**Global AIDS Response Progress Report**

**GEORGIA**

**Country Progress Report**

**Reporting Period**

**January 2010 – December 2011**

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**Acronyms**

|  |  |
| --- | --- |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **AIDS Center** | Infectious Diseases, AIDS & Clinical Immunology Research Center |
| **ANC** | Antenatal Clinics |
| **ARV/ART** | Antiretroviral drugs / Antiretroviral therapy |
| **BSS** | Behavioral Surveillance Surveys with biomarker component |
| **CCM** | Country Coordinating Mechanism |
| **CIF** | Curatio International Foundation |
| **FSWs** | Female Sex Workers |
| **GARP** | Global Country Progress Report |
| **GFATM** | Global Fund to fight AIDS, Tuberculosis and Malaria |
| **GHPP**  **GHRN** | Georgian HIV Prevention Project  Georgian Harm Reduction Network |
| **GIP** | Global Initiative on Psychiatry |
| **GoG** | Government of Georgia |
|  |  |
| **HIV** | Human Immunodeficiency Virus |
| **HR** | Human Resources |
| **IDUs** | Injecting Drug Users |
| **IOM** | International Organization on Migration |
| **M&E** | Monitoring & Evaluation |
| **MARPs** | Most-at-risk populations |
| **MCCU** | Mother and Child Care Union |
|  |  |
| **MoES** | Ministry of Education and Science of Georgia |
| **MoLHSA** | Ministry of Labor, Health and Social Affairs of Georgia |
| **MSM** | Men who have sex with men |
| **NCDCPH** | National Center for Disease Control and Public Health |
| **NCPI** | **N**ational Commitments and Policy Instrument |
| **NSPA** | National Strategic Plan of Action |
|  |  |
| **OIs** | Opportunistic infections |
| **PLWH** | People living with HIV |
| **PTF** | STI/HIV Prevention Task Force |
| **SOPs** | Standard Operating Procedures |
| **STIs** | Sexually Transmitted Infections |
| **TB** | Tuberculosis |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **UNDP** | United Nations Development Programmed |
| **UNICEF**  **UNFPA** | United Nations Children’s Fund  United Nations Population Fund |
| **VCT** | Voluntary Counseling and Testing |
| **VRF** | Vishnevskaya-Rostropovich Foundation |
| **WHO** | World Health Organization |

1. **Status at a Glance**
2. **The Stakeholder’s inclusiveness in the report writing process**

In accordance with recommendations from the Guideline on Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS, this Country Progress Report was developed over the course of several national consultation meetings (the initial Global Progress Report Introductory Workshop in November 2011, the midterm Country Progress Report Workshop in February, and the Report Validation Workshop in March 2012), individual meetings with key stakeholders, and desk reviews. Data for specific indicators were reviewed by experts from governmental, non-governmental, and international organizations. Based on UNAIDS recommendations, data for each national indicator and the draft Country Progress Report were presented, discussed and validated at broad, inclusive meetings involving representatives of the Government of Georgia and other state and non-state actors, both national and international.

This Country Progress Report was developed in a participatory manner, with overall coordination on the part of the National Center for Disease Control and Public Health (NCDCPH) and the Country Coordinating Mechanism (CCM), in close collaboration with the UNAIDS Country Office. The NCDCPH directly facilitated all consultations and relevant data collection endeavors.

The NCPI also was developed through separate participatory meetings with both government and non-state actors. The first draft of the NCPI was shared with the wider audience allowing all stakeholders to give suggestions and input. All these comments were discussed and incorporated into the final report. The NCDCPH presented the final draft document at the concluding National Consultation Meeting attended by a broad forum of stakeholders on 30 March, 2012.

1. **The status of the HIV/AIDS epidemic in Georgia**

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

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

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

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

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

Under these two projects several BSS rounds have been carried out among IDUs, MSM, FSWs and prisoners in several cities of Georgia. A Respondent Driven Sampling methodology (RDS) was employed for BSS application among IDUs and MSM and Time-and-Location Sampling was employed among FSWs. These methodologies are internationally recognized as the most recommended approaches for reaching out to these hidden populations. This BSS methodology uses almost standardized questionnaires for each high-risk group. The use of standard methodologies and survey tools has allowed data collection to be used for a comparative analysis across cities and over years. This report includes aggregated data to present information from as many survey sites as possible as well as separate indicators by survey site wherever applicable.

1. **The Policy and Programmatic Response**

In recognition of the increased health care burden associated with HIV/AIDS, the Government of Georgia has utilized various mechanisms and resources to mitigate the impact of the epidemic. Coordinated involvement of various national and international stakeholders, including broader civil society, has been recognized as essential for an effective HIV response.

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

The CCM operates with a multi-sector mandate for coordinating the national response, and includes broad representation from all relevant ministries, government institutions, the UN, civil society organizations, bilateral and multilateral agencies, as well as organizations representing people living with HIV. In order to enhance representation of the NGO sector within the CCM, local NGOs are selected on a rotating basis through the STI/HIV Prevention Task Force (PTF), a professional network uniting more than 30 governmental, non-governmental, and donor organizations. The PTF is recognized as an effective professional and civil society forum of stakeholders actively involved in HIV policy development and advocacy initiatives in Georgia.

In response to the UNAIDS “Three Ones” principle that call for the best coordination of a National AIDS Response around one agreed action framework, in May 2007 the CCM was deemed Georgia’s sole National Coordinating Authority., The CCM was mandated to take a lead role in fostering a national advocacy program for a coordinated response; to develop the policies and legislation connected to the national HIV strategy: and to monitor and evaluate HIV programs nationwide. The official status of the CCM was legislated in 2009 through the new Law on HIV/AIDS.

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

In 2009-10, with technical and financial support from UNAIDS, the 2011-16 National Strategic Plan of Action (NSPA) was developed through a broadly participatory, inclusive and interactive process. Over 50 key national experts, policymakers, civil society and international stakeholders were directly involved in a series of National Consultations and have greatly contributed to the process.

The final document produced through the above process was carefully reviewed by the AIDS Strategy and Action Plan (ASAP) of the World Bank. After validating the accepted recommendations, the Strategy was endorsed by the CCM in August 2010.

