

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

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

Georgia

Country Report

Reporting Period

January 1-December 31, 2006

Acronyms

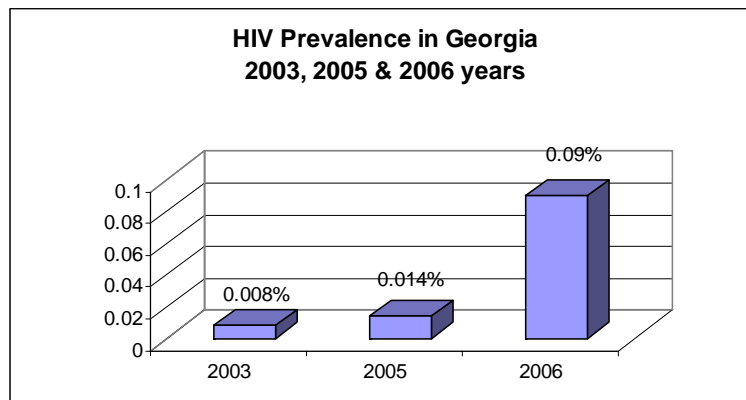
AIDS	Acquired Immune Deficiency Syndrome
AIDS Center	Infectious Diseases, AIDS & Clinical Immunology Research Center
ANC	Antenatal Clinics
ARV	Anti-retroviral drugs
BSS	Behavioral Surveillance Surveys with biomarker component
CCM	Country Coordinating Mechanism
FSWs	Female Sex Workers
GEL	Georgian Lari (official exchange rate for 2006 - 1.78 GEL=1US\$)
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GOGA	Georgian Obstetricians and Gynecologists Association
HIV	Human Immunodeficiency Virus
HLC	Healthy Lifestyle Course
HR	Human Resources
IDUs	Injecting Drug Users
MARP	Most-at-risk populations
MSM	Men who have sex with men
NCDC	National Center for Disease Control
NIS	Newly Independent States
NSPA	National Strategic Plan of Action
MoLHSA	Ministry of Labor, Health and Social Affairs of Georgia
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
VRF	Vishnevskaya-Rostropovich Foundation

Overview of the HIV/AIDS Epidemic in Georgia

Georgia is categorized as having a low-prevalence HIV epidemic with the estimated HIV prevalence rate 0.09% among adults aged 15-49 (based on SPECTRUM epidemic projection model). Estimates suggest that approximately 2800 persons were living with HIV/AIDS by the end of 2006. The methodologies, assumptions and data used to produce HIV/AIDS estimates are changing over time due to enhancement of experts' knowledge of the epidemic. Thus, according to some experts comparing latest estimates with ones from previous years might yield not accurate conclusions. Considering all above mentioned, other available estimates of HIV prevalence in Georgia are also reported below.

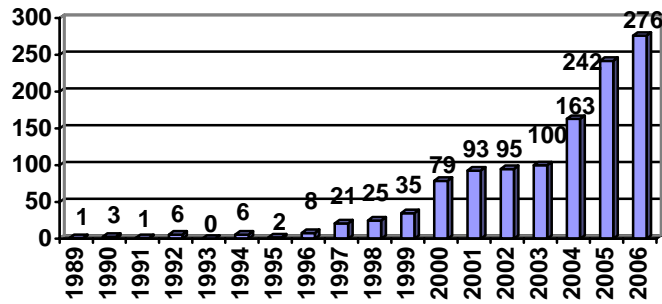
As of December 31, 2006 a total of 1156 HIV cases have been registered in Georgia; among them 897 were males, and 259 – females; 470 patients developed AIDS and 243 persons died. Thus, the HIV point prevalence based on the number of officially registered cases does not exceed 0.02% (2 HIV-positive persons per 10 000 population). 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. In 2006, out of 42430 pregnant women tested for HIV only 14 (0.033%) tested positive; as the data derived from antenatal clinics in countries with expanded PMTCT programs can serve as a good approximation of HIV prevalence among adults aged 15-49 (men and women combined) in the local community, it can be assumed that in 2006 HIV prevalence among adults aged 15-49 in Georgia was approximately 0.033% that is almost three-fold lower than the value derived through the SPECTRUM estimation.

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 22.4 % female and 77.6% male cases.

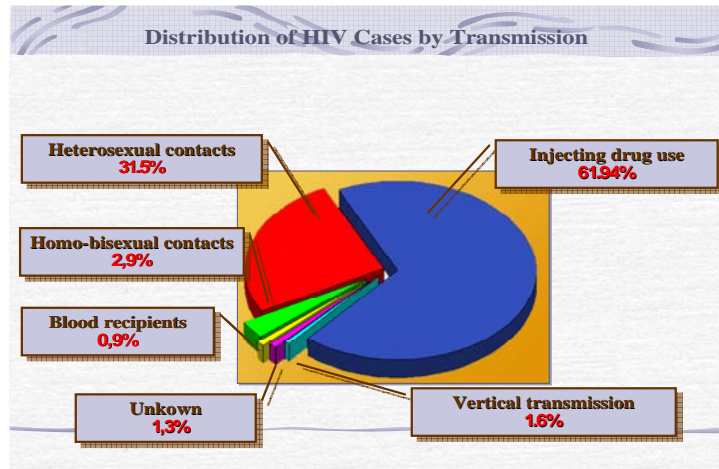


Since the very first case of HIV in 1989, the HIV epidemic has been progressing slowly with sporadic occurrences. Total numbers of newly registered cases are increasing gradually.

