

**United Nations General Assembly Special Session on HIV/AIDS**

**Monitoring the Declaration of Commitment on HIV/AIDS**

**G E O R G I A**

**Country Progress Report**

**Reporting Period**

**2008 – 2009 calendar years**

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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
GEL	Georgian Lari
GIP	Global Initiative on Psychiatry
GoG	Government of Georgia
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOGA	Georgian Obstetricians and Gynecologists Association
HIV	Human Immunodeficiency Virus
HR	Human Resources
IDUs	Injecting Drug Users
IOM	International Organization on Migration
LSBE	Life-skills based Education
MARPs	Most-at-risk populations
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
NCDC	National Center for Disease Control and Public Health
NIS	Newly Independent States
NSPA	National Strategic Plan of Action
OIs	Opportunistic infections
PLWH	People living with HIV
PTF	STI/HIV Prevention Task Force
SHIP	STI/HIV Prevention Project
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
VRF	Vishnevskaya-Rostropovich Foundation
WHO	World Health Organization

## **II. Status at a glance**

### ***The inclusiveness of the stakeholders in the report writing process***

With the purpose to ensure the inclusiveness of the stakeholders, the preparation of the country progress report has involved national consultation meetings, individual meetings with key stakeholders and desk reviews. An introductory workshop on UNGASS reporting requirements organized on November 12 attended by representatives of government, non-governmental organizations, UN agencies and representatives of donor communities. Stakeholders discussed the process of developing country progress report: a consensus was reached on the methodologies and tools for preparing the NCPI (see the indicator #2 for additional information) as well as on collecting information for core indicators. After developing first draft of the country progress report, it was shared with the wide audience allowing stakeholders, including government agencies and civil society to comment on the draft report. All the comments were discussed and incorporated in the final report that was presented at the National Consultation Meeting on March 9, 2010.

### ***The status of HIV/AIDS Epidemic in Georgia***

Georgia is categorized as having a low-prevalence HIV epidemic with the estimated HIV prevalence below 0.01%. Based on Spectrum estimation HIV prevalence did not exceed 0.07% by the end of 2008 and 0.08% in 2009. Estimates suggest that in 2008 the number of people living with HIV/AIDS in the country was around 2940 (2350-3666) in 2008 and 3390 (2369-43330) by the end of 2009 year. HIV remains to be concentrated in most-at-risk populations. The highest HIV prevalence was observed among MSM (3.7%) followed by IDUs and FSWs.

All the data for knowledge, behavior as well as HIV prevalence indicators on MARPs that are presented in the report were generated through the Behavioral Surveillance Surveys with Biomarker Component carried out under the two separate programs: the USAID funded STI/HIV Prevention (SHIP) Project being implemented by Save the Children Georgia Country Office and its local partner NGOs – Information Counseling Center Tanadgoma, and Bemoni Public Union; and the GFATM Project in Georgia being implemented by the Curatio International Foundation (CIF) in partnership with the National AIDS Center and the same two local NGOs – Tanadgoma, and Bemoni. For brevity's sake, all BSSs completed under the SHIP Project hereinafter will be referred to as BSS (SHIP) and the surveys conducted under the GFATM funded project will be referred to as BSS (GF).

Several rounds of BSSs have been successfully completed among IDUs, MSM and FSWs in several cities. All the surveys have been utilizing similar sampling methodologies: Respondent Driven Sampling for BSSs among IDUs and MSM; and Time-and-Location Sampling for BSSs among FSWs. These methodologies have been internationally recognized and most recommended approaches for reaching out to hidden populations. (Electronic versions of BBS reports produced under the SHIP Project are accessible on the USAID website (<http://dec.usaid.gov>). All the reports produced by the GF are accessible for public on the CIF's website – [www.curatiofoundation.org](http://www.curatiofoundation.org).)

All BSSs in Georgia have used almost standardized questionnaires for each high-risk group, with slight modifications from year to year that were incorporated in response to the UNGASS reporting requirements. Utilizing the same methodologies and survey tools has enabled experts to make the data amenable to comparative analysis across the cities by years. To reflect data from as many as possible survey sites, some indicators presented in the report are derived from the aggregated data from BSSs in several cities; however separate indicators by each survey site are also demonstrated wherever possible.

## ***The Policy and Programmatic Response***

National efforts have led to a number of key achievements: establishment of HIV/AIDS service organizational structures, and development of legal, policy and programmatic environment. The State Law on HIV/AIDS was adopted in 1995, with amendments followed in the year 2000; in November 2009 a New Law on HIV/AIDS was adopted. Acknowledging that non-discriminatory and protective legislation creates a supportive legal and political environment for scaling up effective HIV/AIDS prevention efforts, initial steps have been taken to revise anti-drug legislation in Georgia.

Since 1996 the national HIV/AIDS prevention & control programs were coordinated by the multisectoral Governmental Commission on HIV/AIDS, STIs & Other Socially Dangerous Diseases represented by line-ministries and health institutions working in the field of STI/HIV. Built on the Governmental Commission, a Country Coordinating Mechanism was established in 2002. To demonstrate political commitment to HIV/AIDS, the CCM is led by Mrs. Sandra Elisabeth Roelofs, First Lady of Georgia. The CCM includes broad representation from all relevant ministries, government institutions, UN, civil society organizations, bilateral and multilateral agencies as well as organizations representing people living with HIV. While seeking enhanced representation of NGO sector in the CCM, local NGOs are selected on a rotational basis through the STI/HIV Prevention Task Force.

In response to the “Three Ones” principles that call for the coordination of a National AIDS response around one agreed action framework, the CCM became one National Coordinating Authority in May, 2007 taking a leading role in national advocacy for coordinated responses, in development of national HIV strategy, policies and legislation, in monitoring and evaluation of HIV programs nationwide.

The key strategic document on HIV/AIDS – the National Strategic Plan towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Georgia was developed in 2005 outlining policy and programmatic priorities for 2006-2010. The NSP was updated in 2007. Four major strategic objectives have been identified in NSP: Surveillance (1); Prevention (2); Treatment, Care and Support (3); and National Commitment (4). In 2009, through the financial and technical support from UNAIDS, an HIV/AIDS Situation and National Response Analysis has been successfully completed. Based on the findings, a list of national priorities was identified. An Experts’ group supported by UNAIDS have started elaboration of a new National Strategic Plan for 2011-2016.

**UNGASS Indicator Data in an overview table**

National Programmes							
Indicator #3		Value					Comment
Percentage of donated blood units screened in a quality assured manner		0%					All (100%) blood units have been tested for HIV, however there is no External Quality Assurance scheme in place
Indicator #4		All	Males	Females	<15	15+	Comment
2009	Percentage of adults and children with advance HIV infection receiving antiretroviral therapy	95.5%	99.4%	88.6%	133.3%	94.3%	The number of children with advanced HIV infection generated through Spectrum is underestimated
2008	Percentage of adults and children with advance HIV infection receiving antiretroviral therapy	89.6%	93%	81.7%	184.6%	87.3%	The number of children with advanced HIV infection generated through Spectrum is underestimated
Indicator #5		All					Comment
2009	Percentage of HIV-infected pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission	57.14%					Source: Antiretroviral Therapy Patient Registers
2008	Percentage of HIV-infected pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission	115.79%					The number of HIV-infected pregnant women in 2008 generated through Spectrum is underestimated
Indicator # 6		All					Comment
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV		66.7%					
Indicator # 7		All					Comment
HIV Testing in the General Population		No data					Indicator relevant; data not available

<i>Indicator # 8</i>		All males	Females	<25	25+	Comment
FSWs	Percentage of FSWs who received an HIV test in the last 12 months and who knows their results	N/A	27.5%	0%	29.53%	Source: BSS among FSWs in Tbilisi - 2008 y. N=160
MSM	Percentage of MSM who received an HIV test in the last 12 months and who knows their results	23.53%	N/A	11.1%	31.7%	Source: BSS among MSM in Tbilisi ; 2007 y. N=140
IDUs	Percentage of IDUs who received an HIV test in the last 12 months and who knows their results	5.7%	N/A	4.93%	5.79%	Source: BSS among IDUs in 5 cities; 2008-2009 years; N=1127
<i>Indicator # 9</i>		All males	Females	<25	25+	Comment
FSWs	Percentage of FSWs reached with HIV prevention programs	N/A	66.9%	27.3%	69.8%	Source: BSS among FSWs in Tbilisi - 2008 y. N=160
MSM	Percentage of MSM reached with HIV prevention programs	66.4%	N/A	61.4%	69.9%	Source: BSS among MSM in Tbilisi ; 2007 y. N=140
IDUs	Percentage of IDUs reached with HIV prevention programs	11.45%	N/A	16.9%	10.7%	Source: BSS among IDUs in 5 cities; 2008-2009 years; N=1127
<i>Indicator # 10</i>						Comment
Support for Children Affected by HIV and AIDS		No data				Subject Matter not relevant
<i>Indicator #11</i>						Comment
Percentage of schools that provided life skills based HIV Education in the last academic year (30 h. to each grade)		0%				Subject matter relevant; indicator measurement method seems to be irrelevant
<i>Knowledge and Behavior Indicators</i>						
<i>Indicator #12</i>						Comment
Current school attendance among orphans and		No data				Subject Matter not relevant
<i>Indicator # 13</i>						Comment
Young people: knowledge about HIV Prevention		No data				Indicator relevant; data not available

<i>Knowledge and Behavior Indicators</i>							
<i>Indicator # 14</i>		All males	Females	<25	25+	Comment	
FSWs	Percentage of FSWs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	N/A	8.13%	0%	8.7%	Source: BSS among FSWs in Tbilisi - 2008 y. N=160	
MSM	Percentage of MSM who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	25%	N/A	21%	27.7%	Source: BSS among MSM in Tbilisi ; 2007 y. N=140	
IDUs	Percentage of IDUs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	37.5%	N/A	30.3%	38.6%	Source: BSS among IDUs in 5 cities; 2008-2009 years; N=1127	
<i>Indicator #15</i>		No data				Comment	
Sex before the age of 15		No data				Indicator relevant; data not available	
<i>Indicator #16</i>		No data				Comment	
Higher risk sex		No data				Indicator relevant; data not available	
<i>Indicator #17</i>		No data				Comment	
Condom use during higher risk sex		No data				Indicator relevant; data not available	
<i>Indicator #18</i>		All males	Females	<25	25+	Comment	
FSWs	Percentage of FSWs reporting the use of a condom with their most recent client	N/A	98.8%	100%	98.7%	Source: BSS among FSWs in Tbilisi - 2008 y. N=160	
<i>Indicator #19</i>		All males	Females	<25	25+	Comment	
MSM	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	61.7%	N/A	60.4%	62.5%	Source: BSS among MSM in Tbilisi ; 2007 y. N=140	
<i>Indicator # 20</i>		All males	Females	<25	25+		
IDUs	Percentage of IDUs reporting the use of a condom the last time they had sex with <u>paid for sex partners</u>	77.9%	N/A	85.1%	75.9%	Indicator is given only for condom use during last sex with CSWs; Source: BSS among IDUs in 5 cities; 2008-2009 years; N=1127	
<i>indicator #21</i>		All males	Females	<25	25+	Comment	
Percentage of IDUs reporting the use of sterile injecting equipment the last time they injected		48.1%	N/A	43%	48.8%	Source: BSS among IDUs in 5 cities; 2008-2009 years; N=1127	
<i>Indicator #22</i>		N/A				Comment	
Reduction in HIV prevalence		N/A				Subject Matter not relevant	
<i>Indicator # 23</i>		All males	Females	<25	25+	Comment	
FSWs	Percentage of FSWs who are HIV Infected	N/A	1.95%	0%	2.1%	Source: BSS among FSWs in Tbilisi - 2008 y. N=160	
MSM	Percentage of MSM who are HIV Infected	3.6%	N/A	3.5%	3.6%	Source: BSS among MSM in Tbilisi ; 2007 y. N=140	
IDUs	Percentage of IDUs who are HIV Infected	2.2%	N/A	0%	2.5%	Source: BSSs among IDUs in 6 cities; 2008-2009 years; N=1289	
<i>Indicator #24</i>		All	Males	Females	<15	15+	Comment
Percentage of adults and children with know to be on treatment 12 months after initiating ARV		81%	79.3%	86.7%	81.8%	81%	Source: Antiretroviral Therapy Patient Registers



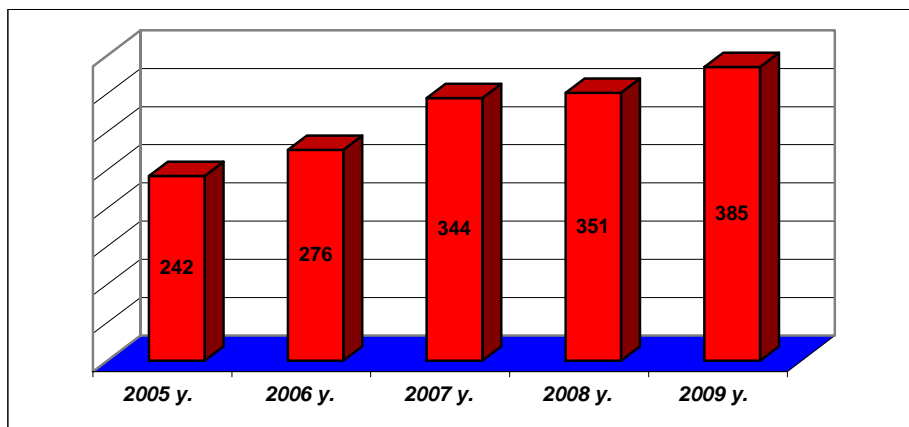
### III. Overview of the AIDS Epidemic

As of December 31, 2009 a total of 2236 HIV cases have been registered in Georgia. The vast majority of people living with HIV/AIDS were aged 25-45-years at the time of diagnosis. The gender distribution is skewed with 25% female and 75% male cases. By the end of 2009, the number of officially registered HIV infected children under 15 reached 54; of them 14 new cases were registered in 2008, and 5 children were diagnosed with HIV in 2009.