The NSPA 2011-16 is aligned with the UNAIDS Outcome Framework (Priority Areas 1, 3, 5, 7 and 9, selected on National Consultations in October 2009) and provides ample space for realizing the three zeros and achieving HLM 2011 commitments in Georgia.

*‘Increase capacity of the CCM’s secretariat and enable with the required systems/instruments that assure effective implementation of the coordinating function’* is one of Strategic Priorities of the NSPA 2011-16 with five main Strategic Areas: (1) coordination and advocacy, (2) prevention, (3) treatment, (4) care and support, and (5) health systems strengthening.

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

In order to effectively plan, coordinate and implement the national response, the HIV/AIDS Monitoring and Evaluation (M&E) System and Framework was developed with the participation of multiple stakeholders under the auspices of the CCM and with financial and technical support from UNAIDS. The Technical Working Group (TWG), composed of independent experts from different organizations involved in implementation of the national HIV response, was established. The experts consulted various international manuals and standardized methodologies on the development of HIV/AIDS M&E systems, and conducted site visits and key-informant interviews to gain a better insight into Georgia’s HIV/AIDS M&E needs (for a detailed description see below, paragraph VII).

The National HIV M&E System and Framework, including the Operations Manual and the Operational Plan was developed through a broadly participatory process of workshops and National Consultations, which allowed the maximum synthesis of this new national instrument of HIV accountability with WHO/UNICEF/UNAIDS HIV reporting and UNGASS declaration monitoring tools. The new M&E system and the documents were endorsed by the Georgian CCM in June 2011.