Trends in newly diagnosed HIV/AIDS by years



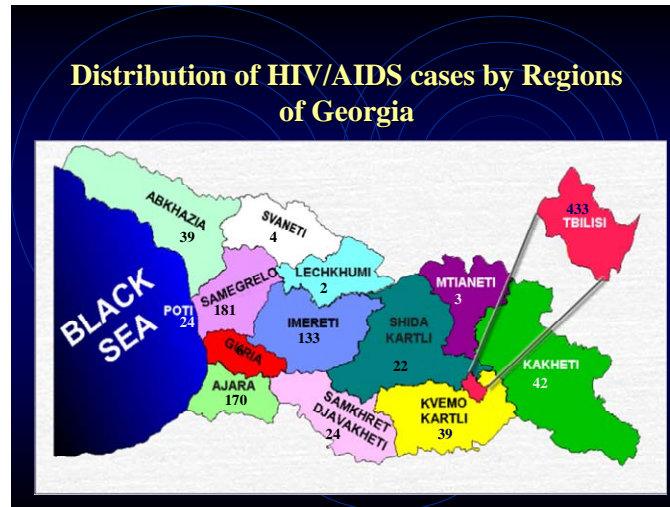
In its early stage HIV epidemics in Georgia showed similarities with the epidemics in most Eastern European countries with injecting drug use being the major transmission mode. However, over the last several years the transmission has shifted to heterosexual spread. As of 2006, IDUs represented 62% of all cases with a known route of transmission followed by 31.5% of the HIV-positive population infected through heterosexual contacts; homo-bisexual contacts account for 2.9 percent; 1.6% was infected through vertical transmission; blood recipients account for less than 1% of all registered cases¹.



While among all cumulative HIV cases 62% is attributed to injecting drug use, the highest HIV prevalence was observed among men who have sex with men (~4%), however due to low number of MSM (compared to IDUs) the data could not visibly change the overall patterns in HIV transmission in the country.

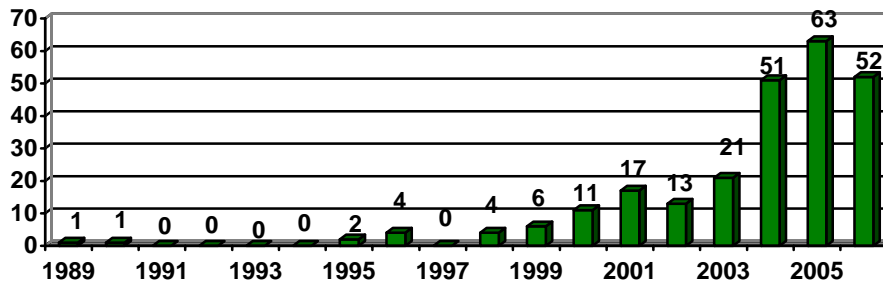
¹ *Date source: State HIV/AIDS Case reporting database, Infectious diseases, HIV/AIDS and Clinical Immunology Research Center*

Even at this low level of spreading the infection, HIV had reached all regions of the country. However, the infection is unevenly distributed through the regions. Tbilisi, the capital city (1 200 000 inhabitants) and the Black sea coastal regions of Georgia appeared to be central scenes where most infections are aggregated.



Since 2002, the number of deaths attributed to AIDS was rising every year until 2006 and this indicator decreased slightly only in the reporting year.

Number of deaths attributed to AIDS by years



Despite HIV low 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.

National Response to the HIV/AIDS Epidemic

Georgia was one of the countries in the NIS that immediately reacted to the epidemic in early 1990s. National efforts have led to a number of key achievements: establishment of HIV/AIDS service organizational structures, development of legal, policy and programmatic environment. Since 1994, HIV/AIDS Prevention & Control interventions in Georgia have been mainstreamed into 3 national programmes: AIDS

Prevention Program; Safe Blood Program, and AIDS Treatment Program. Starting from 2005 a national program on PMTCT has become operational. The State Law on HIV/AIDS was adopted in 1995, with amendments followed in the year 2000.

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); strengthening HIV surveillance system; diagnostics, 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.

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. In 2000, UN Theme Group on HIV/AIDS and other international agencies started collaboration with the Governmental Commission.

Built on the Governmental Commission, a Country Coordination Mechanism was established in 2002. To demonstrate political commitment the CCM is led by Mrs. Sandra E. Roelofs, the 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.

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 2007-2010” (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 PLHA, including ARV therapy
- Prevention of Mother to Child HIV transmission
- Strengthening of HIV surveillance system through the promotion of second generation surveillance in the country
- Organizational and technical capacity building

United Nations and International donor agencies

United Nation agencies and other international donor organizations have been making a significant contribution to confront HIV/AIDS in the country. 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. In 2002, through the UN Theme Group support and leadership from UNICEF the first comprehensive Situation and Response Analysis on HIV/AIDS was carried out. Based on findings the National Strategic Plan of Action 2003-2007 was elaborated. The document served as a basis for application to the Global Fund to fight AIDS, TB and Malaria leveraging USD 12.1 million for full- scale implementation of the 5-year national plan.