It is acknowledged that in the absence of population-based surveys that include testing for HIV antibodies, sentinel surveillance of women attending antenatal clinics generally provides the best available estimates of HIV prevalence in the population. According to the Georgian Health and Social Program Agency all pregnant women attending ANC were tested for HIV under the PMTCT program. In 2008 year 58769, and in 2009 year 58332 pregnant women underwent HIV testing. HIV prevalence among pregnant women was similar in both years ranging from 0.02%-0.03%. Unfortunately, disaggregating prevalence data by age groups (under 25 and 25+) was not possible.

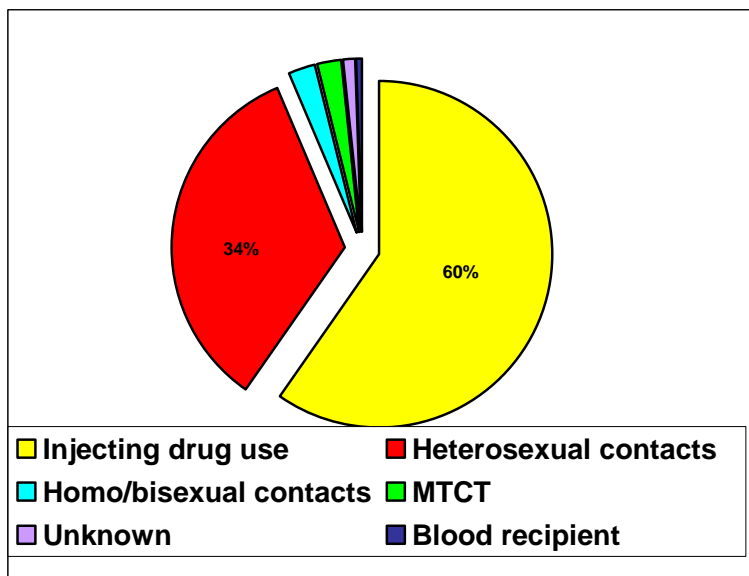
Total number of newly registered cases is increasing slowly every year.

**Figure 1: New HIV Cases by Years**



In its early stage HIV epidemics in Georgia showed similarities with the epidemics in most Eastern European countries with injecting drug use being the major transmission mode. However, over the last several years the transmission has shifted to heterosexual spread. As of 2009, IDUs represented 60% of all cases with a known route of transmission followed by 34% of the HIV-positive population infected through heterosexual contacts; homo-bisexual contacts account for 2.5%; 2.2% was infected through vertical transmission; blood recipients account for less than 1% of all registered cases.

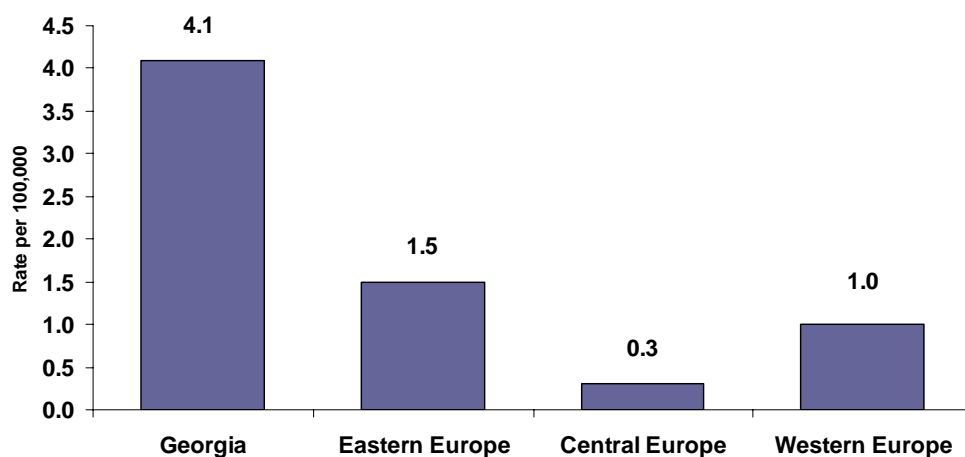
**Figure 2: HIV by Transmission Routes**



The recent epidemiological data confirms that epidemic remains to be located among male population and the risk groups: IDUs, MSM and CSWs remain to be the main drivers of the infection spread. *Behavior Biomarker Surveys* (BBS) regularly implemented since 2002 among these groups have revealed growing HIV prevalence. Among IDUs prevalence rates range from 1.5% to 4.5% depending on the locality, among FSWs between 0.8% (in Batumi) to 1.8% (in Tbilisi); HIV Prevalence among MSM in Tbilisi reaches 3.7%<sup>1</sup>.

The annual number of newly reported AIDS cases has risen each year. The rates per 100,000 population increased from 0.4 in 2000 to 5.3 in 2008. Data from the European Centre for Disease Prevention and Control (ECDC) indicate that Georgia has one of the highest rates of AIDS in the Europe, significantly exceeding average rates in the region.

**Figure 3: Rates of AIDS per 100,000 population in Georgia and European region<sup>2</sup>**



<sup>1</sup> HIV/AIDS Situation and National Response; December 2009, draft report

<sup>2</sup> ECDC/WHO Regional Office for Europe: HIV/AIDS surveillance in Europe 2007. Stockholm, 2008

Despite low HIV prevalence, Georgia is considered to be at high risk for an expanding epidemic due to widespread injecting drug use and population movement between neighboring high-prevalence countries such as Ukraine and Russian Federation.

#### **IV. National Response to the AIDS Epidemic**

Since 1994, HIV/AIDS Prevention & Control interventions in Georgia have been mainstreamed into several national programmes: AIDS Prevention Program; Safe Blood Program, and AIDS Treatment Program. Starting from 2005 a national program on PMTCT has become operational.

The national programmes envisage the following: mandatory testing of all blood donors on HIV, hepatitis B and C infections and syphilis; anonymous and confidential counselling and HIV testing services for high risk groups (IDUs, FSWs, MSM, STI patients, prisoners, TB patients); care and treatment for all opportunistic infections for people living with HIV/AIDS; free PMTCT service for all pregnant women & their families. In addition, the programs cover operation of VCT centres, hotline; strive to build capacity of health care providers; organize community mobilizing and public awareness raising campaigns. In 2008 the Government started supporting Methadone Substitution Therapy.

Drug abuse is considered a criminal offence in the country. There are criminal penalties for personal use and possession varying with the type of drug and the volume possessed. While criminalizing drug abuse, the Government has been very slow to offer free-of-charge treatment for drug dependence. There were no domestic funds allocated for treatment-rehabilitation programs in 2005-2007. It is worth mentioning that in 2008, the GoG initiated a detoxification program, though on a very limited scale, that has only benefited 78 drug addicts.

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

Since 2004, funds mobilized through the GFATM have been critical for scaling up the National Response to HIV/AIDS in Georgia. The country proposal “Strengthening the Existing National Responses for Implementation of Effective HIV/AIDS Prevention and Control in Georgia 2003-2007” led to allocation of 12 million USD (\$12,125,644.00) grant from the GFATM. The second successful proposal was submitted to the GFATM in 2006 “Accelerating HIV/AIDS Prevention, Treatment, Care and Support Interventions in Georgia in 2008-2010” (US\$11, 449, 497).

The GFATM provides substantial support in all major strategic priorities:

- Advocacy for legislation change to improve environment for implementation of preventive programs among most-at-risk populations
- HIV/AIDS Prevention among IDUs, including in penitentiary system
- HIV/AIDS Prevention among FSWs, MSM and their clients
- HIV/AIDS Prevention among youth
- Blood Safety
- Care and Treatment of PLH, including ARV therapy
- Prevention of Mother to Child HIV transmission (while HIV testing is covered by public funds, ARV therapy for all HIV infected pregnant women and their newborns have been provided under the GF project).
- Strengthening of HIV surveillance system through the promotion of second generation surveillance in the country
- Organizational and technical capacity building

## V. Best Practices

Significant achievements have been made in 2008-2009 in terms of policy and National Commitment. In 2009 a new HIV/AIDS State Law was developed and adopted by the Georgian Parliament.

Substantial progress has been made in accelerating treatment and care services. ART program is one of the most successful interventions implemented in the country. Through the GF support Georgia was able to achieve and maintain universal access to ART since 2004.<sup>3</sup> While effective selection algorithm ensures timely identification of those in treatment need, routine use of laboratory tools for ART monitoring, such as CD4 count, viral load and drug resistance testing, allows rapid identification of patients failing on therapy and optimal selection of subsequent regimens. Importantly, along with maintaining access to first-line regimens, treatment options are also available for highly treatment-experienced patients.

Progress was made in terms of scaling up OST services to IDUs. Methadone Substitution Therapy has been provided under the GF since 2006. The GoG, acknowledging the positive potential of harm reduction strategies, in 2008 initiated state funded Methadone Substitution Therapy that has resulted in significant increase in the number of IDUs benefiting from the agonist maintenance therapy.

In 2008 the first ever OST service centre was opened in the pre-detention facility of the Penitentiary System; however the centre is only operational in Tbilisi and this type of services need to be further expanded to respond to the potential needs.

A noticeable progress has been achieved in terms of generating reliable behavioral and biomarker data on most-at-risk populations (IDUs, MSM and FSWs). In 2002 Save the Children Georgia Country Office under the USAID funded STI/HIV Prevention (SHIP) project introduced second generation surveillance studies in the country, and in 2002-2009 SHIP Project has conducted a total of 13 BSSs among various MARPs in three major cities of Georgia – Tbilisi, Batumi and Kutaisi. In 2008-2009, the CIF under the GFATM Project managed to expand surveillance studies geographically (in addition to Tbilisi and Batumi, first baseline BSSs among IDUs in Telavi, Gori and Zugdidi also were carried out). Two repeated BSSs among FSWs in Tbilisi and Kutaisi were completed; and the first ever BSS among prisoners was also conducted generating unique data on drug use practices, prevailing risky behaviours and HIV prevalence in correctional settings. In total, eleven BSSs in 2007-2009 were successfully completed in the country.

## VI. Major Challenges and Remedial Actions

### Progress made in the reporting period

Since the inception of the GF project “*Establishment of Evidence Base for HIV/AIDS National Program by Strengthening HIV/AIDS Surveillance System*” in February 2008, significant achievements have been made in the area of HIV/AIDS surveillance in Georgia. The project is being implemented by the Curatio International Foundation in partnership with Georgian Infectious Diseases, AIDS and Clinical Immunology Research Institute, and two local NGOs – Public Union “Bemoni,” and Information Counselling Center “Tanadgoma.” Within the framework of the aforementioned project the Assessment of HIV/AIDS

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<sup>3</sup> WHO/UNAIDS/UNICEF. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress report 2008. Geneva, 2008

Surveillance System in Georgia<sup>4</sup> was carried out. Based on the assessment findings, the National Plan for HIV/AIDS surveillance<sup>5</sup> was developed in 2008. By the end of 2008, the CIF developed detailed guideline for HIV routine as well as sentinel surveillance including registration/notification/reporting forms and standard operational procedures. New HIV/AIDS surveillance system was piloted in two regions of Georgia (Tbilisi and Adjara region) from January to June, 2009.

Operations research was conducted in July 2009, with the aim to assess the pilot and reveal the factors, hindering effective functioning of the newly designed system, as well as negative and positive aspects of standard operational procedures and registration/notification/reporting forms. Based on the study findings, a set of recommendations was elaborated; routine and sentinel surveillance guidelines were revised, and medical personnel throughout the country were trained. Since January, 2010 the new HIV/AIDS surveillance system has been introduced countrywide.

In the frame of the GF project CIF developed HIV surveillance electronic data base. Newly designed routine surveillance system collects electronic case-based data on every tested individual by epidemiological groups. The data allows and software automatically produces different types of analytical reports.

It also should be mentioned that under the GF projects VCT centers in prisons were established and in 2008-2009 nine VCT service centres have become operational covering 9 out of 18 correctional facilities existing in the country. Around 800 prisoners received HIV counselling and testing in prisons.

