public Union(BPU); Curatio International Foundation (CIF)
19. HIV risk and prevention behaviors among Prison Inmates in Georgia; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/157.pdf
20. http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators#
21. http://eeca.unfpa.org/en/publications/health-rights-and-well-being
22. http://www.euro.who.int/__data/assets/pdf_file/0007/357478/HIV-action-plan-en.pdf?ua=1
23. http://www.ge.undp.org/content/georgia/en/home/library/democratic_governance/gender-equality-in-georgia.html
24. http://www.unaids.org/en/regionscountries/countries/georgia
25. http://www.unaids.org/sites/default/files/country/documents/GEO_narrative_report_2015.pdf

26. http://www.who.int/hiv/pub/toolkits/msm-implementation-tool/en/
27. https://aidscenter.ge/epidsituation_eng.html
28. https://sustainabledevelopment.un.org/memberstates/georgia
29. https://www.un.org/sustainabledevelopment/sustainable-development-goals/
30. https://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-transgender-people-practical-guidance
31. Integrated Bio-behavioral surveillance and population size estimation survey among Female Sex Workers in Tbilisi and Batumi, Georgia; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/167.pdf
32. Law on Public Health https://matsne.gov.ge/en/document/view/2805785
33. MoF: https://mof.ge/images/File/mimartulebebi/19-22-BDD-PIRVELADI-04.07.2018.pdf
34. National AIDS Center. https://aidscenter.ge/epidsituation_eng.html
35. National Bank of Georgia; https://www.nbg.gov.ge/index.php?m=340&newsid=3320 Accessed on April 10, 2018[1] https://www.theglobalfund.org/media/5641/core_projectedtransitionsby2025_list_en.pdf?u=636570636710000000020
36. Population Size Estimation of Female Sex Workers In Tbilisi and Batumi, Georgia 2014; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/150.pdf
37. Population Size Estimation of Men Who Have Sex with Men in Georgia, 2014; Curatio International Foundation Center for Information and Counseling on Reproductive Health – Tanadgoma; http://www.georgia-ccm.ge/wp-content/uploads/MSM-PSE-09.12.2014_Geo.pdf
38. Population Size Estimation of People Who Inject Drugs in Seven Cities of Georgia, 2016-2017, Bemoni Public Union(BPU); Curatio International Foundation (CIF)
39. STRATEGIC PLAN FOR THE ELIMINATION OF HEPATITIS C VIRUS IN GEORGIA, 2016-2020. http://www.moh.gov.ge/uploads/files/2017/akordeoni/failebi/Georgia_HCV_Elimination_Strategy_2016-2020.pdf
40. The Georgia Law on the State Budget of Georgia, MoF, 2016.
41. The Georgian National HIV/AIDS Strategic Plan for 2016-2018. p. 18
42. The Georgian National HIV/AIDS Strategic Plan for 2016-2018. P. 10; 11; 14
43. The GF Concept Note, p. 42
44. Transition from the Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries. Georgia Country Report. Curatio International Foundation
45. World Drug Report 2017
46. World Health Organization. Global Tuberculosis Report 2017. Geneva: WHO; 2017.
47. World Health Organization. Tuberculosis country profiles (http://www.who.int/tb/country/data/profiles/en/). 2018 vol; 2018
48. World Health Organization. World Tuberculosis Report 2016. Geneva: WHO; 2016.