In 2006, the UN Theme Group on HIV/AIDS continued to support the policy and strategic planning process at country level. The national consultation on universal access was organized in February 2006, with the participation of more the 40 country-level partners (government, civil society, UN, international organizations, donors). The consultation led to development of the Universal Access Roadmap for Georgia.

UNAIDS provided technical assistance and organized series of consultations for revision of the National Strategic Framework and development of the 2006-2010 National Strategic Plan towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support in Georgia. In 2006 UN Theme Group on HIV/AIDS continued to support experts in development of the country application to the Global Fund Round 6 (USD11.4 million approved for the 2007-2010).

WHO organized several workshops on HIV/AIDS surveillance, VCT and novel trends in antiretroviral treatment of AIDS patients. It has assisted the country in development of relevant national guidelines and protocols.

UN agencies in Georgia provide continuous support for the advocacy and communication efforts of the government and major stakeholders (e.g. World AIDS Day, AIDS Candlelight Memorial Day and media events, such as talk shows, press conferences).

Since 2002 USAID continues to support Save the Children Federation that implements an STI/HIV Prevention Project in Georgia. The major goal of the project is 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 operates in three urban cities– Tbilisi, Batumi and Kutaisi. Since 2006 it has been operational in a breakaway region of Abkhazia. Further to the service delivery the project has promoted second generation surveillance studies in the country and conducted numbers of behavioral surveillance surveys with biomarker component (BSSs) among IDUs, FSWs and MSM.

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 Commission; Vishnevskaya-Rostropovich Foundation (VRF); Open Society Georgia Foundation (OSGF), World Vision International (WV Canada and WV USA); Cordaid; American Civilian Research and Development Foundation (CRDF); the Dutch Ministry of Foreign Affairs (TMF), and British Petroleum (BP).

HIV/AIDS Legal Environment

Human rights of the population including those affected with and/or by HIV/AIDS are safeguarded by the Constitution as well as by the HIV/AIDS State Law (adopted in 1995, amended in 2000), the Public Health Law (June, 2007), the State Law on Health Care (1997); State Law on Patients' Rights (2000, amended in 2007) and other international treaties and conventions acceded to and ratified by Georgia.

Acknowledging that non-discriminatory and protective legislation creates a supportive legal and political environment for scaling up effective HIV/AIDS prevention efforts, the revision of current law and other regulatory acts is underway within the framework of GFATM project and through the financial and technical support from UNDP. Amendment of the state law and relevant regulatory acts has been accompanied by active engagement of people living with HIV and interested social networks (such as IDUs).

According to the national policies, all research protocols involving human subject are evaluated by the ethical review committees. It should be noted that people living with HIV are also included in the ethics committee and most researches on HIV/AIDS in Georgia are approved by them.

Major Risk Factor – Injecting Drug Use

Georgia has the potential to be a transit country for narcotics flowing from Afghanistan to Western Europe. Breakaway territories South Ossetia and Abkhazia that are not controlled by the Government of Georgia might also provide additional routes for illicit drug flow. However, it should be noted that since the Rose Revolution there have been

notable improvements in border control that have resulted in an increase in the seizure of contraband narcotics².

There are no reliable statistics on drug use or drug dependency in Georgia. Some reports indicate that there are an estimated 240,000 - 350,000 (total population 4 474 000). Some experts mention that an increase in drug consumption is probably due to the growing popularity of Subutex, a licit pharmaceutical produced in France that is used in drug treatment. Over the last years, local experts in Georgia are becoming concerned about Subutex abuse injection.

BSSs conducted among IDUs in the capital city, Tbilisi in 2002, 2004 and 2006 have revealed that Subutex has quickly become the drug of choice of drug users and it has replaced heroin as the most commonly used drug: 65% of drug addicts have switched to Subutex in the last 3 years. In Georgia, one tablet of Subutex that is originally designed for sub-lingual use, is dissolved into an injectable solution and shared among seven to eight people. One “hit” costs approximately \$12-15.

Drug abuse is considered a criminal offense 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 2005-2006. However, the program budgeted at 200000 GEL (~ USD 125 000) is planned to resume in 2007.

Identifying the extent of drug use/addiction requires further researches, though it is obvious that illicit drugs are easily accessible in the country. Moreover, the population, especially the adolescent population is tolerant to drug use. A survey of teenagers found that 63.2 percent of surveyed boys and 48% of girls would not blame a person for trying illicit drugs once or twice³.

² International Narcotics Control Strategy Report, 2006. U.S. Department of State

³ Children and Women in Georgia: A Situation Analysis, 2003 UNICEF

Indicator 1: AIDS Spending

In 2006 (calendar year) total HIV/AIDS actual expenditure in Georgia amounted to 9'423'530.92 GEL (~US\$ 5'294'118.49)⁴. AIDS expenditure disbursed by the Government of Georgia for HIV/AIDS totaled 1'017'030 GEL (~571'365). Domestic funds accounted for only 11% of the total HIV/AIDS expenditure in the reporting year. In 2006, 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.

Approximately 56% of all AIDS spending is channeled through the Global Fund (5'291'139 GEL ~US\$ 2'972'550). Another substantial portion of funds (28%) is contributed by bilateral agencies and international donor organizations. UN agencies in Georgia accounted for 4% of the total AIDS expenditure in 2006.