During the reporting period special attention was paid to ART adherence as it is an important determinant of treatment success. Assessment of adherence has been specifically addressed in the National HIV/AIDS Treatment and Care guidelines. In addition, in 2008 intervention to provide home-based adherence support became operational.

Palliative care has been recognized as an essential component of a comprehensive package of care for PLHIV. Since 2008 palliative care services started operating in Georgia with the aim of improving the quality of life of patients and their families, through the prevention, assessment and treatment of physical, psychosocial and spiritual problems.

### **Challenges faced throughout the reporting period**

Major challenge in scaling up HIV prevention has been restrictive legal environment in terms of illicit drug use. Even though that the data on drug use prevalence in Georgia has been very scarce, it is well acknowledged that injecting drug use has been the main driver of the spread of HIV in the country. In such situation non-restrictive and human-rights based legislation is one of the most important determinants of success. According to the law on Narcotic Drugs and Psychotropic Substances, not only the sell and possession, but also consumption of narcotic drugs is punishable. In addition, according to the State Law on Prisoners, the possession of a syringe by a prisoner is prohibited. These restrictive provisions of the state laws create serious barriers to implementation of harm reduction services not only in correctional settings, but also in the whole country.

It is worth mentioning that in 2007 a package of amendments to the drug law and relevant articles of the Criminal Code was developed and submitted to the Georgian Parliament. Although the extent to which the amendment can change restrictive regulations is quite limited, its adoption will be a positive development and incremental step towards lessening barriers to HIV prevention. However, the process has been

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<sup>4</sup> Assessment of the HIV/AIDS surveillance; CIF; GFATM; MoLHSA; full report available at: [www.curatiofoundation.org](http://www.curatiofoundation.org)

<sup>5</sup> National Plan for HIV/AIDS Surveillance; full report available at: [www.curatiofoundation.org](http://www.curatiofoundation.org)

excessively slow as by the end of 2009, no hearings have taken place. More advocacy initiatives are needed to facilitate the process of adoption of new, less restrictive legislation in the country.

Despite commendable success in the treatment and care, significant challenges remain in terms of treatment outcomes. Although Georgia assured universal access to ART, survival rates are unfavourable, with 12-month ART attrition rates averaging 20%. The factors most likely affecting the disease outcome include late HIV diagnosis, low treatment adherence, inadequate capacity for the management of OIs and lack of instrumental diagnostic capacity. Universal availability of ARVs uncovered consequences of high burden of HIV/HCV co-infection, resulting in increased liver-related morbidity and mortality. Efforts should be made to improve early HIV diagnosis, scale-up management of OIs and co-infections.

Stigma and discrimination of risk groups and PLWH remains to be a major challenge as it creates significant barriers to HIV Prevention and service utilization. Low awareness of HIV not only among general public, but also among health care workers remains to be a major obstacle.

## **VII. Support from the Country's Development Partners**

USAID has been making significant contribution to confront HIV/AIDS in the country. In 2002-2009 Save the Children Federation with its partner organizations, PATH and local NGOS – Bemoni and Tanadgoma successfully implemented the USAID funded STI/HIV Prevention (SHIP) Project in Georgia. The major goal of the project was to develop a cohesive and sustained response to prevent the future spread of STIs and HIV among high-risk groups and prevent transmission to the general public. The project operated in three urban cities– Tbilisi, Batumi and Kutaisi. In 2006-2008 project activities were expanded to the breakaway region of Abkhazia and despite the huge success project was achieving in Abkhazia, it was ceased as a result of the Georgia-Russia war in August, 2008.

The SHIP Project made significant achievements to scale up voluntary counseling and testing services targeting MARPs. In 2008, with the purpose to increase coverage of MARPs with VCT services, Medical Mobile Laboratories became operational in three cities of the country – Tbilisi, Kutaisi and Batumi. Further to the service delivery the project has promoted second generation surveillance studies in the country and conducted several rounds of behavioral surveillance surveys with biomarker component (BSSs) among IDUs, FSWs and MSM (total 13 BSSs) in Tbilisi, Batumi and Kutaisi. The SHIP Project ended on September 30, 2009; however, in February 2010, the USAID initiated another 5-year project named Georgia HIV Prevention Project (GHPP) that will be operational till December 2014. The GHPP will be implemented by Research Triangle Institute (RTI) in partnership with Save the Children, PATH and number of civil society organizations.

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 UNAIDS's contribution became most apparent and well acknowledged. Through the UNAIDS support HIV/AIDS Situation and National Response Analysis was completed in 2009. A list of future priorities in HIV/AIDS was developed, shared with all stakeholders and endorsed by the CCM in February 2010. Based on the Situation Analysis, a new HIV/AIDS National Strategic Plan for 2011-2016 is being now elaborated. In 2010, UNAIDS will also provide financial and technical support to develop a National HIV/AIDS M&E System in the country.

WHO's support was significant to improve blood safety in Georgia. In 2008 through the WHO technical support a three-day workshop was organized on Blood Safety Issues and development of Standard Operating Procedures. The training was very productive and at the end of 2008 almost all blood banks/blood screening centers involved in Safe Blood Program had developed Standard Operating Procedures (SOPs).

Important support has been provided by WHO country office in Georgia in the field of treatment and care. Annual national workshops on HIV/AIDS clinical management facilitated by leading European experts, along with out-of-country trainings of Georgian specialists, and update of National guidelines contributed to provision of quality treatment and care.

There are many other international organizations and donors that must receive acknowledgment for their valuable contributions to the development and implementation of wide-range HIV prevention, treatment and research activities in the country: European Union; European Commission; Vishnevskaya-Rostropovich Foundation (VRF); Open Society Georgia Foundation (OSGF), World Vision International (WV Canada and WV USA); Oxfam/Novib; IOM; GIP, and North Carolina University.

### **VIII. Monitoring and Evaluation Environment**

Almost no progress has been made since the last UNGASS reporting period in terms of development National HIV/AIDS Monitoring and Evaluation System. Program monitoring and evaluation takes place sporadically for specific donor-supported programs. No operational researches to evaluate state funded HIV prevention and treatment services have taken place. The major obstacle was unavailability of adequate financial resources. It should be noted that in 2010, UNAIDS will establish a National Experts Group that will start working on elaboration of National M&E System in the country.

## UNGASS Indicators

### Indicator 1: AIDS Spending

Total HIV/AIDS actual expenditures in Georgia amounted to USD 8,2 million in 2008 and USD 9,3 millions in 2009.

Spending by Categories (in USD)	2008 y.	2009 y.
Prevention	\$3 393 199	\$3 861 329
Care and Treatment	\$2 408 239	\$2 794 218
Management & Administration	\$591 076	\$1 278 323
Human Resources	\$1 189 589	\$1 016 886
Enabling Environment	\$504 522	\$198 905
Research	\$132 058	\$103 709
<b>Total</b>	<b>\$8 218 683</b>	<b>\$9 253 370</b>

AIDS expenditure disbursed by the Government of Georgia for HIV/AIDS totaled 1,268,408 USD in 2008, and increased to 2,232,703 in 2009.

Public Spending on HIV/AIDS by Years (USD)	2006 year	2007 year	2008 year	2009 year
	339520	412869	1268408	2232703

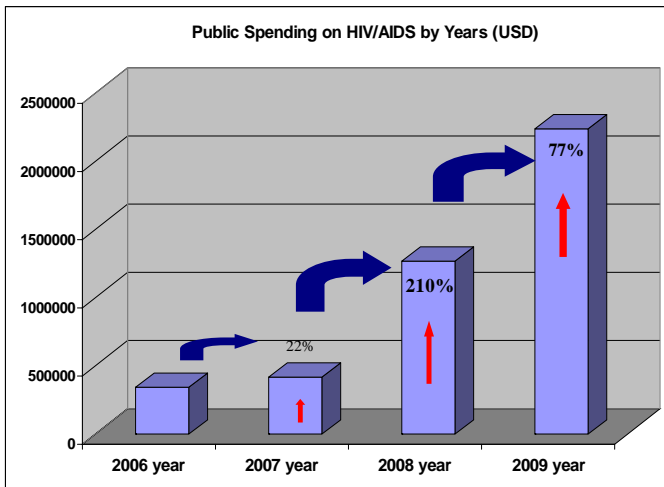
Domestic funds accounted for 15,4% of the total HIV/AIDS spending in 2008; though the share of the GOG increased to 24,1% in 2009 year. In the reporting period four state funded programs were operational in Georgia: National HIV Prevention Program (1), National Safe Blood Program (2), National AIDS Treatment Program (3), and National PMTCT Program. In addition, the Government started financing detoxification therapies in 2008, though due to limited funds, the coverage of IDUs with state funded programs lags far behind the real needs. In 2008, the GoG also launched a state-funded OST program for IDUs and introduced co-payment system meaning that patients willing to pay 150 GEL (~USD 90) in a month are getting enrolled in the OST program subsidized by the Government. Since then around 1000 drug users have been benefiting from the program; consequently, in 2009 out-of-pocket payments (household funds) accounted more than 9% of total HIV/AIDS spending in the country.

Spending by Funding Sources	2008 year	2009 year
<b>Public</b>	<b>15,4%</b>	<b>24,1%</b>
<b>Global Fund</b>	<b>56,9%</b>	<b>53,9%</b>
<b>USAID</b>	<b>12,8%</b>	<b>6,8%</b>
<b>UN Agencies</b>	<b>6,7%</b>	<b>2,9%</b>
<b>All other International</b>	<b>6,0%</b>	<b>3,0%</b>
<b>Private (household funds)</b>	<b>2,1%</b>	<b>9,4%</b>

The table above demonstrates HIV/AIDS spending breakdown by funding sources. Analyzing spending data for 2006-2009 has revealed that public funds spent on HIV prevention, treatment and care services have been increasing steadily and significantly (see Figure 4).



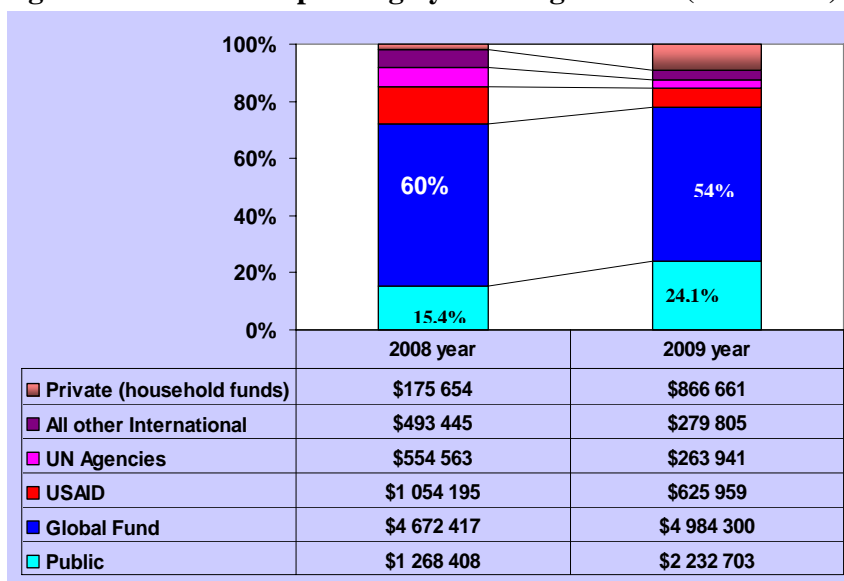
**Figure 4: Public Spending on HIV/AIDS (2006-2009 years)**



Approximately 60% in 2008 and 54% in 2009 of total HIV/AIDS spending was channeled through the Global Fund. Other substantial portion of funds was contributed by USAID (13% & 7% in 2008 & 2009, respectively) that remains to be the second largest donor (after the GFATM) supporting HIV/AIDS National Response in Georgia. Decline in USAID spending in 2009 is due to the end of STI/HIV Prevention (SHIP) Project (2002-2009) in September. In February 2010, USAID funded another five-year project - Georgia HIV Prevention Project (GHPP) that evidences USAID's continued commitment to HIV Prevention in the country. UN agencies in Georgia accounted for 7% of the total AIDS expenditure in 2008, and its share reduced to 3% in 2009.

Donor funded programs mostly were focused on prevention among MARPs, youth and general population as well as on advocacy and policy initiatives. In 2008-2009 the following donors contributed to HIV/AIDS response in the country: USAID; WHO, UNAIDS, UNFPA; UNDP; OSGF; GIP; Oxfam/Novib; EU; EC; World Vision Int.; IOM; VRF; and North Carolina University.