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

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

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

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

1. **Indicator Data in the Overview Table**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Target 1. Halve sexual transmission of HIV by 2015** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Indicator #1.1*** | | **Value** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.**  **(percentage of respondents who gave correct answer to all 5 questions)** | **All**  **Males** | | | **Males** | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
| **10.22%** | | | **11.23%** | | | | | | **9.25%** | | | | | | **9.47%** | | | **15.65%** | | | | | | | **6.60%** | | | | | | **14.85%** |
|  | | **All** | | **Males** | | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** |  | | |
| **2011** | **Question 1: "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"** | **66.74%** | | **66.30%** | | | | | | | **67.15%** | | | | | | **64.27%** | | | **71.37%** | | | | | | | **62.88%** | | | | | | **76.13%** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
|  | | **All** | | **Males** | | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** |  | | |
| **2011** | **Answered Yes to Question 2: “Can a person reduce the risk for getting HIV by using a condom every time they have sex?”** | **65.46%** | | **72.08%** | | | | | | | **59.15%** | | | | | | **72.06%** | | | **72.14%** | | | | | | | **54.45%** | | | | | | **69.03%** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
|  | | **All** | | **Males** | | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** |  | | |
| **2011** | **Answered Yes to Question 3: “Can a healthy-looking person have HIV”?** | **49.33%** | | **47.44%** | | | | | | | **48.47%** | | | | | | **46.26%** | | | **50.38%** | | | | | | | **48.47%** | | | | | | **56.77%** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
|  | | **All** | | **Males** | | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** |  | | |
| **2011** | **Answered Yes to Question 4: “Can a person get HIV from mosquito bites?” (Or country specific question.)** | **26.72%** | | **28.35%** | | | | | | | **25.16%** | | | | | | **26.87%** | | | **32.06%** | | | | | | | **22.70%** | | | | | | **30.32%** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
|  | | **All** | | **Males** | | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** |  | | |
| **2011** | **Answered Yes to Question 5: “Can a person get HIV from sharing food with someone who is infected?” (Or country specific question.)** | **46.78%** | | **44.27%** | | | | | | | **49.17%** | | | | | | **41.37%** | | | **51.53%** | | | | | | | **45.40%** | | | | | | **57.10%** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
| ***Indicator #1.2*** | | **All** | | **Males** | | | | | | | **Females** | | | | | | **M 15-19** | | | **M 20-24** | | | | | | | **F 15-19** | | | | | | **F 20-24** | **Comment** | | |
| **2011** | **Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15** | **11.44%** | | **23.34%** | | | | | | | **0.10%** | | | | | | **25.50%** | | | **17.94%** | | | | | | | **0.15%** | | | | | | **0.00%** | **The BSS survey was conducted only in the capital city, among youth who were enrolled or attending either public or private school at the time of the survey and therefore the findings cannot be generalized to youth nationwide.** | | |
| ***Indicator#1.3*** | | **All**  **Females**  **Females** | | | | **Females** | | | | | | | | | | | **F 15-19** | | | | **F 20-24** | | | | | | | | | | **F 25-49** | | | **Comment** | | |
| **2010** | **Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months** | **0.52%** | | | | **0.52%** | | | | | | | | | | | **0.35%** | | | | | **0.45%** | | | | | | | | | | **0.58%** | | **The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years**,  **Data for males N/A** | | |
| ***Indicator#1.4*** | | **All**  **Females**  **Females** | | | | **Females** | | | | | | | | | | | **F 15-19** | | | | | **F 20-24** | | | | | | | | | | **F 25-49** | | **Comment** | | |
| **2010** | **Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse** | **18.18%** | | | | **18.18%** | | | | | | | | | | | **0%** | | | | | **0%** | | | | | | | | | | **24.00%** | | **The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years**,  **Data for males N/A** | | |
| ***Indicator# 1.5*** | | **All**  **Females**  **Females** | | | | **Females** | | | | | | | | | | | **F 15-19** | | | | | **F 20-24** | | | | | | | | | | **F 25-49** | | **Comment** | | |
| **2010** | **Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results** | **6.45%** | | | | **6.45%** | | | | | | | | | | | **3.02%** | | | | | **10.65%** | | | | | | | | | | **6.12%** | | **The data has been taken from the Georgian Reproductive Health survey The survey population included females between the ages 15 and 44 years**,  **Data for males N/A** | | |
| ***Indicator# 1.6*** | | **All** | | | | | | | | | | | **15-19** | | | | | | | | | **20-24** | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of young women aged 15-24 who are HIV-infected.** | **0.002%** | | | | | | | | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | | | | | | **Georgia is categorized as having a low-prevalence HIV epidemic. No data disaggregated by following age groups available. Number of antenatal clinic attendees (15-24) tested whose HIV test results are positive is 5.**  **15-19: 1 20-24: 4** | | |
| ***Indicator# 1.7*** | | **All FSW**  **FSW** | | | | | | | | | | | **<25**  **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2008** | **Percentage of sex workers who answered “Yes” to both questions** | **66.88%** | | | | | | | | | | | **9.09%** | | | | | | | | | **69.80%** | | | | | | | | | | | | **Source: BSS among female SWs in Tbilisi –** **2008 y. N=160 (Male CSWs N/A)** | | |
|  | |  | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | |  | | |
| **2008** | **Answered Yes to Question 1, “Do you know where you can go if you wish to receive an HIV test?”** | **81.25%** | | | | | | | | | | | **50.00%** | | | | | | | | | **88.73%** | | | | | | | | | | | | **Source: BSS among female SWs in Tbilisi –** **2008 y. N=160 (Male CSWs N/A)** | | |
|  | |  | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | |  | | |
| **2008** | **Answered Yes to Question 2 “In the last 12 months, have you been given condoms?”** | **58.75%** | | | | | | | | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | | | | | | **Source: BSS among female SWs in Tbilisi –** **2008 y. N=160 (Male CSWs N/A)** | | |
| ***Indicator# 1.8*** | | **All FSW** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2008** | **Percentage of female and male sex workers reporting the use of a condom with their most recent client.** | **98.75%** | | | | | | | | | | | **100%** | | | | | | | | | **98.66%** | | | | | | | | | | | | **Source: BSS among female SWs in Tbilisi –** **2008 y. N=160 (Male CSWs N/A)** | | |
| ***Indicator# 1.9*** | | **All FSW**  **Females** | | | | | | | | | | | **<25**  **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2008** | **Percentage of CSWs who received an HIV test in the last 12 months and who knows their results** | **27.50%** | | | | | | | | | | | **0%** | | | | | | | | | **29.53%** | | | | | | | | | | | | **Source: BSS among female SWs in Tbilisi –** **2008 y. N=160 (Male CSWs N/A)** | | |
| ***Indicator# 1.10*** | | **All CSW** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2008** | **Percentage of sex workers who are living with HIV** | **1.95%** | | | | | | | | | | | **0.00%** | | | | | | | | | **2.10%** | | | | | | | | | | | | **Source: BSS among female SWs in Tbilisi –** **2008 y. N=160 (Male CSWs N/A)** | | |
| ***Indicator# 1.11*** | | **All MSM** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2010** | **Percentage of men who have sex with men reached by HIV prevention programs**  **Percentage of MSM who answered “Yes” to both questions** | **20.86%** | | | | | | | | | | | **20.99%** | | | | | | | | | **20.81%** | | | | | | | | | | | | **Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)** | | |
|  | | **All MSM** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | |  | | |
| **2010** | **Percentage of MSM who answered “Yes” to Question 1, “Do you know where you can go if you wish to receive an HIV test?”** | **58.63%** | | | | | | | | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | | | | | | **Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)** | | |
|  | | **All MSM** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | |  | | |
| **2010** | **Percentage of MSM who answered “Yes” to Question 2 “In the last 12 months, have you been given condoms? “** | **36.33%** | | | | | | | | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | | | | | | **Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)** | | |
| ***Indicator# 1.12*** | | **All MSM** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2010** | **Percentage of men reporting the use of a condom the last time they had anal sex with a male partner** | **67.29%** | | | | | | | | | | | **75.29%** | | | | | | | | | **63.59%** | | | | | | | | | | | | **Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)** | | |
| ***Indicator# 1.13*** | | **All MSM** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2010** | **Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results** | **25.90%** | | | | | | | | | | | **27.91%** | | | | | | | | | **25.00%** | | | | | | | | | | | | **Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)** | | |
| ***Indicator# 1.14*** | | **All MSM** | | | | | | | | | | | **<25** | | | | | | | | | **25+** | | | | | | | | | | | | **Comment** | | |
| **2010** | **Percentage of men who have sex with men who are living with HIV** | **7.01%** | | | | | | | | | | | **3.61%** | | | | | | | | | **8.51%** | | | | | | | | | | | | **Bio-behavioral surveillance survey among men who have sex with men in Tbilisi, Georgia (2010)** | | |
| ***Indicator# 1.15*** | | **All** | | | | | | | **Public** | | | | | | | | **Private** | | | | | | | | **Unknown** | | | | | | | | | **Comment** | | |
| **2011** | **Health facilities that provide HIV testing and counseling services** | **35.02%** | | | | | | | **N/A** | | | | | | | | **N/A** | | | | | | | | **N/A** | | | | | | | | | **No data disaggregated by health facility type is available.** | | |
| ***Indicator# 1.17*** | | **Females** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit** | **88.09%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Statistics Department, National Centre for Disease Control and Public Health** | | |
|  | | **Total** | | | | | | | | | | **15-19** | | | | | | | | | | | **20-24** | | | | | | | | | | |  | | |
| **2011** | **Percentage of antenatal care attendees who were positive for syphilis** | **0.03%** | | | | | | | | | | **N/A** | | | | | | | | | | | **N/A** | | | | | | | | | | | **Statistics Department, National Centre for Disease Control and Public Health.**  **No data disaggregated by age groups available.** | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| **2011** | **Percentage of antenatal care attendees positive for syphilis who received treatment** | **N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **No data available** | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | **Percentage of sex workers with active syphilis** | **No Data Available** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **No Data Available** | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | **Percentage men who have sex with men (MSM) with active syphilis** | **No Data Available** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **No Data Available** | | |