Due to the absence of National AIDS Spending Assessment Tool in the country, disaggregating actual expenditures by spending categories proposed by UNGASS appeared to be complicated. Thus, data provided in the National Funding Matrix do not exclude the possibility of some deviations.

Donor funds account for the larger portion of HIV/AIDS expenditure in Georgia. This fact raises concerns for the sustainability of HIV prevention, treatment and care activities in the country. Unfortunately, at present there is no indication that the GoG will be able to allocate sufficient amount of funds to ensure the full-scale implementation of the NSPA.

Indicator 2: National Composite Policy Index

Data for the National Composite Policy Index (NCPI) were collected by administering NCPI questionnaire recommended by the UNGASS.

An extensive consultation meeting with participation of government institutions (Country Coordinating Mechanism; Ministry of Labor, Health and Social Affairs; the National Center for Disease Control; the National AIDS Center; Research Institute on Drug Addiction; the Georgian Health and Social Projects Implementation Center), civil society (NGO – Tanadgoma; Bemoni Public Union; OSGF; NGO- New Way; HIV/AIDS Patients Support Foundation; Youth Network Juvenco; Georgian Children's Federation) and international organizations (UN Theme Group in Georgia; Save the Children Federation) was held on December 14, 2007.

⁴ The data on AIDS expenditure were collected through surveying government, NGO, international and donor organizations as well as UN agencies operational in Georgia

Results of the survey were reviewed and endorsed at the Consensus meeting held on January 21, 2008. The meeting was attended by representatives from the following organizations:

Government:

1. Country Coordinating Mechanism
2. The Ministry of Labor, Health and Social Affairs
3. Ministry of Justice
4. National Center for Disease Control
5. Infectious Diseases, HIV/AIDS and Clinical Immunology Research Center
6. Research Institute on Drug Addiction
7. Georgian Health and Social Projects Implementation Center

NGOs:

8. AIDS Patients Support Foundation
9. Counseling Center Tanadgoma
10. Bemoni Public Union
11. New Way
12. "Alternativa" Georgia
13. Save the Children Federation (SC)

Final results have been entered into CRIS.

Corresponding CRIS file is attached

Indicator 3: Blood Safety

The importance of blood safety in public health has long been recognized. Georgia was among the first countries that developed Safe Blood National Program in early 1997. The mandatory screening of all donated bloods is endorsed by the State Law on HIV/AIDS Prevention. According to the National standards, all bloods were routinely screened on four infections: HIV, syphilis, hepatitis B and C. The following methods for screening were used: Enzyme Linked ImmunoSorbent Assay (ELISA), Microparticles Enzyme Immunoassay (MEIA), and HIV rapid testing.

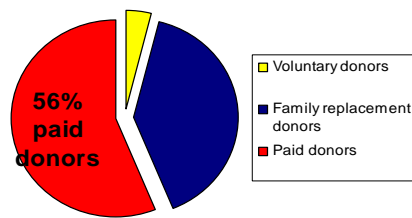
In 2006, to fill the gaps in funding and respond to unmet needs, the GFATM started supporting the National Blood Safety Program. State funded program was run by the Georgian Blood Preparation Center, and the GFATM funded program was implemented by the Tbilisi Blood Bank of Jo Ann Medical Center. In total 34 354 blood units were donated to all blood-screening laboratories and virtually all of them (100%) were screened on all infections. No accurate data on total number of blood units transfused in the reporting year were available.

A total of 53 blood centers/screening laboratories were involved in the implementation of Blood Safety programs nationwide. Unfortunately, none of the centre/laboratory reported

following any Standard Operating Procedures, and none of them participated in an External Quality Assessment Scheme. Thus, even though that 100% of all blood donors were screened, the value of the indicator is equal to 0%.

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 (%)
Georgian Blood Preparation Center	No	No	27354	27354 (100%)	0
Blood Bank of Jo Ann Medical Center	No	No	7000	7000 (100%)	0
Total	No	No	34354	34354	0

It is of utmost importance that test results be accurate and reliable that is a key to program's success. A considerable effort is needed to improve laboratory systems to meet international requirements. A vital step in strengthening the capacity of laboratories is the development of comprehensive recommendations and Standard Operating Procedures. Clearly defined monitoring and evaluation plan should be elaborated and an adequate external quality control mechanism should be in place. Taking into account the expansion of testing sites (nationwide in total 53 laboratories were involved in Blood Safety Programs in 2006), it would be quite challenging to foster the implementation of quality assurance system plan at all laboratories, including central, regional and peripheral locations. The situation is further exacerbated by the fact that less than 4% of blood was collected from voluntary blood donors; family/replacement donors account approximately for 40% of all donors.



The reliance on paid donors can adversely affect the safety of blood as they show higher prevalence of HIV and other blood borne infections than voluntary donors. Further steps should be taken to develop effective strategy for recruitment and retention of low-risk non-remunerated blood donors.

Indicator 4. HIV Treatment: Antiretroviral Therapy

New advancements in treatments and medical management continue to help people with HIV/AIDS live longer and healthier lives. Since 2004, within the framework of the Global Fund Project in Georgia, all registered patients eligible for treatment (100%) receive free-of-charge antiretroviral treatment. Prior to the treatment initiation all registered HIV positive individuals are being examined for CD4 count and viral load to assess treatment needs. All individuals who met the treatment criteria as per the national protocols are offered free-of-charge ARV treatment.