**Figure 5: HIV/AIDS Spending by Funding Sources (2008-2009)**

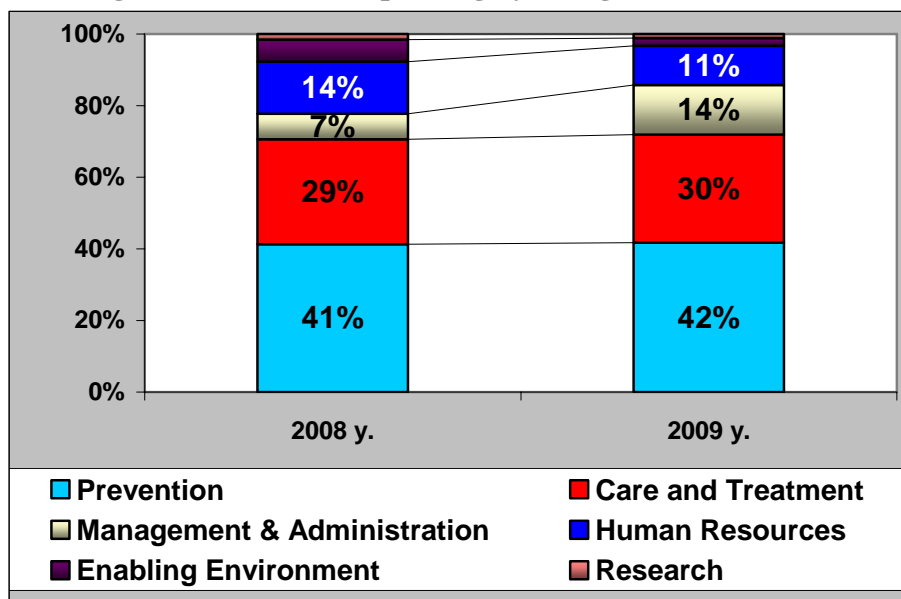


It should be noted that disaggregating actual expenditures by spending categories requested by the UNGASS appeared to be sophisticated. Thus, data provided in the National Funding Matrix do not exclude the possibility of minor inaccuracies.

Spending by Categories (in USD)	2008 y.	2009 y.
Prevention	\$3 393 199	\$3 861 329
Care and Treatment	\$2 408 239	\$2 794 218
Management & Administration	\$591 076	\$1 278 323
Human Resources	\$1 189 589	\$1 016 886
Enabling Environment	\$504 522	\$198 905
Research	\$132 058	\$103 709
<b>Total</b>	<b>\$8 218 683</b>	<b>\$9 253 370</b>

The graph below demonstrates spending patterns by categories. As shown, over the last two years the percentage of spending on prevention as well as on treatment, care and support has been remaining stable. The share of spending on management/administration has doubled (from 7% to 14%).

**Figure 6: HIV/AIDS Spending by Categories (2008-2009)**



Donor funds account for the larger portion of HIV/AIDS expenditure in Georgia. This fact raises real concerns for the sustainability of HIV prevention, treatment and care activities in the country. Despite the strong political will, unfortunately at present there is no indication that the GoG will be able to secure adequate domestic funds for HIV/AIDS in case the GF & donor agencies start withdrawing financial support to Georgia.

## **Indicator 2: National Composite Policy Index**

Data for the National Composite Policy Index (NCPI) have been collected by administering NCPI questionnaire recommended by the UNGASS. The questionnaire was translated into Georgian and distributed among all key stakeholders on December 16. Part (A) of the questionnaire has been completed by the Government officials, and Part (B) by the Civil Society Organizations, Bilateral Donors and UN Agencies. All completed NCPI questionnaires were reviewed by the technical coordinators, data consolidated and preliminary results were discussed at the National consultation meeting organized by the UNAIDS on December 28. Two separate meetings were held for government organizations, and NGOs/donor organizations.

The following organizations participated in the NCPI development process.

### **Government: (NCPI Part A)**

1. Country Coordinating Mechanism
2. The Ministry of Labor, Health and Social Affairs
3. Penitentiary System
4. Ministry of Finance
5. Ministry of Education
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. Georgian Health and Social Projects Implementation Center
10. National Center for TB and Lung Diseases

### **NGOs, donors and international organizations: (NCPI Part B)**

1. Open Society Georgia Foundation (OSGF)
2. AIDS Patients Support Foundation
3. Counseling Center Tanadgoma
4. Georgian Peer Foundation
5. WFP
6. UNHCR
7. "Alternativa" Georgia
8. Curatio International Foundation
9. United Nations Agencies in Georgia (UNFPA, UNAIDS)
10. GFATM
11. WHO
12. The World Bank
13. Save the Children Federation (SC)

Based on completed questionnaires and consensus reached during the consultation meetings, the NCPI responses were finalized and presented at the final workshop held on March 9, 2010 for validation and approval. Filled in NCPI was entered into CRIS and attached to the UNGASS Georgia Country Progress Report.

### Indicator 3: Blood Safety

Georgia was one of the first countries among FSU that developed Safe Blood National Program in early 1997. The mandatory screening of all donated blood is endorsed by the State Law on HIV/AIDS. According to the National standards, all bloods have been routinely screened on four infections: HIV, syphilis, hepatitis B and C.

Due to budget constrains, public funds could not entirely cover all expenses for the National Blood Safety Program, and in 2006, to fill the gaps in funding the GFATM started supporting the GoG and provided diagnostic test-kits for the program. Before 2008, the number of blood-screening laboratories involved in the implementation of Blood Safety programs nationwide was quite high and the supervision and quality control was loose and ineffective. To optimize functional network of blood screening centers, laboratories with more capacities and higher workloads were selected and the number of laboratories involved in the state funded Blood Safety program significantly reduced in 2008 -2009 from 53 to 14 and 15, respectively.

Unfortunately, since 2007 very little progress has been made towards establishing external quality assurance system for HIV testing in laboratories involved in the implementation of Blood Safety programs nationwide. In 2007 none of these laboratories had SOPs, and over the last two years most of the laboratories managed to develop SOPs. However due to the absence of the External Quality Assurance Scheme the value of the indicator has not changed since last reporting period.

Year	Name of the blood Center	Quality Assurance in HIV screening		Blood units		
		Standard Operating Procedures	External Quality Assurance Scheme	Donated blood	Screened blood (%)	Blood screened in quality-assured manner
2007	Georgian Blood Preparation Center & /Blood Bank of Jo Ann Medical Center & other laboratories (in total 53)	Yes/No*	No	35113	35113	0%
					100%	
2008	Georgian Blood Preparation Center & /Blood Bank of Jo Ann Medical Center & other laboratories (in total 14 )	Yes/No*	No	37892	37892	0%
					100%	
2009	Georgian Blood Preparation Center & /Blood Bank of Jo Ann Medical Center & other laboratories (in total 15 )	Yes/No*	No	38033	38033	0%
					100%	

\*

UNGASS 2007 reporting round demonstrated the urgent needs for establishment of external quality assurance system for HIV screening and the GoG became quite alarmed for the safety of donated blood. Some initial steps were taken, and through the WHO technical support a three-day workshop was organized on Blood Safety Issues and development of Standard Operating Procedures. At the end of 2008 almost all blood banks/blood screening centers involved in Safe Blood Program had developed Standard Operating Procedures (SOPs); however these SOPs have not yet been standardized.

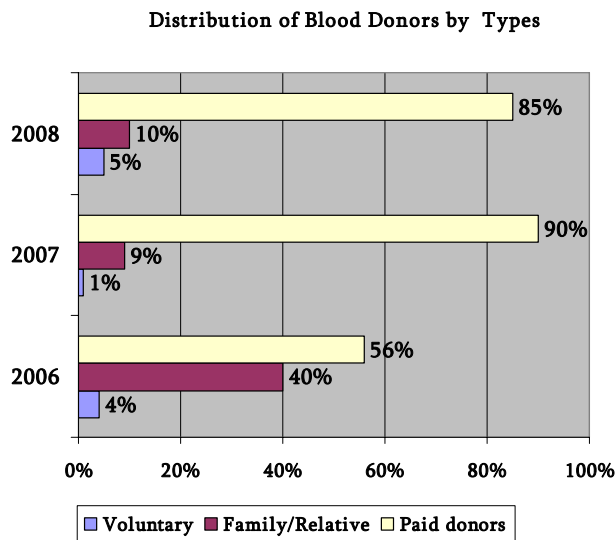
Recognizing the importance of blood safety in the country, comprehensive strategies (including establishment of External Quality Assurance mechanism) were envisaged in the country proposal to GFATM Round-6 that was awarded. Implementation of planned activities will start from 2010 and

\* Precise number of laboratories that have developed and followed SOPs in 2008-2009 was not known.

hopefully for the UNGASS reporting next round Georgia’s indicator on Safe Blood will be significantly higher.

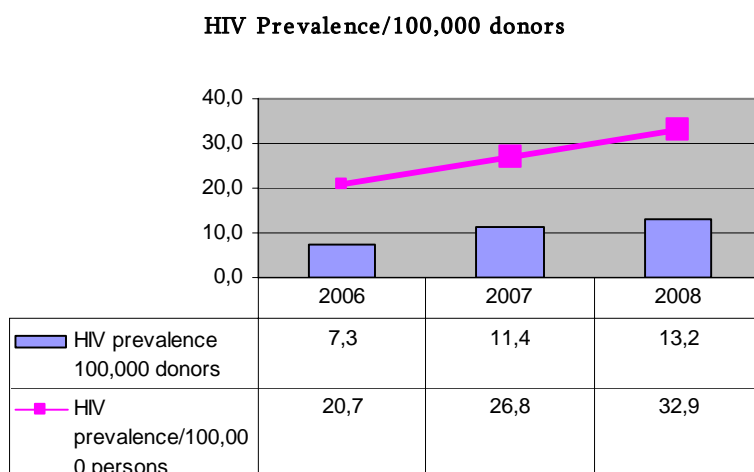
The situation is further exacerbated by the fact that the largest portion of blood was collected from paid donors and the share of voluntary/non-remunerated blood donors remains to be extremely low during 2007-2009.

**Figure 7: Distribution of Blood Donors by Types**



It is well-known that heavy reliance on paid donors adversely affects the safety of blood as they show higher prevalence of HIV and other blood borne infections than voluntary donors. However, analyzing HIV testing data has revealed that HIV prevalence among paid donors is lower than that among general population.

**Figure 8: HIV Prevalence among general population and blood donors (per 100,000)**



However, this finding does not provide a ground for optimism, and promotion, recruitment and retention of voluntary blood donors, along with effective external QA system for screening laboratories is required to assure safety of transfused blood.

#### Indicator 4. HIV Treatment: Antiretroviral Therapy

Georgia has made significant progress in scaling-up antiretroviral therapy (ART). Since 2004 through the GF grants the country achieved universal access to free-of-charge ART. Joint WHO, UNAID and UNICEF progress report on universal access ([http://www.who.int/entity/hiv/pub/towards\\_universal\\_access\\_report\\_2008.pdf](http://www.who.int/entity/hiv/pub/towards_universal_access_report_2008.pdf)) published in 2008, identified Georgia among 9 low- and middle-income countries with antiretroviral coverage of at least 75%. Systematic approach for ART provision, including regular update of standard treatment guidelines, routine clinical and laboratory assessment of patients for treatment need, ensures sustainability of this success.

All HIV patients who are not on ART, are evaluated against treatment initiation criteria set by national guidelines every 4 months for timely identification of those in need of treatment. The standard of clinical care among patients on ART in Georgia relies on laboratory monitoring of the immune system using CD4 cell counts, of viral suppression using viral loads, and of the development of drug resistance using genotypic testing. Treatment is provided in 5 dedicated facilities countrywide (one national and four regional centers). The number of patients receiving ARV therapy is on the rise from years-to-years. Cumulative 876 patients were enrolled in ART program since its inception in 2004 and 655 patients remained on therapy as of January 1, 2010. It should be noted that more women got involved in treatment programs partly due to increased HIV detection since universal screening of pregnant women started in 2006.

Estimation of ARV coverage is based on methodology suggested by the UNAIDS Reference Group on Estimates, Modeling and Projections. Number of patients on ART was derived from national ART registry and estimated treatment need was generated using 2009 version of Spectrum projection software. ART coverage among adults approaches 95%. However, the estimated number of children in need of treatment generated by Spectrum might be underestimated, which in turn overestimates the total value.

**Table: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy**

	2008			2009		
	# patients on ART	Estimated # patients in need of ART	%	# patients on ART	Estimated # patients in need of ART	%
<b>Total adults and children</b>	<b>498</b>	<b>556</b>	<b>89.6%</b>	<b>655</b>	<b>686</b>	<b>95.5%</b>
Male	360	387	93.0%	468	471	99.4%
Female	138	169	81.7%	187	211	88.6%
<b>Total adults (&gt;15)</b>	<b>474</b>	<b>543</b>	<b>87.3%</b>	<b>627</b>	<b>665</b>	<b>94.3%</b>
Male adults	346	380	91.1%	451	460	98.0%
Female adults	128	163	78.5%	176	201	87.6%
<b>Total children (&lt;15)</b>	<b>24</b>	<b>13</b>	<b>184.6%</b>	<b>28</b>	<b>21</b>	<b>133.3%</b>
Male children	14	7	200.0%	17	11	154.5%
Female children	10	6	166.7%	11	10	110.0%

Treatment is provided to all patients regardless their age, sex or transmission routes. The table below presents distribution of AIDS patients on treatment by groups and HIV transmission ways.