| ***Indicator# 1.21*** | | **All** | | | | | | | | | | | **Male** | | | | | | | | | **Female** | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of prisoners who are living with HIV** | **0.25%** | | | | | | | | | | | **0.26%** | | | | | | | | | **0%** | | | | | | | | | | | | **BSS study among prisoners. 2424 prisoners were tested on HIV. Among them 2302 were males and 122 – females. 6 new HIV cases were revealed.** | | |
| [Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015](http://aidsreportingtool.unaids.org/ungass/display/4) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Indicator# 2.1*** | | **N:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Number of syringes distributed per person who injects drugs per year by Needle and Syringe Programs** | **22** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **The data are aggregated according to databases that each ten center products and delivers to program director.** | | |
| ***Indicator# 2.2*** | | **All** | | | | **Males** | | | | | | | | | **Females** | | | | | | | **<25** | | | | | | | **25+** | | | | | **Comment** | | |
| **2009** | **Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse** | **22.42%** | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | **N/A** | | | | | | | **N/A** | | | | | **BSS study N=1127. The IDUs were studied in five different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi and Batumi during 2008-2009.**  **( According to BSS questionnaire in the denominator we can count only number of people who injects drug and having had sexual intercourse in the last YEAR, not month)** | | |
| ***Indicator# 2.3*** | | **All** | | | | **Males** | | | | | | | | | **Females** | | | | | | | **<25** | | | | | | | **25+** | | | | | **Comment** | | |
| **2009** | **Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected** | **48.09%** | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | **42.96%** | | | | | | | **48.83%** | | | | | **BSS study N=1127. The IDUs were studied in five different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi and Batumi during 2008-2009 Disaggregation by sex is not available.** | | |
| ***Indicator# 2.4*** | | **All** | | | | **Males** | | | | | | | | | **Females** | | | | | | | **<25** | | | | | | | **25+** | | | | | **Comment** | | |
| **2009** | **Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results** | **5.68%** | | | | **N/A** | | | | | | | | | **N/A** | | | | | | | **4.93%** | | | | | | | **5.79%** | | | | | **BSS study N=1127. The IDUs were studied in five different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi and Batumi during 2008-2009**  **Disaggregation by sex is not available.** | | |
| ***Indicator# 2.5*** | | **All IDUs** | | | | **Males** | | | | | | | | | **Females** | | | | | | | **<25** | | | | | | | **25+** | | | | | **Comment** | | |
| **2011** | **Percentage of people who inject drugs who are living with HIV** | **3.91%** | | | | **3.95%** | | | | | | | | | **2.08%** | | | | | | | **0.32%** | | | | | | | **4.44%** | | | | | **Source: National HIV surveillance database** | | |
| ***Indicator# 2.6*** | | **N:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2010** | **Number of people on opioid substitution therapy (OST)** | **1632** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **State Program and Global Fund** | | |
| **2011** | **Estimated number of opiate users nationally (injectors and non-injectors)** | **10000** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Experts opinion** | | |
| ***Indicator# 2.7*** | | **N:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Number of needle and syringe program (NSP) sites** | **10** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Among of this 10 sites, 1 center “Tanadgoma” is working in the conflict region of Abkhazia, mainly in Sokhumi.** | | |
| **2011** | **Number of substitution therapy (OST) sites** | **16** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **10 State Program, 6 Global Fund** | | |
| [Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths](http://aidsreportingtool.unaids.org/ungass/display/4) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Indicator# 3.1*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission** | **112.50%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **National Clinical Database; Spectrum EPP.** | | |
| ***Indicator# 3.2*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth** | **96.5%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **One newborn out of 26 left the country before PCR test for HIV was performed.** | | |
| ***Indicator# 3.3*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months** | **12.50%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Spectrum EPP.** | | |
| ***Indicator# 3.4*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labor and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status** | **82%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **We used real registered number of pregnant women, not estimated number for denominator (source NCNCPH Department of Statistics)** | | |
| ***Indicator# 3.7*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission (PMTCT)** | **87.5%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System.** | | |
| ***Indicator# 3.10*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed**  **feeding/other) for infants born to HIV-infected women at DPT3 visit** | **100% replacement breastfeeding** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **All newborn born from HIV positive mothers are provided replacement breastfeeding by Global Fund for 6 months.** | | |
| ***Indicator# 3.13*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment:** | | |
| **2011** | Pregnant Women Who Inject Drugs | **N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **No IDU Pregnant Women has been registered in Georgia in 2011** | | |
| [Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015](http://aidsreportingtool.unaids.org/ungass/display/4) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Indicator# 4.1b*** | | **All** | **Male** | | | | | **Females** | | | | | | | **<15** | | | **15+** | | | | | | **MSM** | | | | | | **IDUs** | | | | **Migrants** | **Prison** | **Comment** |
| **2011** | **Percentage of people diagnosed with HIV infection who need antiretroviral therapy and who receive it** | **97.6%** | **97.76%** | | | | | **97.1%** | | | | | | | **100%** | | | **97%** | | | | | | **100%** | | | | | | **98%** | | | | **100%** | **100%** | **Denominator A is calculated for CD4 <200, which was eligibility criteria in 2011 in Georgia.** |
| ***Indicator# 4.2*** | | **All** | | | | | **Males** | | | | | | | | | **Females** | | | | | | **<25** | | | | | | | | **25+** | | | | **Comment** | | |
| **2011** | **Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy** | **78.81%** | | | | | **76.33%** | | | | | | | | | **85.07%** | | | | | | **70%** | | | | | | | | **79.20%** | | | | **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System.** | | |
| ***Indicator# 4.2a*** | | **All** | | | | | **Males** | | | | | | | | | **Females** | | | | | | **<25** | | | | | | | | **25+** | | | | **Comment** | | |
| **2011** | **Percentage of IDU with HIV known to be on treatment 12 months after initiating antiretroviral therapy** | **75.19%** | | | | | **75.59%** | | | | | | | | | **50.00%** | | | | | | **0%** | | | | | | | | **75.19%** | | | | **HIV/AIDS National Surveillance Data** | | |
| ***Indicator# 4.2c*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiating antiretroviral therapy (from 2006)** | **63%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, national electronic database for HIV aids care and support program.** | | |
| ***Indicator# 4.2d*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of IDU with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (from 2006)** | **57%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **HIV/AIDS National Surveillance Data** | | |
| ***Indicator# 4.4*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of health facilities dispensing ARVs that experienced one or more stock-outs of at least one required ARV drug in the last 12 months.** | **0%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System.** | | |
| ***Indicator# 4.5*** | | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **All** | **Males** | **females** | **<25** | **25+** | **MSM** | **IDUs** | **Migr.** | **CSW** | **Pris.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2011** | **Percentage of people with HIV infection who already need antiretroviral therapy at the time of diagnosis** | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **45.52%** | **47.00%** | **41.94%** | **50%** | **45.45%** | **24.00%** | **49.21%** | **50.00%** | **0.00%** | **56.25%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| [Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015](http://aidsreportingtool.unaids.org/ungass/display/4) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Indicator# 5.1*** | | **All** | | | | **Males** | | | | | | | | **females** | | | | | **<15** | | | | | | | | | **15+** | | | | | | **Comment** | | |
| **2011** | **Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV** | **113%** | | | | **N/A** | | | | | | | | **N/A** | | | | | **N/A** | | | | | | | | | **N/A** | | | | | | **2011 Antiretroviral Patient Registers from and Estimates from WHO Stop TB database 2010**  **(Estimated denominator disaggregated by sex and age is not available in Stop TB database)** | | |
| ***Indicator# 5.3*** | | **Number** | | | | | | | | | | | | | | | **%** | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Number and percentage of adults and children newly enrolled in HIV care who start on treatment**  **for latent TB infection (isoniazid preventive therapy) among the total number of adults and children newly enrolled in HIV care over a given time period** | **64** | | | | | | | | | | | | | | | **15.76%** | | | | | | | | | | | | | | | | | **Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System** | | |
| ***Indicator# 5.4*** | | **Number** | | | | | | | | | | | | | | | **%** | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Number and percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit among all adults and children enrolled in HIV care in the reporting**  **period** | **387** | | | | | | | | | | | | | | | **100%** | | | | | | | | | | | | | | | | | **Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System** | | |
| [Target 7. Critical enablers and synergies with development sectors](http://aidsreportingtool.unaids.org/ungass/display/4?dsp=4)   |  |  | | --- | --- |  |  | | --- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Indicator# 7.2*** | | **Females All** | | | | | | | | **F 15-19** | | | | | | | **F 20-24** | | | | | | | | | **F 25-49** | | | | | | | | **Comments:** | | |
| **2011** | **Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months** | **1.87%** | | | | | | | | **5.38%** | | | | | | | **2.19%** | | | | | | | | | **1.69%** | | | | | | | | **The data has been taken from the Georgian Reproductive Health survey. (RHS)** | | |
| ***Indicator# 7.6*** | | **Number:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Number of adults and children with HIV enrolled in HIV care** | **1852** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **HIV/AIDS National Surveillance Data** | | |
| ***Indicator# 7.7*** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Comment** | | |
| **2011** | **Percentage of adults and children enrolled in HIV care who were screened for Hepatitis C** | **100%** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Based on national guidelines all cases enrolled in HIV care were tested on hepatitis** | | |