In March, 2004, the country has approved its first HIV/AIDS National Treatment Protocol that was based on WHO/UNAIDS standards and recommendations for NIS countries. Moreover, the national protocols are exceeding the WHO standards for developing countries and are in compliance with treatment standards for developed countries.

Diagnostics and treatment of AIDS patients are provided at the highest attainable standards. Most of modern hi-tech laboratory methods and diagnostic techniques are implemented at the National Infectious Diseases, HIV/AIDS and Clinical Immunology Research Center in Tbilisi including qualitative and quantitative PCR (viral load, since 1996); determination of CD4 performed using BD FACSCalibur; in June 2005 through the Global Fund support an HIV genotypic resistance testing using Bayer Open Gene DNA Sequencing System was introduced in the country.

In the recent past, the National AIDS Center had been the only institution providing treatment services to all patients. However, over the last three years a transition from highly centralized treatment delivery system to decentralized one has been underway. Two AIDS Treatment Centers in Batumi and Zugdidi became operational through the support of the GFATM projects that greatly contributed to improved accessibility of treatment services for the populations in regions.

In 2007, through the support of WHO regional office, the Georgia AIDS center has developed and published a clinical Guideline “HIV/AIDS Patients’ Treatment and Care,” that was officially endorsed by the Ministry of Labor, Health and Social Affairs of Georgia in March, 2007.

The data for this indicator are derived from the ARV treatment national registers at the Infectious Diseases, HIV/AIDS and Clinical Immunology Research Center. The total number of adults and children with advanced HIV infection who received antiretroviral

treatment at the end of 2006 totaled 267; among them 193 were males and 74 - females. The total number of children under 15 was 8. No pregnant women taking ARV treatment only for the purpose of PMTCT are included in the numerator for this indicator.

The denominator was generated through Spectrum estimation model by estimating the number of people with advanced HIV infection requiring ARV therapy. According to the data there were estimated 388 patients with advanced HIV by the end of the reporting period. Thus, the percentage of adults and children with advanced HIV infection receiving antiretroviral therapy in 2006 was equal to 68.8% (267/388).

To track annual trends in coverage in AIDS treatment the indicator for 2007 was also calculated. A total of 334 AIDS patients received Anti-retroviral therapy by the end of 2007. Total estimated number of persons with advanced HIV infection for the year 2007 was 476; thus the percentage of adults and children with advanced HIV Infection receiving ART in 2007 was 70.2% (334/476).

For more visibility, the two indicators for the years 2006 and 2007 disaggregated by sex and age groups (<15, 15+) are presented in the table below.

At the end of the reporting period		<u>2006</u>	<u>2007</u>	
Total # of persons on ART	267		334	
Estimated # of persons with advanced HIV infection	388	68.8%	476	70.2%
Total # of female on ART	74		95	
Estimated # of female with advanced HIV infection	85	87.1%	106	89.6%
Total # of male on ART	193		239	
Estimated # of male with advanced HIV infection	303	63.7%	370	64.6%
Total # of adults (>15) on ART	259		319	
Estimated # of adults with advanced HIV infection	364	71.2%	439	72.7%
# of female adults (>15) on ART	72		90	
Estimated # of female adults (>15) with advanced HIV infection	70	102.9%	85	105.9%*
# of male adults (>15) on ART at the end of the reporting year	187		229	
Estimated # of male adults with advanced HIV infection	294	63.6%	354	64.7%
# of children (<15) on ART	8		15	
Estimated # of children (<15) with advanced HIV infection	24	33.3%	37	40.5%
# of female children (<15) on ART at the end of the year	2		5	
Estimated # of female children (<15) with advanced HIV infection	15	13.3%	21	23.8%
# of male children (<15) on ART now at the end of the year	6		10	
Estimated # of male children (<15) with advanced HIV infection	9	66.7%	16	62.5%

* The value exceeds 100% suggesting that the number of female adults (>15) with advanced HIV infection by the end of 2007 generated through Spectrum might be underestimated.

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 has completely covered the VCT component of PMTCT program. It should be mentioned that the program has been supported by the Vishnevskaya-Rostropovich Foundation (VRF) that established its presence in Georgia in 2004.

Since 2006 the VRF has been providing HIV diagnostic test-kits to cover testing of the entire cohort of pregnant women throughout the country. According to the National PMTCT protocol all women should be offered free-of-charge HIV counseling and testing services during their first visit at ANC. Universally all pregnant women with confirmed HIV diagnosis are involved in the PMTCT program funded by the GFATM and being implemented by the Georgian Obstetricians and Gynecologists Association (GOGA) in partnership with the National AIDS Center. All infected women are prescribed prophylactic regimens using a combination of three ARVs: Zidovudine + Lamivudine + Saquinavir/Ritonavir. According to internationally accepted standards, intravenous Zidovudine is administered during labor; in addition to neonatal Zidovudine a standard single dose of Nevirapine is given to all babies born to HIV infected mothers to reduce the risk of HIV transmission.

According to the official statistics in total 42 430 pregnant women at ANC were screened for HIV in 2006. Among them 14 women tested positive for HIV. Thus HIV prevalence among antenatal women was 0.03% in the reporting year. All infected pregnant women received ART treatment. Only one case of HIV infection was detected during labor and standardized treatment was provided to both – mother and newborn.