	IDUs	Hetero	MSM	Blood recipient	MTCT	Unknown	total
<b>Male</b>	<b>321</b>	<b>80</b>	<b>13</b>	<b>4</b>	<b>15</b>	<b>1</b>	<b>434</b>
<b>Female</b>	<b>3</b>	<b>148</b>		<b>5</b>	<b>10</b>	<b>6</b>	<b>172</b>
<b>Total</b>	<b>324</b>	<b>228</b>	<b>13</b>	<b>9</b>	<b>25</b>	<b>7</b>	<b>606</b>

### Indicator 5: Prevention to Mother-to-Child Transmission

The Government of Georgia is strongly committed to preventing mother-to-child HIV transmission in the country. In 2005 integration of PMTCT programs into existing routine antenatal health services was initiated by the Ministry of Health. Since then, the Government in partnership with Vishensvkaya-Rostropovich Foundation has completely covered the HIV screening component of PMTCT program.

Treatment and care of HIV positive pregnant women is governed by the national PMTCT program and funded by the GF. Universally all HIV positive pregnant women enter clinical care and are prescribed antiretroviral regimen according to the National guidelines. Prophylactic ARV therapy is initiated at 24<sup>th</sup> week of gestation, unless a woman requires treatment because of her HIV disease status. The standard prophylactic regimen for the prevention of MTCT consists of: Zidovudine + Lamivudine + Saquinavir/Ritonavir, followed by Intravenous Zidovudine during labor. Newborns are given prophylactic treatment with Zidovudine and Nevirapine. Importantly, none of the HIV positive mothers completing full course of prophylaxis transmitted the virus to their infants.

According to official statistics the number of pregnant women screened for HIV increased from 42,000 in 2006 to nearly 59,000 in 2008 and 2009. Even though that all pregnant women visiting ANC undergo HIV testing, single cases of HIV infection have been still detected during labor. HIV testing at labor warts is not a mandate and occurs only at the discretion of management of individual maternity houses. As of 2009, there were nine HIV cases detected among children <3 years with vertical mode of transmission. This indicates that not all pregnant women are tested or few HIV positive cases are missed by prenatal screening program.

The number of HIV positive pregnant women who received ART 2008 and 2009 were 22 and 12 respectively. All 34 women received standard prophylactic regimen Zidovudine + Lamivudine + Saquinavir/Ritonavir. Ten women (45%) were under 25 years of age in 2008, and 7 (58%) – in 2009. When used Spectrum estimates, the percentage of HIV-infected pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child exceeded 100% in 2008, and equaled to 57% in 2009.

**Table: Percentage of HIV-infected pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission**

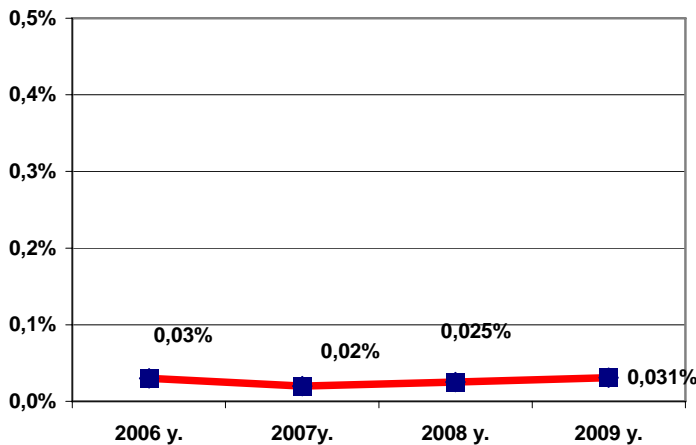
Year	Number of HIV-infected pregnant women who received antiretrovirals to reduce the risk of MTCT*	Estimated number of HIV-infected pregnant women in the last 12 months	Percentage
<b>2008</b>	22	19	<b>115.8%</b>
<b>2009</b>	12	21	57.1%

\*Includes women who became pregnant after HIV diagnosis

This major fluctuation between the two values of the indicator by years could be indicating the inaccuracy in Spectrum estimates and/or deficiency of MTCT program. An operational Research or well-designed program evaluation study is needed to identify real reasons.

Since initiation of the PMTCT program the HIV prevalence among pregnant women has been stable ranging from 0,02% to 0,03%.

**Figure 9: HIV Prevalence among Pregnant Women**



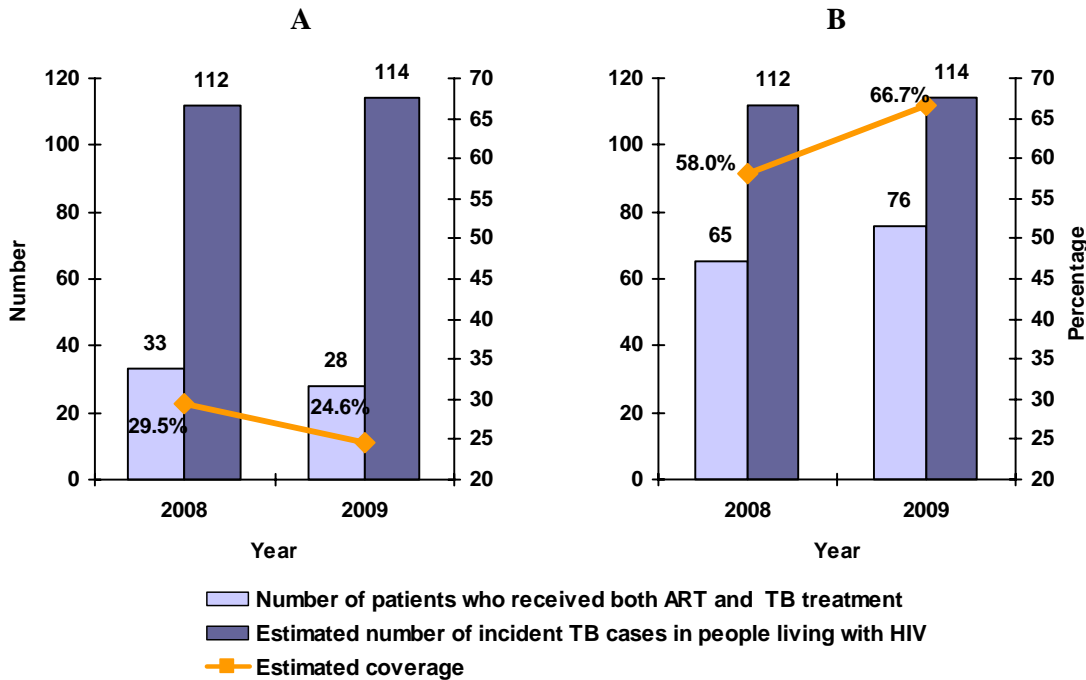
### **Indicator 6: Co-management of Tuberculosis and HIV Treatment**

Acknowledging the need to effectively address intersecting epidemics of HIV and TB, Georgia has adopted national TB/HIV strategic plan of action in 2007. Major directions of the strategic plan include intensified case finding and treatment of patients with dual infection. Since 2006 routine HIV testing of TB patients has been implementing resulting in increased testing rates from 13% in 2006 to 46% in 2008. Although ART and TB treatment are freely available to all patients in need, TB remains most common opportunistic infection and leading cause of death among patients on ART.

Overall 65 and 76 patients accessed treatment for both TB and HIV in 2008 and 2009 respectively making up coverage with HIV/TB treatment of 58 and 67%. The calculation included all patients who were on concomitant treatments regardless of which therapy started first -- TB or HIV. If calculation included only those patients who received ARV and then started on TB therapy, the coverage is 30 and 25% for 2008 and 2009 respectively. The latter method of calculation may not adequately measure access to treatment for both diseases and is irrelevant for Georgia for the following reasons: all patients in need have access to free-of-charge ARV and TB treatment; according to national guidelines patients who require both ART and TB treatment first are started on TB therapy followed by ART; before initiating ART all patients undergo comprehensive evaluation for the presence of TB, if so TB treatment is initiated immediately. Therefore, we believe that inclusion of all patients on concomitant therapy irrespective of timing treatment initiation is more appropriate to assess co-management of TB and HIV in Georgia.



**Figure 10: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV. A: Including patients who received ARV and were started on TB treatment. B: Including all patients who received both ART and TB treatment regardless of treatment initiation sequence**



**Indicator 7: HIV Testing in the General Population**

Unfortunately, no population-based surveys were carried out in Georgia.

**Indicators for MARPs**

**Indicator 8: HIV Testing in Most-at-risk Populations**

*HIV Testing among Female Sex Workers*

Data for this indicator are obtained from the BSSs conducted 2008 in Tbilisi and Batumi. A total of 160 street-based FSWs in Tbilisi and 120 facility-based commercial sex workers in Batumi participated in surveys.

Respondents were asked two questions:

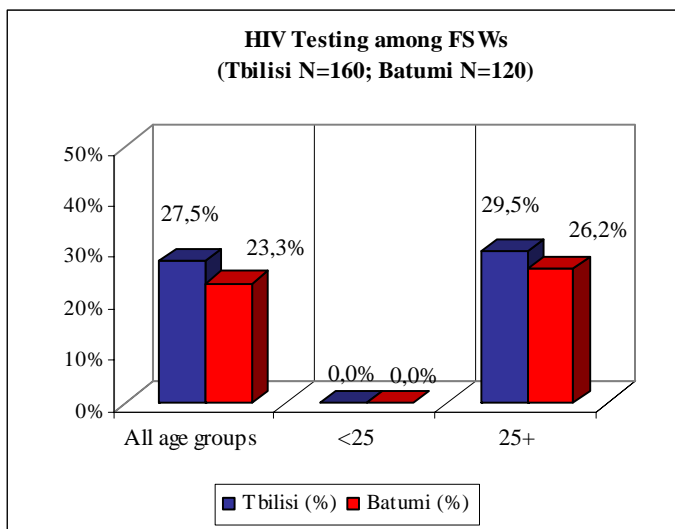
1. Have you ever been testing for HIV in the last 12 months?  
If Yes:
2. I don't want to know the results, but did you receive the results of this test?

**Indicator 8 for FSWs:** Analyzing data showed that only 27,5% of FSWs in Tbilisi and 23,3% in Batumi reported having had an HIV test in the last 12 months and received their test results.

Indicator #8 HIV testing in most-at-risk populations-Commercial Sex Workers
Percentage of most-at-risk populations who received an HIV test in the last 12 months and who knows their results

	Tbilisi (%)	Batumi (%)
All age groups	27,5%	23,3%
<25	0,0%	0,0%
25+	29,5%	26,2%

**Figure 11: HIV Testing among Street-based Female Sex Workers in Tbilisi and Facility-based Female Sex Workers Batumi**



### *HIV Testing among IDUs*

A total of 1127 respondents participated in BSSs (GF) conducted in 2008-2009 in 5 major cities of Georgia (Tbilisi, Batumi, Zugdidi, Telavi and Gori). The table below presents aggregated data by all research sites.

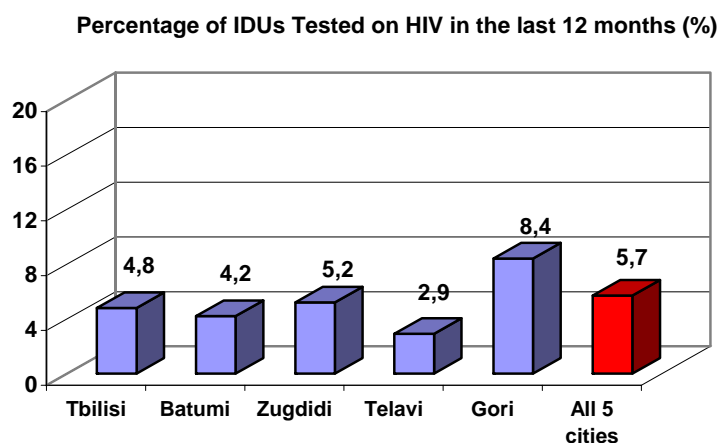
HIV testing among male IDUs		
BSSs in Tbilisi, Zugdidi, Batumi, Telavi & Gori	# of IDUs who received an HIV test in the last 12 months and knows their results	Percentage of most-at-risk populations who received an HIV test in the last 12 months and who knows their results
Total (N=1127)	64/1127	5,7%
<25 (N=142)	7/142	4,9%
>=25 (N= 985)	57/985	5,8%

**Indicator 8 for IDUs:** the percentage of IDUs who received an HIV test in the last 12 months and who know their test results does not exceed 5,7% (64/1127).

HIV Testing by each city participating in BSSs as well as breakdown by two age groups is also presented below.

Percentage of IDUs who received an HIV test in the last 12 months and who know their test results						
	Tbilisi	Batumi	Zugdidi	Telavi	Gori	All 5 cities
All age groups	4,8	4,2	5,2	2,9	8,4	5,7
<25	0	4,1	3,1	0,7	3,5	4,9
>=25	5	4,6	5,2	3,6	12,1	5,8

Figure 12: HIV Testing among IDUs in 5 Cities of Georgia



### HIV Testing among MSM

The first BSS among MSM was conducted in 2005 (under the GFATM project), and repeated BSS (under the USAID/SHIP Project) was carried out in 2007. The percentage of MSM who *ever* tested on HIV and received test results increased from 30% in 2005 to 44.1% in 2007. When an HIV test is taken, almost all MSM return to find out the result (100% for the youngest and 96% for the oldest age group). Relatively small percentage of MSM reported having HIV *test in the last 12 months*. Statistically significant difference was observed by age groups: HIV testing indicator was three-fold lower for the youngest MSM compared to those aged 25 and older.