1. **Overview of the AIDS epidemic**

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

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

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

***Figure 2. New HIV/AIDS Cases by Years***

The epidemiological distribution of the disease by gender and age indicates more cases among the 25-40 age group. The biggest difference between the number of infected men and women was also detected in this age group (25+), while the gender difference is minimal among the 15-24 year olds. In previous years, the proportions of male and female HIV+ cases were 75% and 25% respectively. In 2011, the proportion was changed, with males accounting for 70% of cases and females at 30%. This shift would be explained by the spread of HIV among sexual partners of IDUs.

The available evidence from the National Surveillance Database reveals that the 25+ age group shows the highest prevalence of HIV infection (Figures 3, 4), and within this group male case account for nearly three times more than females (Figure 3). Notably, among those under 25, there is almost no gender difference reflected. By the end of 2011, the number of officially registered HIV infected children under 15 reached 73, with 12 new cases registered in 2010 and 6 diagnosed in 2011.

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



***Figure 4*.**

***Incidence of HIV/AIDS per 100000 populations, Georgia***

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

It is acknowledged that women attending antenatal clinics (ANC) generally provide the best available estimates of HIV prevalence in the general population as a proxy-indicator. This number is ascertained from routine surveillance. According to the surveillance data (NCDCPH, 2010) the vast majority of pregnant women attending ANCs were tested for HIV under the PMTCT program.

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

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

In the early years of the HIV epidemic in Georgia, as in most Eastern European countries, IV drug use was the major transmission mode. Since 2009, transmission has shifted toward the heterosexual mode (Figure 5) which became dominant by 2011. In 2010, IV drug use represented 46.7% of the transmission mode, while heterosexual activity represented 43.3%. By 2011, IV drug use dropped to 44.6 % while heterosexual activity rose to 47.4%. It should be noted that, in the recent report, the above-mentioned tendency (shown on Fig.5) is based solely on the distribution of new cases.

***Figure 5: Percentage mode of HIV transmission by year***

Source: National Surveillance Database, 2011

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

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



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

***Figure 7. Number of people receiving antiretroviral therapy in Georgia***

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1. **National Response to the AIDS Epidemic**

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

The main purpose of the State Program on HIV/AIDS prevention is early detection of new HIV/AIDS cases to reduce the spread of HIV/AIDS and provide access to treatment for HIV/AIDS+ patients. This program covers voluntary counseling and testing for high risk groups, including IDUs, TB patients, STI patients, prisoners, patients with Hepatitis B and C, patients with clinical signs of HIV/AIDS, persons having contact with HIV infected, blood donors, pregnant women, MSM, and FSWs.

The State Program on HIV/AIDS treatment covers outpatient and inpatient services, and ART is fully funded by the Global Fund. The State Program on Safe Blood envisages the mandatory testing of all blood donors for HIV, Hepatitis B and C and Syphilis.

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

VCT centers have also been established in prisons under the GF supported project. Sixteen VCT service centers have become operational in Georgia, with approximately 5,600 receiving HIV counseling and testing in prisons.

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

Palliative care has been recognized as an essential component of a comprehensive care package for PLWHIV. Since 2008 palliative care services have continued to operate in Georgia with the aim of improving quality of life for patients and their families, through the prevention, assessment, and treatment of physical, psycho-social and spiritual problems.