Based on the data from the National Center for Diseases Control (NCDC), the total number of deliveries in 2006 reached 48181 (of them 47 593 (98.8%) occurred at hospitals and 588 (1.2%) at homes). Thus, HIV screening coverage at antenatal services was 88% in 2006.

The number of HIV infected pregnant women who received ARV therapy during the last 12 months was 18; the estimated number of HIV infected pregnant women in 2006 calculated through Spectrum was 23. Thus, the percentage of HIV-infected pregnant women who received antiretroviral treatment to reduce the risk of mother-to-child transmission equaled 78% (18/23). None of the infants born to infected mothers was diagnosed with perinatal HIV in 2006.

In 2007, in total 17 pregnant women were on ARV treatment; and the estimated number of HIV-infected pregnant women was 25. Thus the indicator for 2007 shows that 68% HIV-infected pregnant women benefited from free-of-charge ARV treatment under the PMTCT program.

Unfortunately, reliable statistics on HIV testing acceptance rate among pregnant women as well as data on pre-test and post test counseling services are not available. However, it should be noted that with the purpose to identify major gaps and improve perinatal health

outcomes, the Government of Georgia requested an assessment study of antenatal and perinatal health care in Georgia be conducted. The study funded by the UNICEF Georgia commission was carried out by the local NGOs – Curatio International Consulting, and the Georgian Obstetrics and Gynecologists’ Association. The assessment used both quantitative and qualitative analyses to evaluate antenatal and perinatal health care in the country. The assessment’s sample design and survey tools were based on the World Health Organization’s guide for Safe Motherhood Needs Assessment. The tools were modified according to local needs and context. Surveys were conducted in 40 perinatal care providing institutions: 16 maternities, 15 hospitals and 9 perinatal clinics. In addition, patient exit interviews among 175 pregnant women at antenatal clinics were conducted.

Several service gaps were identified through the assessment in terms of prevention of mother-to-child HIV transmission. Namely, only 74.2% of pregnant women surveyed reported being tested for HIV/AIDS, and 61% of those who got tested reported that they received information about HIV. The finding suggests that some pregnant women (74.2% vs 88%) were tested for without consent.

According to the National PMTCT Program, it is a mandate that HIV rapid test kits be available in all ANC, however diagnostic kits were not found in 11% of surveyed facilities. The survey also looked at availability of educational materials in maternity facilities. Educational materials on STI/HIV/AIDS were available in only 44.5% of facilities⁵.

Indicator 6: Co-management of Tuberculosis and HIV Treatment

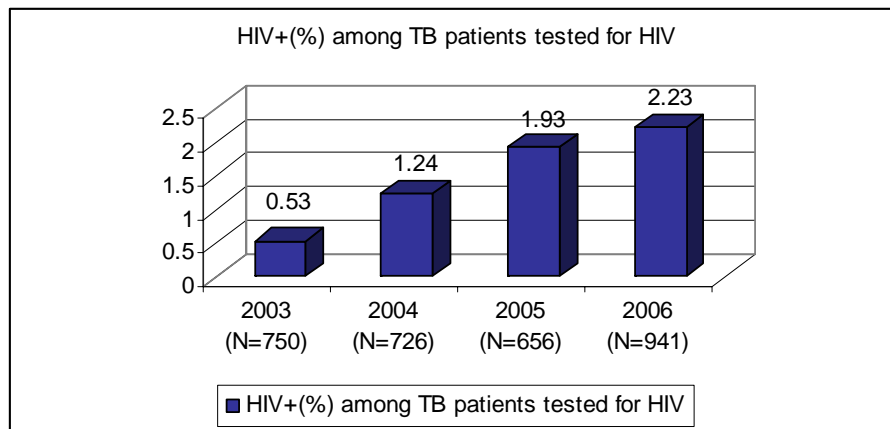
More international and domestic efforts should be made to control dual epidemic of HIV and TB in Georgia. It is evidenced that the risk of TB development in HIV-infected persons is 10 times greater than in people without HIV. At the same time, the presence of TB among HIV positive people significantly accelerates the progression of non-symptomatic HIV infection to AIDS (WHO, 1997). This combination shows that unified and aggressive strategy to control TB/HIV dual epidemics should be an integral part of HIV/AIDS national strategies in high TB prevalence countries.

Since the launching of the USAID funded Tuberculosis Treatment and Control Program (TTCP) as well as the Global Fund projects in Georgia, further steps were taken to intensify TB/HIV case finding. However, much remains to be done. In March, 2007 a national guideline “Clinical Management of TB/HIV Co-infection” was adapted and approved by the MoLHSA of Georgia. According to the national protocol, all TB patients should have an access to HIV information and testing; furthermore, medical doctors are obliged to offer HIV counseling and testing to all TB patients. The following treatment regimen is approved for HIV infected TB patients: combination of three ARV drugs – Zidovudine + Lamivudine + Efavirenz; if the treatment regimen appears to be ineffective, the second-line ARV drugs are prescribed.

⁵ Assessment of Perinatal Care in Georgia, 2006 Curatio International Consulting, UNICEF

In 2006, 6486 TB patients (147/100 000 population) were notified including 4283 new TB cases (97/100 000 population); of them 68% were male and 31.8% women. There were 1814 new sputum smear positive pulmonary patients (41/100 000) in 2006.