HIV testing among MSM		
BSS among MSM in Tbilisi 2007 y.	# of MSM who received an HIV test in the last 12 months and know their results	Percentage of MSM tested in the last 12 months and who know test results
Total (N=136)	32/136	23,5%
<25 (N=54)	6/54	11,1%
25+ (N= 82)	26/82	31,7%

**Indicator 8 for MSM:** the percentage of MSM who received an HIV test in the last 12 months and who know their results – 23,5%.

### Indicator 9: Most-at-risk Populations: Prevention Programs

As requested, this indicator is also calculated separately for each population that is considered most-at-risk: FSWs, IDUs and MSM. The data are generated through the BSSs described above.

Answers to the following two questions were measured to evaluate progress in implementing HIV prevention programs for female sex workers:

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms?

**Indicator #9 – Prevention Programme coverage among FSWs**

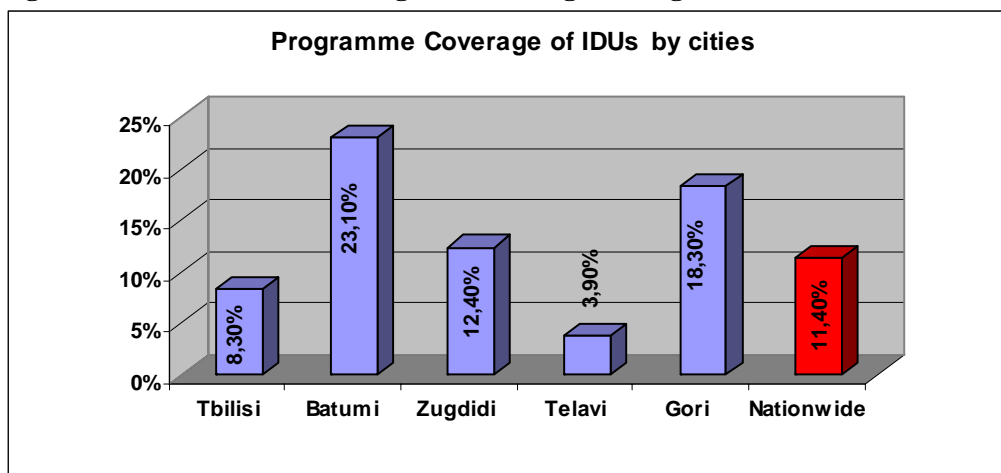
Indicator #9	BSS Tbilisi 2008	BSS Batumi 2008
Percentage of FSWs reached with HIV prevention programs	66.9% (107/160)	85.8% (103/120)
<25	27.3% (3/11)	69.2% (9/13)
25+	69.8% (104/149)	87.9% (94/107)

**Indicator #9 – Prevention Programme coverage among IDUs**

Prevention Programme Coverage - IDUs		
BSSs in Tbilisi, Zugdidi, Batumi, Telavi & Gori	# of IDUs who knows HIV testing sites and received free condoms	Percentage of IDUs who knows HIV testing sites and received free condoms
Total (N=1127)	129/1127	11,4%
<25 (N=142)	24/142	16,9%
25+ (N= 985)	105/985	10,7%

As demonstrated, the percentage of IDUs who know HIV testing site in their communities and received free condoms during the last 12 months is extremely low and only 129 IDUs out of 1127 surveyed gave positive answers to both questions. Younger IDUs are more aware of HIV preventive programs and are more tended to use services provided by these programs.

**Figure 13: HIV Prevention Program Coverage among IDUs in 5 Cities**



The graph presents this indicator for IDUs in each city participating in BSSs. Programme coverage indicator is the highest in Batumi, the port city where several donor-supported HIV prevention programs

have been operational since 2002. The second highest level of programme coverage is observed among IDUs in Gori, the city most affected by the Georgia-Russia military conflict in August 2008.

According to the UNGASS reporting requirement in addition to the above mentioned two questions, IDUs should be asked the following question:

3. In the last twelve months, have you ever been given sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle exchange program)?

Given that this indicator is designed to assess progress in implementing HIV prevention programs for most-at-risk populations, intensive consultations were held among local experts working in the field of drug use and HIV prevention to discuss the applicability of recommended indicator to the local context. As a result, a consensus was reached not to include the 3rd question in the indicator.

According to the BSSs data absolutely all IDUs reported that they could obtain new sterile needle/syringes when they needed them. Thus, accessibility to needles/syringes is not a problem in the country. Pharmacies are authorized to sell sterile injecting equipment without doctor's prescription; in addition syringes are extremely cheap (approximately 0.05-0.01 USD/per syringe) and IDUs can afford to buy them. Virtually all IDUs who participated in BSSs reported obtaining needles/syringes from pharmacies.

Taking into account that the score for the last individual question is very low, it has become obvious that the composite indicator (for all three questions) would not have reflected the real coverage level. Given that the problem of HIV and drug use in Georgia has been more associated with low awareness and other social habits (e.g. sharing injecting equipment, IDUs' networking), HIV programs targeting IDUs have been placing much emphasis on awareness raising interventions and promotion of safe injection practices rather than needle exchange strategies.

### **Indicator #9 – Prevention Programme coverage among MSM**

Last BSS conducted among MSM in the capital city surveyed 140 men with homosexual contacts. Two out of every three respondents were aware of HIV testing sites in their communities and received free condoms from prevention programs.

<b>Prevention Program Coverage among MSM in Tbilisi</b>	<b>&lt;25</b>	<b>25+</b>	<b>Total</b>
	<b>(n=57)</b>	<b>(n=83)</b>	<b>(n=140)</b>
1. Do you know where you can go if you wish to receive an HIV test?	85.2% (46/57)	91.6% (76/83)	87.1% (122/140)
2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	75.4% (43/57)	71.1% (59/83)	72.9% (102/140)
Percentage of MSM who replied "Yes" to both questions	<b>61.4%</b> <b>(35/57)</b>	<b>69.9%</b> <b>(58/83)</b>	<b>66.4%</b> <b>(93/140)</b>

### **Indicator 10: Support for Children Affected by HIV and AIDS**

Not applicable.

### **Indicator 11: Life-skills based HIV Education in Schools**

None of the schools provided life skills-based HIV education (at least 30 hours to each grade) in the 2008 and 2009 academic years. However it is worth mentioning that over the last several years significant

progresses have been made by the USAID funded Healthy Women (HWG) in Georgia Project. National experts group has elaborated Life-Skills Based Education (LSBE) curriculum for school teachers and students. Teaching materials consist of 8 modules, including ones on HIV/AIDS; illicit drug use; reproductive health. The LSBE curriculum was officially approved by the Ministry of Education and Science in Georgia. Within the framework of HWG project around 6000 adolescents aged 15-17 from 150 schools underwent LSBE training course. Of them, 600 successful students were trained as peer educators and got engaged in peer outreach and HIV prevention education activities targeting youth.

Even though the LSBE curriculum was officially adopted by the MoES, the Healthy Life-style training course has been regarded as an optional (facultative) subject, meaning that every school is advised to support LSBE program, though the decision regarding its integration into the school academic curriculum remains at the discretion of individual school boards.

**Indicator 12: Orphans: School Attendance - No data**

Indicator is not relevant to the country context. No survey on school attendance was carried out in the country.

**Indicator 13: Young People: Knowledge about HIV prevention**

No population based survey among youth aged 15-24 was carried out in Georgia.

There have been several small scale surveys among school students and adolescents conducted by various projects; however, thus far, no studies have generated reliable data to assess the level of HIV knowledge among young people. The last survey among youth in Georgia was conducted in 2009 through the financial support from EU/UNFPA. The Adolescent Reproductive Health Survey enrolled only young people aged 14-19. A set of questions about HIV transmission routes and major misconceptions was asked to respondents. Unfortunately, questions used during the survey were not identical to those recommended for UNGASS reporting. In addition, though results for each individual question are available, calculating the percentage of respondents correctly answering all questions was not possible.

**Knows that HIV can be transmitted through:**

N= 476	Total	Male	Female	Male age		Female age	
				14-16	17-19	14-16	17-19
				Transfusion of infected blood	95.9	95.8	96.1
Any kind of heterosexual contact	86.1	83.3	89.2	83.5	83.1	88.2	89.9
Homosexual contact	47.0	49.4	44.4	38.5	59.7	38.7	48.9
Use of non-sterile syringe	90.3	86.5	94.5	89.6	83.5	95.1	94.0
From HIV infected pregnant to fetus	60.4	54.2	67.1	59.2	49.5	66.3	67.7
Through mother's milk	41.2	37.4	45.3	39.5	35.3	41.4	48.3
Insufficient sterilization of medical instruments	82.5	78.0	87.3	70.3	85.3	87.0	87.6

Respondents were also asked questions on major misconceptions prevailing about HIV transmission. Survey results by gender as well as by age groups (14-16; and 17-19) are presented in the table below.

**Knows that HIV cannot be transmitted through:**

N= 476	Total	Male	Female	Male age		Female age	
				14-16	17-19	14-16	17-19
Use of public toilet	64.6	67.1	61.9	67.3	66.9	63.3	60.9
“Dry” kiss on lips	74.4	73.9	75.0	71.3	76.3	66.4	81.6
“Wet” kiss on lips	47.2	50.3	43.9	51.3	49.5	41.5	45.8
Shaking hands	90.0	89.7	90.4	88.1	91.1	91.1	89.8
Mosquito sting	39.6	38.4	40.9	44.1	33.0	41.5	40.5
Use of things of an AIDS/HIV carrier	49.6	48.4	50.9	48.2	48.6	48.6	52.7

As demonstrated, young girls and boys are equally aware of HIV; Majority of adolescents can correctly identify HIV transmission ways (contaminated injecting equipment and blood, unprotected sex). However less than half knows that virus can be transmitted through unprotected homosexual contacts, and through breastfeeding from infected mother to child. Only every 2 adolescents out of five respondents know that HIV cannot be transmitted via mosquito bite. More focused interventions are warranted to increase HIV awareness among young people.

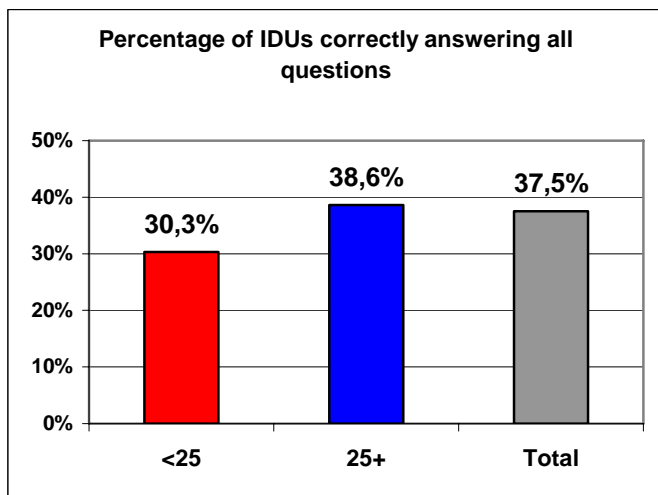
**Indicator 14: Most-at-risk Populations: Knowledge about HIV prevention**

***Knowledge about HIV among IDUs***

According to the UNGASS reporting requirement, five questions were recommended for calculating this indicator. One of the standard question proposed - “Can a healthy-looking person have HIV”- was not included in BSSs conducted before 2007. To generate complete data for standardized indicators, BSSs carried out in 2008-2009 have used adjusted questionnaires where all requested questions were formulated according to the UNGASS reporting requirements.

	number of IDUs correctly answering all questions n/N	Percentage of IDUs correctly answering all questions
<25	43/142	30,3%
25+	380/985	38,6%
Total	423/1127	37,5%

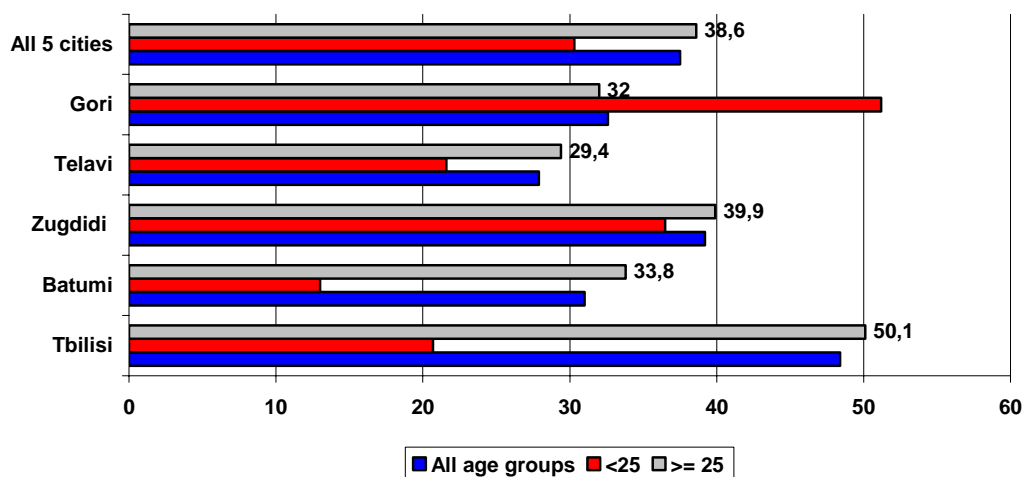
**Figure 14: HIV Knowledge among IDUs by age groups**



As demonstrated above approximately one-third of surveyed IDUs could give correct answers to all five questions. In general, older respondents are relatively more knowledgeable of HIV transmission than younger IDUs. This trend is similar in almost every city (except Gori) participating in BSSs.