1. **Best Practices**

International experts regard the Georgian model of HIV/AIDS treatment and care as the best among the countries of the former Soviet Union (FSU) and one of the best, if not the best, among low and middle income countries. The HIV/AIDS treatment and care program is implemented by the Infectious Diseases, AIDS and Clinical Immunology Research Center (National AIDS Center) which, along with three affiliated regional facilities, provides free medical services through the national program and GF supported projects. Remarkably, TGF support was critical in scaling-up ART in the country and since 2004 Georgia has remained the only FSU country to achieve almost universal access to ART.

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

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

In 2011 over 90% of newly diagnosed patients were linked to HIV clinical care at national or regional facilities.

Trusted provider-patient relationships and the availability of ancillary services for patients promote high retention rate, with only a 5% loss in follow-up. ART program data indicates that early attrition largely results from cases of death, which in turn is the result of late HIV detection.

Other services that contribute to improving the quality of life of people living with HIV in Georgia include palliative (institutional and home-based) care, food assistance, close linkages with drug dependence and tuberculosis services and a network of patient self-support centers.

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

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

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

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

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

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

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

1. **Major Challenges and Remedial Actions**

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

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

The stigmatization of and discrimination against HIV + groups continues to be a major barrier to HIV prevention and service utilization. Negative social attitudes and low public awareness also remain obstacles. Along with societal attitudes, state criminal laws, regulations and policies relevant to drug use and preventive work among IDUs and prisoners are among the limiting factors. The laws regarding drug use are not compatible with addiction prevention and treatment, which in turn hinders the implementation of effective interventions in the public and penal sectors. Therefore, issue-focused and targeted advocacy efforts aimed at improving the legal environment are essential for the future success of Georgian HIV policy and response.

The UN Joint Team is actively engaged with the CCM of Georgia and the broader community of national and international HIV response stakeholders to achieve a more balanced legal environment regarding the official approach to handling drug use and addiction. In 2009 progressive new legislation on HIV and AIDS was developed with close collaboration between the GF supported HIV Program and the UN Theme Group on HIV and AIDS and was endorsed by the Parliament. These new drug legislation projects were developed in close collaboration with UN agencies and, more specifically, the EU-supported UNDP South Caucasus Anti-Drug (SCAD) program, and submitted to the Parliament of Georgia for discussion. Despite the bold advocacy of these international agencies towards improving Georgia’s official narcotic drugs policy and laws, adequate steps to decriminalize drug use and enable effective HIV prevention among people who inject narcotic drugs have, regrettably, yet to be made.

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

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

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

1. **Support from the Country’s Development Partners**

**U.S. Agency for International Development (USAID)**

The U.S. Agency for International Development (USAID) has been making significant contributions in the effort to control HIV/AIDS in Georgia. In February 2010, USAID initiated a new five-year plan entitled the “Georgia HIV Prevention Project” (GHPP). The goal of the project is to support HIV prevention among high-risk groups in order to avert the spread of HIV to the general population.

GHPP awarded RTI International and its subcontracting partners, Save the Children, and Program for Appropriate Technologies in Health (PATH), to work with a number of local nongovernmental organizations to develop and implement HIV-prevention activities aimed at the most-at-risk populations (MARPs), specifically IV drug users and their partners, men who have sex with men, female sex workers, and at-risk youth. The project works at the individual, community, societal, and policy levels to reduce HIV-related stigma and discrimination in Georgia. Activities in 2010-2011 were implemented in six major cities of Georgia.

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

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

As a part of its youth-focused component, GHPP, in partnership with the Ministry of Education and Science (MoES) of Georgia, has successfully pilot-tested a consolidated Healthy Lifestyles Curriculum (HLC) in Tbilisi and Telavi. Currently steps have been taken to institutionalize the use of the HLC in all secondary schools nationwide.

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

**UNAIDS**

Since 1999, the United Nations (UN) Theme Group on HIV/AIDS has played a crucial role in providing financial and technical assistance to expand the national response to AIDS in Georgia. Over the last two years, the UNAIDS contribution has became visible and well-acknowledged. With the support of the Joint United Nations Program on HIV/AIDS (UNAIDS), a new National Strategic Plan of Action – NSPA 2011-16 – was developed through broadly inclusive and interactive process and approved by the CCM in August 2010. The NSPA 2011-16 is aligned with and based on the UNAIDS Outcome Framework (2009-11). It provides ample space for realizing the new global strategy of “Getting to Zero” and achieving the 2011 HLM on HIV targets, as well as new political declaration commitments in Georgia by 2015. It has five main Strategic Areas: 1) coordination and advocacy; (2) prevention; (3) treatment; (4) care and support, and; (5) health systems strengthening. Remarkably, the new National Health Care Strategy 2011-2015 supported the main goal of the HIV NSPA.

In 2010-11 the one National HIV M&E System and Framework was developed through UNAIDS- supported participatory national process and endorsed by the CCM of Georgia in June 2011. This allowed for maximum harmonization of this new national instrument of accountability with well-practiced international HIV-monitoring and reporting tools.

**The Global Fund to Fight AIDS, Malaria and Tuberculosis**

Since 2004, funds mobilized through The Global Fund (TGF) have been critical for scaling up the National Response to HIV/AIDS in Georgia. The country consolidated proposal:  “Sustaining and scaling up the existing national responses for implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care interventions in Georgia,” started on January 1, 2010. This project ensures sustainability and expands where feasible, effective HIV/AIDS prevention, treatment, care and support interventions initiated through Round 2 and Round 6 projects in Georgia, as well as newly submitted Round 9 projects aiming at the treatment of opportunistic infections and the implementation of an HIV drug resistance strategy in Georgia. Consolidated proposals led to the allocation of EUR 24+ million (EUR 24,209,417.00 was the board approved amount), from the TGF for Phase 1 (Jan 2010 – 31 Dec 2012).

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

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

**Curatio International Foundation**

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

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

The first component implied the following activities: a) Assessment of the current HIV/AIDS Surveillance System; b) Development of the National HIV/AIDS Surveillance Plan; c) Development of HIV/AIDS Surveillance guidelines/protocols (including standard case definition, registration, notification, reporting, and investigation forms); c) Trainings of the personnel working in institutions/ facilities involved in HIV/AIDS surveillance, and; d) Development of software application for processing and analysis of case-based data for HIV/AIDS at the regional and central levels.