Acknowledging the importance of TB/HIV case detection, in 2006 the National TB Control Program provided HIV testing to patients in TB facilities in 6 cities of Georgia. In total 941 TB patients were tested of whom 21 turned to be HIV-positive (2.23%). The comparison of data from the last four years has revealed an increasing trend of HIV seropositivity among TB patients tested for HIV; however it should be acknowledged that this increase could be partly due to more aggressive TB/HIV case-finding efforts.



Taking into account that these studies were conducted in different centers at different time without using any scientifically proven sampling methodologies findings from these studies should not be generalized; though the data do provide an insight on the magnitude of HIV/TB problems in Georgia.

By the end of 2006 in total 96 AIDS patients were receiving both, ARV and TB treatment. Among them 34 adults with advanced HIV who were on ARV therapy also started on TB treatment within the reporting year. The Country-specific annual estimates calculated by WHO indicate that TB incidence (all cases/100 000 pop/year) equals to 83 and approximately 1.3 per cent of new adult TB cases is infected with HIV. Thus, an estimated number of new TB patients living with HIV in 2006 reached 48. The percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV is 70.8% (34/48) in 2006.

Indicator 7: HIV Testing in the General Population

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

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

HIV Testing among Female Sex Workers

Data for this indicator are derived from the BSS surveys that were conducted in 2006 in two major cities of Georgia – Tbilisi and Batumi. The BSSs were carried out under the USAID funded STI/HIV Prevention (SHIP) Project. Given that identical methodologies were used in both cities, the data from Tbilisi and Batumi have been aggregated and the chart below demonstrates the summative results from the two BSSs.

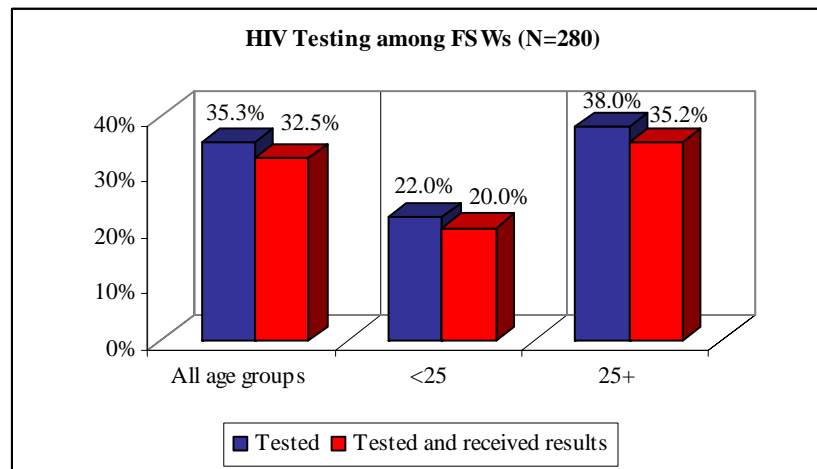
Respondents were asked two questions:

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?

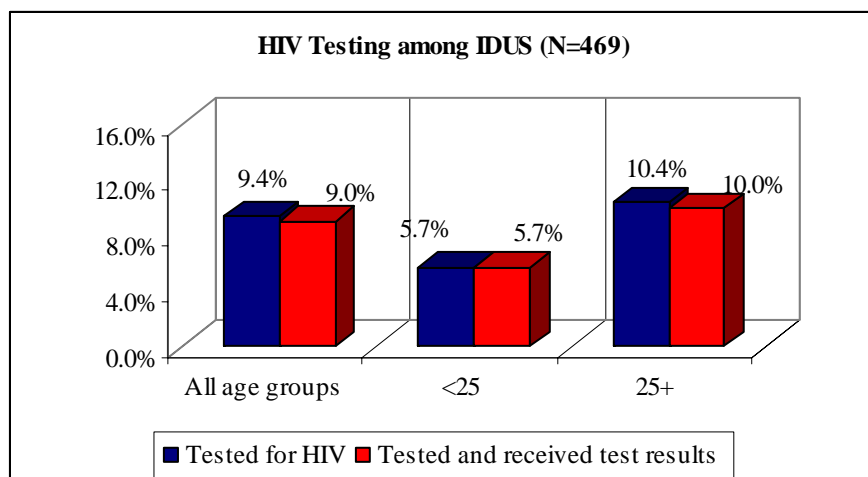
In total 160 street based FSWs were surveyed in Tbilisi, and 120 FSWs participated in the BSS in Batumi. Analyzing data showed that 35.3% (99/280) reported having had an HIV test in the last 12 months; of them 92% (91/99) received their test results.



Indicator 8 for FSWs: the percentage of FSWs who received an HIV test in the last 12 months and who know their results is equal to 32.5% (91/280).

HIV Testing among IDUs

Data for this indicator are also generated through the BSS surveys conducted in 2006 in two major cities of Georgia – Tbilisi and Batumi. The BSSs were carried out under the USAID funded STI/HIV Prevention (SHIP) Project. Given that identical methodologies were used in both cities the data from Tbilisi and Batumi have been aggregated.