	Tbilisi	Batumi	Zugdidi	Telavi	Gori	All 5 cities
All age groups	48,4	31	39,2	27,9	32,6	37,5
<25	20,7	13	36,5	21,6	51,2	30,3
>= 25	50,1	33,8	39,9	29,4	32	38,6

**Figure 15: HIV knowledge among IDUs disaggregated by cities and age groups**



**Knowledge about HIV among FSWs**

Percentage of FSWs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Tbilisi	Batumi
All age groups	8.1%(13/160)	5.8%(7/120)
<25	0% (0/11)	7.7%(1/13)
25 +	8.7%(13/149)	5.6%(6/107)



As demonstrated in the table above, the level of HIV knowledge remains to be extremely low among FSWs in both cities. A total of 160 FSWs in Tbilisi and 120 FSWs in Batumi were surveyed in 2008. Of them 8,1% in Tbilisi and 5,8% in Batumi gave correct answers to all five standard questions.

It should be noted that none of the sex workers aged under 25 in Tbilisi could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV. Slightly different picture was observed in Batumi where sex workers under 25 appeared to be more aware of HIV than FSWs aged 25 and older.

### ***Knowledge about HIV among MSM***

During the BSS among MSM conducted in 2007 in Tbilisi 140 male respondents participated and of them 57 were aged under 25. Only 25% of all respondents could correctly answer all five questions on HIV transmission. This indicator for the youngest group was lower than for oldest group – 21.1% and 27.7%, respectively.

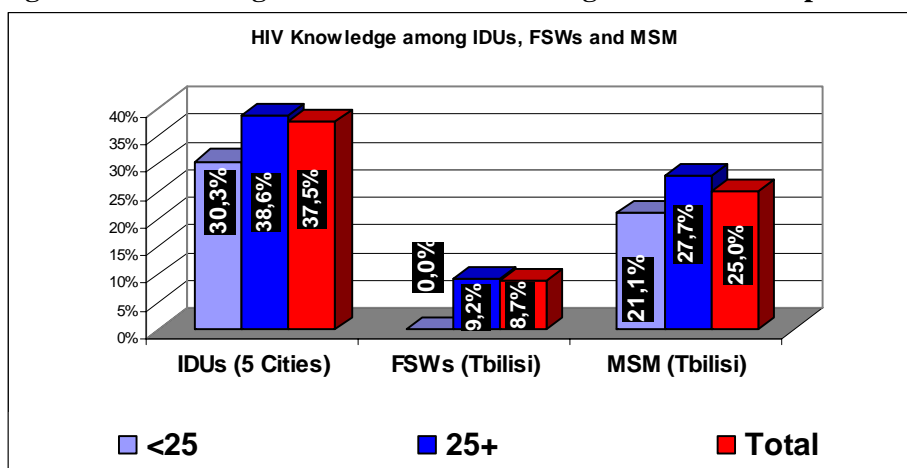
<b>HIV Knowledge among MSM in Tbilisi</b>	<b>Correct Answers</b>		
	<b>All</b>	<b>&lt;25</b>	<b>25+</b>
<b>Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? (Yes)</b>	<b>85.0%</b> (119/140)	<b>82.5%</b> (47/57)	<b>86.7%</b> (72/83)
<b>Can using condoms reduce the risk of HIV transmission? (Yes)</b>	<b>89.3%</b> (125/140)	<b>84.2%</b> (48/57)	<b>92.8%</b> (77/83)
<b>Can a healthy-looking person have HIV? (Yes)</b>	<b>85.7%</b> (120/140)	<b>77.2%</b> (44/57)	<b>91.6%</b> (76/83)
<b>Can a person get HIV from mosquito bites? (NO)</b>	<b>45.7%</b> (64/140)	<b>47.4%</b> (27/57)	<b>44.6%</b> (37/83)
<b>Can a person get HIV by sharing a meal with someone who is infected? (NO)</b>	<b>57.1%</b> (80/140)	<b>50.9%</b> (29/57)	<b>61.4%</b> (51/83)
<b>Correctly answered all five questions</b>	<b>25.0%</b> (35/140)	<b>21.1%</b> (12/57)	<b>27.7%</b> (23/83)

Further analyses of individual questions has revealed that, like other MARPs, vast majority of MSM knows the ways of transmitting HIV and percentages of respondents answering questions on condom use, having one faithful partner and asymptomatic HIV are quite high for both age groups. However, almost half of them do not know that HIV cannot be transmitted via either mosquito bite or meal sharing with infected persons.

HIV Knowledge	Total (n=140)	Age Groups	
		<25 (n=57)	25+ (n=83)
Can people protect themselves from the HIV virus by using a condom correctly every time they have sex? ( <i>Yes answer</i> )	93.4% (127/136)	90.7% (49/54)	95.1% (78/82)
Can one get HIV as a result of a mosquito's bite? ( <i>No answer</i> )	47.1% (64/136)	50.0% (27/54)	45.1% (37/82)
Do you believe that one may protect oneself from HIV/AIDS by having one uninfected and reliable sexual partner? ( <i>Yes answer</i> )	87.5% (119/136)	87.0% (47/54)	87.8% (72/82)
Do you believe that one can get HIV/AIDS by taking food or drink that contains someone else's saliva? or Can a person get the HIV virus by sharing a meal with someone who is infected? ( <i>No answer</i> )	58.8% (80/136)	53.7% (29/54)	62.2% (51/82)
Do you believe that a person who looks healthy can be infected with HIV, which causes AIDS? ( <i>Yes answer</i> )	88.2% (120/136)	81.5% (44/54)	92.7% (76/82)

Comparing this indicator for MSM, IDUs and FSWs demonstrates that IDUs are most knowledgeable of HIV followed by MSM population (see Figure 16).

**Figure 16: Knowledge about HIV/AIDS among Most-at-risk Populations**



Indicator 15: Sex before the Age of 15

No population based survey asking the question about having sexual intercourse before the age of 15 was carried out in Georgia. Scarce information can be obtained from the findings of Adolescent Reproductive Health Survey (EU/UNFPA) conducted by the Cultural Study Center in 2009. Unfortunately, only young people age 14-19 were eligible to participate in the study. A total of 600 adolescents participated in the survey; 198 (33%) respondents reported having had sex by the time of survey; of them only 24.6% had sex before the age of 15.

**Indicator 16: Higher-risk Sex**

No data

**Indicator 17: Condom Use during Higher-risk Sex**

No data

### Indicator 18: Sex Workers: Condom Use

*Percentage of female and male sex workers reporting the use of a condom with their most recent client*

Condom use	Tbilisi	Batumi
Percentage of female sex workers reporting the use of a condom with their most recent client	98.8% (158/160)	92.5% (111/120)
≤ 24	100% (11/11)	100% (13/13)
≥ 25	98.7% (147/149)	91.6% (98/107)

Condom use with most recent client was quite high (99%) and this indicator slightly increased compared to the data from BSSs in 2006 (92%). Condom use indicator reached 100% for FSWs in the youngest age group in both cities. However, safe sex practice is less common for FSWs as only 13% of sex workers in Tbilisi and 9% in Batumi reported using condom during last sexual encounter with regular/non-paying partners.

### Indicator 19: Men Who Have Sex with Men: Condom Use

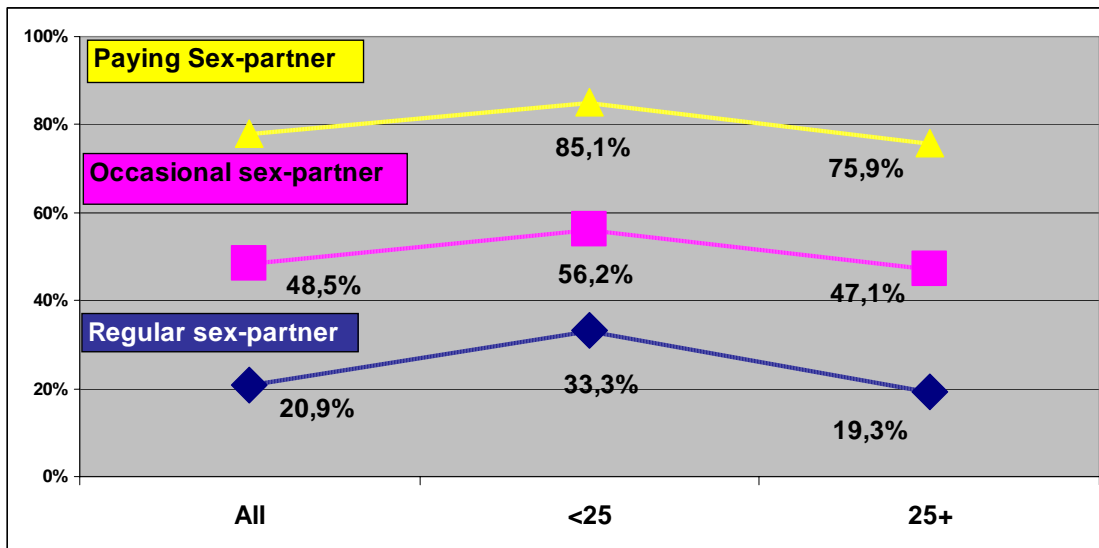
BSS among MSM in 2007 showed that condom use during last anal sex is almost identical for both age groups and remains low. Much more focused interventions will be required to promote safe sex behavior among this group.

Condom use during last anal sex	Total both groups N=140 (20 missing cases)	Age group <25 (9 missing cases)	Age group 25+ (11 missing cases)
<b>Yes</b>	61.7% (74/120)	60.4% (29/48)	62.5% (45/72)
<b>No</b>	36.7% (44/120)	37.5% (18/48)	36.1% (26/72)
<b>Don't remember/No response</b>	1,7% (2/120)	2,1% (1/48)	1.4% (1/72)

### Indicator 20: Injecting Drug Users: Condom Use

According to the UNGASS reporting requirement only those respondents who have injected drugs at any time in the last month should be included in the calculation of this indicator. This requirement was one of the criteria of admitting IDUs into the study. Hence, all IDUs participating in BSSs reported injecting drugs at any time in the last month (N=1127); however not all of them reported having sex in the last month. Considering that, traditionally in Georgia, condom use practices are quite different with regular, accessional and paying sex partners, three separate questions were asked to assess safe sex practices by each type of sexual partner. Accordingly, the number of respondents who reported having sex in the last month with paid-for sex partners, occasional and regular sex partners varies considerably (316/1127; 550/1127 and 870/1127, respectively).

**Figure 17: Condom Use among IDUs by types of sex partners**



As demonstrated, condom use rate is the lowest (21%) during last sex with regular partners, is relatively high for occasional sex partner (48,5%) and reaches its highest level for paying sex workers (77,8%). More detailed data is provided in the table below.

IDUs: Condom use during last sexual intercourse by sex partners	<25		25+		Total	
	N	%	N	%	N	%
Condom was used the last time they had sex with <b>paid for sex partner</b>	57		189		246	
Respondents who report having injected drugs and having had sexual intercourse with <b>paid for sex partners</b> in the last month	67	<b>85,10%</b>	249	<b>75,90%</b>	316	<b>77,80%</b>
Condom was used the last time they had sex with <b>occasional sex partner</b>	50		217		267	
Respondents who report having injected drugs and having had sexual intercourse with <b>occasional sex partners</b> in the last month	89	<b>56,20%</b>	461	<b>47,10%</b>	550	<b>48,50%</b>
Condom was used the last time they had sex with <b>regular sex partner</b>	33		149		182	
Respondents who report having injected drugs and having had sexual intercourse with <b>regular sex partners</b> in the last month	99	<b>33,30%</b>	771	<b>19,30%</b>	870	<b>20,90%</b>

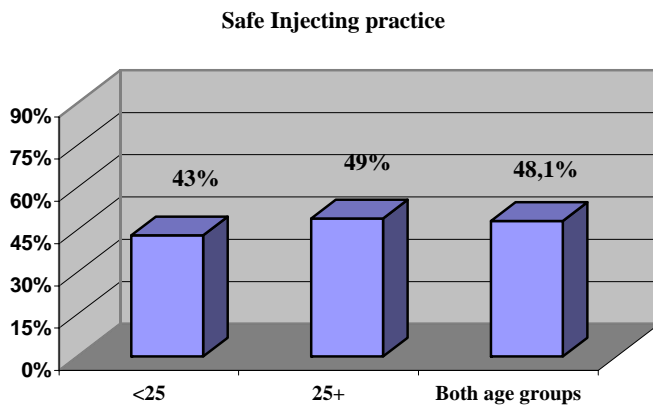
**Indicator 21: Injecting Drug Users: Safe Injecting Practices**

The majority of IDUs surveyed have shared used needles and/or syringes in their lifetime at least once. However, unsafe injecting practice lessens when it comes to the last injection.