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

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

**World Health Organisation**

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

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

**United Nations Population Fund (UNFPA)**

Within the framework of the UNFPA second 2011-2015 Country Programme for Georgia SRH&R of youth is one of the special directions covering HIV/AIDS prevention and promotion of healthy life-style.

* In 2010 UNFPA, UNICEF and USAID jointly supported incorporation of the principles of the “National Concept and Curriculum on Healthy and Harmonious Education” (developed within the framework of EU/UNFPA “RHIYC” project) in the National Educational Plan approved by MoES. The above includes youth awareness raising on HIV/AIDS prevention.
* Youth Policy encompassing youth sexual and reproductive health and rights and HIV prevention was developed in 2011 through the participatory approach with leadership of the Ministry on Sports and Youth Affairs and UNICEF and UNFPA support.
* UNFPA/Georgia continues its partnership with the “All Party Group on MDGs” at the Parliament of Georgia. This group works on broad range on policy issues connected with MDG Goals, including Youth SRH&R and HIV prevention.
* UNFPA in collaboration with UNICEF and USAID supported the 3rd national Reproductive Health Survey in 2010 with a separate set of questions regarding HIV/AIDS, including those related to UNGASS indicators.
* UNFPA remains one of the main providers of free of charge contraceptives to the country and ensures continuous provision of the supply of modern contraceptives including condoms.
* UNFPA supported opening of 20 youth friendly RH medical and informational centers (Centers) throughout the country. Partnership strategy with the private sector is used to ensure sustainability of youth-friendly integrated HIV/AIDS and RH services at the primary health care level. UNFPA ensures continuous provision of Combo Test Kits (HIV, HCV, HBsAg, and Syphilis) to the Centers.
* UNFPA/Georgia has been supporting youth awareness raising on SRH&R and HIV prevention including peer to peer education at youth summer camps, expanding peer educators network in Georgia, organizing national Youth Festivals to promote healthy life style and knowledge sharing among youth.
* UNFPA/Georgia addressed HIV prevention among vulnerable key target groups, in particular: men in uniform, IDP youth and street children, FSWs, MSMs.
* A series of training sessions were conducted within the framework of UN Cares Programme, (with UNFPA/Georgia as a Managing Agent), on different aspects related to the HIV prevention, for the UN personnel and staff of the Georgian Parliament Committees (2010-2011).

World Vision Georgia

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

Based on subsequent evaluation and the lessons learned from the results of the project, WV Georgia started a new three-year undertaking: the “Cross Border Joint Advocacy for HIV Prevention Project”. This new project aims to decrease the vulnerability of migrants to HIV/STIs and to strengthen the protection of their human rights. The project fosters advocacy for victims of gender and family violation through the joint advocacy efforts of civil society actors and governmental organizations. The project intends to reduce migrants’ socio-cultural vulnerability, and increase access to improved and sustainable prevention, care and support services in both the home and the destination country.

***Several local NGOs functioning in Georgia have made a significant contribution towards the prevention of HIV/AIDS:***

**Centre for Information and Counselling on Reproductive Health – Tanadgoma**

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

Since 2002 Tanadgoma has been involved in providing services to key populations – FSWs, MSM, IDUs, and prison convicts – in Georgia. It offers individual counseling through hotlines and face-to-face visits, outreach, voluntary HIV counselling and testing at Tanadgoma centers as well as through the GFATM-funded “Offices of Health” mobile laboratories which offer STI testing and treatment, peer education and condom and materials distribution.

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

Tanadgoma’s main donors in the field of HIV/AIDS are USAID/RTI, and GFATM, as well as advocacy-related support from amfAR (2011), RFSU/SIDA (sexuality education), and UNFPA (training on HIV to all UN staff).

**Georgian Harm Reduction Network**

GHRN was established in 2006 and since 2008 it has been a sub recipient of GFATM HIV grants in Georgia. GHRN unifies 21 member organizations and operates 10 harm reduction service sites in Tbilisi and other 8 towns across Georgia. GHRN mission is to develop cooperation for implementing effective drug policy and expanding medical, social and legal services for drug users in Georgia.

GHRN is the key actor to deliver low threshold harm reduction services to IDUs in Georgia. The services provided by service sites include but are not limited to needle/syringe programs, safe injection and safe sex devices, and information material distribution among IDUs. GHRN service sites also offer medical counseling and other supplementary services. GHRN reaches out to over 3500-4000 IDUs per month and plays a crucial role in HIV/AIDS prevention among this key population.

Apart from service delivery, GHRN pursues active advocacy and strategies for human rights protection and promotion of best public health principles in the country. The organization is represented in the Inter-agency Council on Drug Policy and actively promotes evidence based approach in drug control and decision-making. GHRN is a strong advocate for strengthening community systems and inclusive response at all levels.

**Maternal and Child Care Union**

The NGO “Maternal and Child Care Union” (MCCU) has been functioning since 2000. The activities of MCCU are related to prevention, counseling and education connected to various infectious diseases, including HIV/AIDS. The main target groups are women of childbearing age and their partners, children and adolescents.

MCCU has undertaken a range of different projects in the field of HIV/AIDS:

* “Prevention of mother-to-child HIV transmission in Georgia”, funded by the Elizabeth Glaser Pediatric AIDS Foundation. The goal of the project was the development and implementation of HIV voluntary counseling and testing services for pregnant women and the prevention of mother-to-child HIV transmission. About 400 healthcare workers (obstetricians/gynecologists and pediatricians) were HIV infection-specific training. =MCCU also wrote and published the training manual “HIV/AIDS”. Voluntary HIV counseling and testing services were implemented in all prenatal care centers in Tbilisi. More than 30,000 pregnant women were counseled and tested on HIV infection and prophylactic antiretroviral treatment was administered to HIV-positive mothers and their infants.
* “HIV information for expecting and breastfeeding mothers,” in partnership with World Vision. The objective of the project was to increase HIV awareness among socially disadvantaged young women. Through the project social workers and health care workers at maternity hospitals were trained on HIV infection and HIV pre- and post-test counseling. Two HIV manuals (for social workers and for health care workers) and different educational materials for young women were developed, printed and distributed. Trained social workers conducted HIV counseling for young mothers and the evaluation of counseling effectiveness using pre- and post-counseling surveys was carried out.
* “Prevalence and awareness of blood borne infections among Georgian Health Care Workers,” funded by the Fogarty International Center (NIH) and the NATO Science for Peace and Security program. Within the project 1,480 HCWs were surveyed on HIV and hepatitis (KAP survey) and blood tests were done to estimate the prevalence of blood borne infections.