It should be noted that the majority of respondents reported using sterile needles and syringes the last time they injected drugs. However, given that in Georgia, needles and syringes may be exposed to HIV without being shared between users (through shared drug solutions, bowls and other drug paraphernalia), for calculating this indicator experts decided to include all relevant questions ascertaining that injection practice was actually safe (safe injection is defined as: not usage of contaminated needle/syringe, not usage of needle/syringe left at a place of gathering by somebody else, not usage of syringe filled by somebody else, not usage of shared equipment, not usage of drug solution from shared container, not usage of liquid diluted with somebody else's blood).

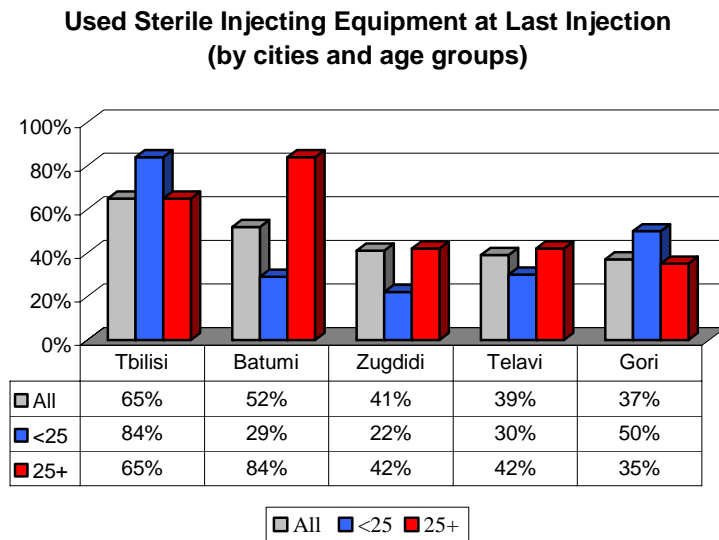
<b>Percentage of IDUs reporting safe injecting practices (BSSs in Tbilisi, Batumi, Zugdidi, Telavi and Gori; N=1127)</b>			
<b>Used sterile injecting equipment the last time they injected drugs</b>	<b>&lt; 25</b>	<b>25+</b>	<b>Total</b>
		<b>43%</b> (61/142)	<b>48,8%</b> (481/985)

**Figure 18: Safe Injecting Practices: IDUs by age groups**



The indicator on sharing practice the last time they injected drugs varies by cities – with the highest proportion of respondents reporting safe injection in Tbilisi (65%) and the lowest - in Gori (37%). The graph below presents data for IDUs by each city participating in BSSs.

**Figure 19: Safe Injecting Practices at Last Injection**



Given that injecting drug use is the major route of HIV transmission in Georgia, much more emphases should be placed on prevention programs targeting IDUs.

**Impact Indicator 22: Reduction in HIV Prevalence**

Not applicable.

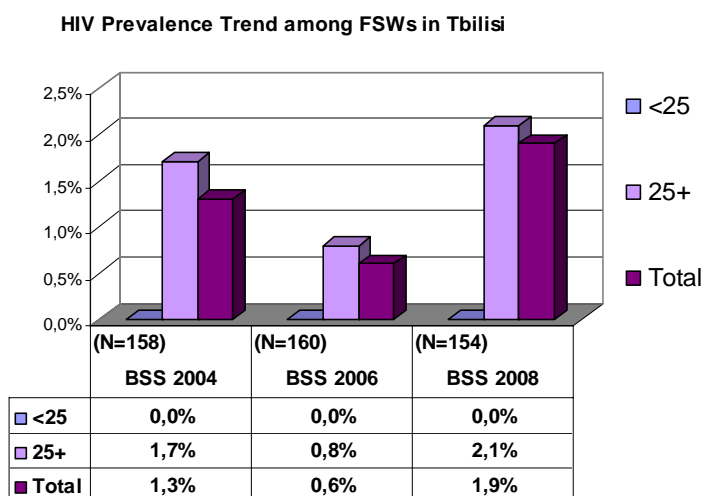
**Impact Indicator 23: Most-at-risk Populations: Reduction in HIV Prevalence**

*HIV prevalence among female sex workers*

The table below represents data generated through last BSSs conducted in 2008/2009 in two cities – Tbilisi, the capital, and Batumi, the port city, the capital of Adjara Autonomous Republic. HIV prevalence among female sex workers in Tbilisi was 1,9%, and the prevalence among facility-based female sex workers in Batumi did not exceed 0,8%. It should be noted that out of 119 surveyed one FSW aged under 25 tested positive on HIV. Thus, HIV prevalence in the age group under 25 (7,7%) should be interpreted with caution as the sample size in the youngest age group was too small (only 13 women).

<b>HIV Prevalence among FSWs by cities (BSS 2008-2009)</b>	<b>Tbilisi</b>	<b>Batumi</b>
<b>Percentage of most-at-risk populations who are HIV-infected</b>	<b>1.9% (3/154)</b>	<b>0.8% (1/119)</b>
<b>&lt;25</b>	<b>0% (0/11)</b>	<b>7.7% (1/13)</b>
<b>25+</b>	<b>2.1% (3/143)</b>	<b>0% (0/106)</b>

**Figure 20: HIV prevalence Trend among FSWs in Tbilisi since 2004.**



HIV prevalence among female sex workers in the capital city remains relatively stable over time with minor changes in percentages that are not statistically significant.

**HIV prevalence among MSM**

Unfortunately, the last BSS among MSM in Tbilisi was conducted only in 2007. Therefore the prevalence data presented in the report can be considered as outdated. HIV prevalence among MSM in the capital city has been stable since 2005 and remains to be under 5%.

In total 70 MSM were recruited for BSS 2005. All of the respondents were tested for HIV and of them three men appeared (4.3%) to be HIV positive. Repeated BSS in 2007 surveyed 140 MSM. Of them 5 respondents were found to be HIV positive (confirmed with Western Blot test).

HIV prevalence among MSM for 2005 and 2007 disaggregated by age (<25/25+) are demonstrated in the table below.

	<25		25+		Overall total	
Men Who Have Sex with Men in Tbilisi	BSS 2005 (n=34)	BSS 2007 (n=57)	BSS 2005 (n=36)	BSS 2007 (n=83)	BSS 2005 (n=70)	BSS 2007 (n=140)
HIV Prevalence among MSM	2.9% (1/34)	3.5% (2/57)	5.5% (2/36)	3.6% (3/83)	4.3% (3/70)	3.6% (5/140)

**HIV Prevalence among IDUs**

HIV prevalence for 2008-2009 is generated through the BSSs (GF) among IDUs carried out in 5 cities of Georgia as well as the BSS among IDUs in Kutaisi carried out by the USAID funded SHIP Project in 2009. The HIV prevalence was calculated by the software specifically designed for the RDS studies data analyses (RDSAT 6.0). RDSAT generates population estimates considering the study participants network sizes.

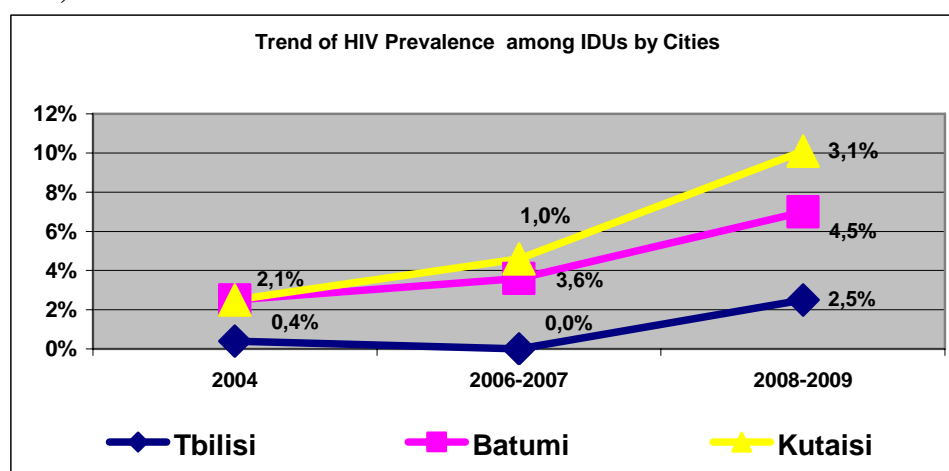
The number of tested IDUs as well as HIV prevalence for each survey site is as follows:

Tbilisi, N= 306; HIV prevalence– 2.5%;  
 Zugdidi, N= 204, HIV prevalence– 2.2%;  
 Batumi, N= 206; HIV prevalence - 4.5%;  
 Telavi, N= 205, HIV prevalence – 1.5%;  
 Gori, N=187, HIV prevalence -0%.  
 Kutaisi N=195, HIV prevalence (SPSS)- 3,1% (6/195)

HIV Prevalence	Tested	Tested +	%
<b>Total IDUs</b>	<b>1289</b>	<b>28</b>	<b>2,17%</b>
<25	162	0	0%
>25	1127	28	2,48%

A total of 1303 IDUs were tested in all 6 survey sites; confirming HIV sero-status in 14 cases was impossible and due to uncertainty of test results these 14 respondents were excluded from the analysis. Out of 1289 respondents, 28 persons tested HIV positive. All HIV infected IDUs were among respondents aged 25 and older. No positive case among youngest respondents (aged <25) was detected. Overall HIV prevalence among IDUs in 2008-2009 was 2,1% (RDSAT generated calculation; 95% CI - 1.38% – 3.19%). It should be noted several rounds of BSS were carried out among IDUs in Tbilisi, Batumi and Kutaisi that have enabled us to examine the trend in HIV prevalence over time. As the BSSs in Telavi, Gori and Zugdidi were baseline surveys in these cities, analyzing HIV prevalence trends has not been possible.

**Figure 21: HIV Prevalence Trend among Injecting Drug Users in Tbilisi, Batumi and Kutaisi (2004-2009)**



Unfortunately, HIV prevalence has increased since 2006 in all three cities where baseline data were available. As demonstrated in the chart above, HIV prevalence are on the rise and these findings call upon all stakeholders to scale up HIV prevention programs in a more concerted and well-coordinated manner. More emphases should be placed on providing comprehensive packages of prevention services to injecting drug users that beyond counseling and testing services would involve harm reduction strategies, substitution therapy and psycho-social rehabilitation. Latest analyses revealed that HIV testing uptake is quite low and the coverage of drug users with programs should be increased to ensure early detection of HIV among injecting drug users and prevent further spread of HIV to general public.



**Impact Indicator 24. HIV Treatment: Survival after 12 Months on Antiretroviral Therapy**

Despite the success in achieving universal access to ART, outcome among those started on therapy falls short of satisfactory. Analysis of 5 years of ART program operation showed that on average 80% of patients survive and retain on ART after 12 months of commencing therapy. The data also showed the major attrition from treatment program occurs within the first year of therapy and stabilized thereafter. Cumulative survival rates at 24 and 36 month after treatment initiation were 75 and 73% respectively.

<b>Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy</b>		
	<b>2008, % (n/N)</b>	<b>2009, % (n/N)</b>
<b>Total adults and children</b>	<b>76.9% (103/134)</b>	<b>81.0% (158/195)</b>
Male	73.7% (73/99)	79.3% (119/150)
Female	85.7% (30/35)	86.7% (39/45)
<b>Total adults (&gt;15)</b>	<b>76.8% (96/125)</b>	<b>81.0% (149/184)</b>
Male adults (>15)	74.5% (70/94)	79.2% (114/144)
Female adults (>15)	83.9% (26/31)	87.5% (35/40)
<b>Total children (&lt;15)</b>	<b>77.8% (7/9)</b>	<b>81.8% (9/11)</b>
Male children (<15)	60.0% (3/5)	83.3% (5/6)
Female children (<15)	100.0% (4/4)	80.0% (4/5)

n = Number of patients alive and on ART at 12 months after initiating treatment  
 N = Total number of patients who initiated ART

Survival rates of 77% and 81% in 2008 and 2009 are comparable those of reported in previous years. Gender sub-analysis showed higher survival among women compared to male patients (86% vs. 74% in 2008, and 87% vs. 79% in 2009). Gender-specific difference can be explained by higher proportion of men diagnosed late in the course of their HIV infection, higher prevalence of co-morbid conditions among males and lower antiretroviral adherence compared to women. Lower survival of children under 15 years of age (78% and 82% in 2008 and 2009 respectively) likely is the result of missed opportunities to diagnose HIV positive pregnant women through prenatal screening program.