In 2011 MCCU carried out the project “Peer education on healthy lifestyle issues, including HIV/AIDS” reaching out to young people at universities, vocational training centers, secondary schools and juveniles in conflict with the law. The project was performed in partnership with the Research Triangle Institute International (RTI) which is implementing the USAID-funded Georgia HIV Prevention Program. Within the project more than 1,000 persons were educated on HIV/AIDS in Tbilisi and different regions of Georgia.

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

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

1. **Monitoring and Evaluation Environment**

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

The Georgia National HIV/AIDS Monitoring and Evaluation Framework was adopted in 2011. Several consultative meetings were conducted to agree on a core set of indicators and institutions were aligned to improve coordination within the M&E system. The M&E framework document incorporated stakeholder feedback and was submitted to the CCM for endorsement in March 2011.

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

* 1. It provides opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV/AIDS;
  2. It assists in responding to the international commitments and reporting requirements;
  3. It provides the platform for partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating national and decentralized responses to HIV/AIDS.

The document outlines an HIV/AIDS M&E system for Georgia. It contains three separate sections: HIV national M&E system design; M&E operations manual (which describes how individual components of the national M&E system works), and; the operationalization plan (which provides an overview of the priorities to be undertaken within the first three years of establishing the system).

The M&E system in the country is crucial for the Government of Georgia to estimate the magnitude of the problem based on more accurate data, identify contributing factors, and generate realistic estimates of required resources. These results will be used to delineate the scope and coverage of this programmatic intervention. Adequate data collection and reporting mechanisms ensure transparency in the implementation of the national response and encourage the participation of multiple local and international partners and civil society.

An appropriate and efficient M&E system is the cornerstone of a country’s HIV response. The results provide the data needed to make evidence-based decisions for program management and improvement, policy formulation and advocacy, and are necessary for satisfying accountability requirements.

More importantly, an appropriate and efficient M&E system enhances local community and health-facility-based programs. The National HIV/AIDS M&E Framework provides stakeholders with a tool for well-coordinated, harmonized and functional HIV/AIDS M&E systems that allow them to efficiently assess how well HIV/AIDS interventions are contributing to achieving the national program goals.

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

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

1. In order to ensure effective functioning of the national HIV M&E system, the NCDCPH is assigned to serve as a technical arm for the CCM. The NCDCPH, in close collaboration with the CCM technical secretariat, is responsible for the overall coordination on the various data flows and the availability and easy access to data. The NCDCPH M&E coordinator will use a national HIV/AIDS database as a warehouse to store monitoring and evaluation information, to undertake periodic and/or specific analysis of available data, and make the M&E research products readily available to stakeholders as required.
2. A core function of NCDCPH is to coordinate the national HIV/AIDS surveillance system. The center through its HIV-surveillance unit will fulfill the following functions:

Core Functions:

* Analyze data (through appropriate IT infrastructure and software administration).
* Based on data analysis, generate reports, and conduct regular assessment and analyses of the epidemiological situation.
* Prepare recommendations on revisions needed to modify variables, indicators or definitions for epidemiological analysis.
* Run the HIV National web portal to ensure that all M&E products are collected and are easily available to all stakeholders. This will serve as a common platform at the country level for storage of M&E documents and publications.

Quality Control Functions:

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

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

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

**Annex 1.**

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

In accordance with recommendations from the Guideline on Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS, this Country Progress Report was developed over the course of several national consultation meetings (initial Global Progress Report Introductory Workshop in November 2011, Midterm Country Progress Report Workshop in February, and the Report Validation Workshop in March 2012), individual meetings with the key stakeholders, and desk reviews. Data for specific indicators were reviewed by experts from governmental, non-governmental, and international organizations. Based on UNAIDS recommendations, data for each national indicator and the draft Country Progress Report were presented, discussed and validated at the broad inclusive meetings involving representatives of the Government of Georgia and other state and non-state actors, both national and international.

This Country Progress Report was developed in a participatory manner, with overall coordination on the part of the National Center for Disease Control and Public Health (NCDCPH) and the Country Coordinating Mechanism (CCM), in close collaboration with the UNAIDS Country Office. The NCDCPH directly facilitated all consultations and relevant data collection endeavors.

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

**Annex 2.**

**National Commitments and Policy Instrument (NCPI) 2012**

Data for the **N**ational Commitments and Policy Instrument (NCPI) have been collected by administering NCPI questionnaire in accordance with recommendations from the Guideline on Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS. The questionnaires have been translated into Georgian and distributed among all key stakeholders. Part (A) of the questionnaire was completed by government officials and Part (B) by the civil society organizations, bilateral donors and UN agencies.

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

Two separate meetings were held for government officials, civil society organizations, bilateral donors and UN agencies.

The following organizations participated in the NCPI :

1. Government (Part A)

1. Country Coordinating Mechanism

2. The Ministry of Labor, Health and Social Affairs

3. Penitentiary System

4. Ministry of Justice

5. Ministry of Education and Science

6. National Center for Disease Control and Public Health

7. Infectious Diseases, AIDS and Clinical Immunology Research Center

8. Research Institute on Drug Addiction

9. National Center for TB and Lung Diseases

1. NGOs, donors and international organizations: (NCPI Part B)
2. Association “ Tanadgoma”
3. Curatio International Foundation
4. World Vision Georgia
5. UNICEF
6. UNAIDS
7. UNFPA
8. Public Union “Bemoni”
9. World Bank
10. USAID
11. The Global Fund
12. Harm Reduction Network
13. USAID Georgia HIV prevention project
14. WHO Country Office

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

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

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

1. NCDCPH Statistics Yearbook [↑](#footnote-ref-1)
2. NCDCPH Statistics Yearbook [↑](#footnote-ref-2)