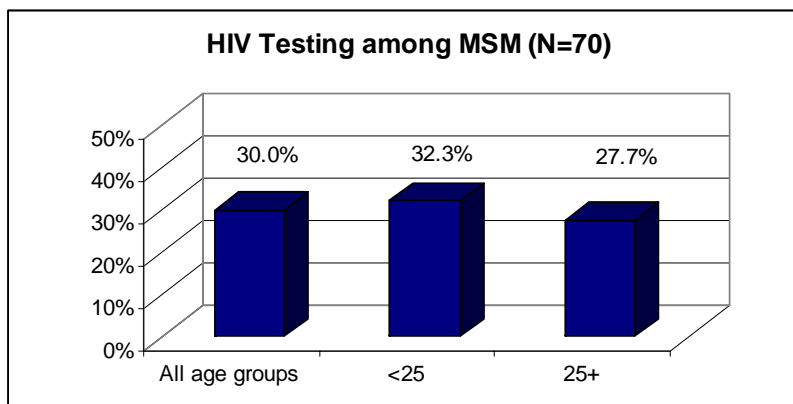
In total, 469 injecting drug users were recruited for the BSSs (274 respondents in Tbilisi and 195 in Batumi). All of them were males. Injecting drug use is not widespread among women and those female (small number) who inject drugs are extremely marginalized and hard to reach through researches. Therefore, the indicator is not disaggregated by sex. In total, 44 IDUs (10.4%) reported having had an HIV test in the last 12 months, and 42 of them (9.0%) received their test results.

Indicator 8 for IDUs: the percentage of IDUs who received an HIV test in the last 12 months and who know their test results equals to 8.96% (42/469).

HIV Testing among MSM

Data for this indicator is generated from the baseline Behavioral Surveillance Survey among MSM in the capital city – Tbilisi. The BSS was carried out in 2005 under the GFATM project by local NGO – Tanadgoma. In total 70 MSM were recruited through respondent driven sampling methodology; of them 34 men were aged under 25.

Almost one third of all respondents reported having had an HIV test in the last 12 months and received their test-results. In total 21 (30%) MSM replied “yes” to both questions; this indicator was slightly higher for younger age group: 32.3% (11/34) for respondents under 25 vs. 27.7% (10/36) for MSM aged 25 and older.



Indicator 8 for MSM: the percentage of MSM who received an HIV test in the last 12 months and who know their results equals to 30.0% (21/70).

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

In order to prevent the spread of HIV among most-at-risk populations as well as into the general population numbers of HIV prevention programs targeting MARP groups are being implemented in Georgia. 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 most-at-risk populations:

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?

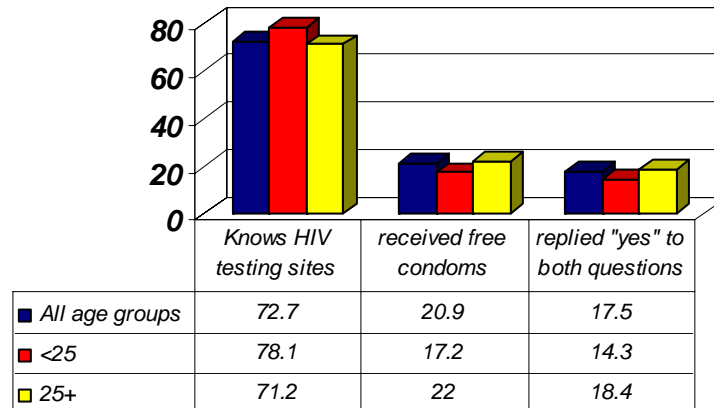
Unfortunately, the question #2 was not asked to respondents during the BSSs among FSWs and MSM. Thus we present only answers to the first questions for each most-at-risk population.

Indicator 9 for Female Sex Workers:	<25	25+	Total
	(n=50)	(n=230)	(n=280)
	Q. 1. Do you know where you can go if you wish to receive an HIV test?	78% (39/50)	80% (184/230)
Indicator 9 for MSM:	<25	25+	Total
	(n=34)	(n=36)	(n=70)
	Q. 1. Do you know where you can go if you wish to receive an HIV test?	76.5% (26/34)	66.6% (24/36)
Q. 2. In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	No data	No data	No data

As the table above demonstrates, the percentages of respondents who know where they can go if they wish to receive an HIV test are quite high for both groups: 79.6% (223/280) for FSWs and 71.4% (50/70) for MSM.

Relatively completed data were available from the BSS conducted among 469 IDUs in 2006. The chart below represents the percentage of IDUs who gave answers “yes” to the first two questions. The overall picture was similar to ones for FSWs and MSM. In total 72.7% of all injecting drug users reported they knew where they could get an HIV test. However, relatively small number of respondents (20.9%) received condoms through an outreach service, drop-in centre or sexual health clinic in the last 12 months. Combining responses yielded that only 17.5% of IDUs replied “yes” to both questions.

Percentage of IDUs reached with HIV prevention programs (N=469)



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. It should be emphasized that some questions regarding harm reduction programs were asked to respondents during the surveys. Major findings are presented below: in the capital city,

about 2 of every 5 IDUs had heard or seen information about a needle exchange program in Georgia; anecdotally only one IDU reporting obtaining needles/syringes from this program in 2004 and none in 2006. About 1 of every 6 IDUs had heard or seen information about a needle exchange program in Batumi, and only 1 of every 20 IDUs (5%) reported obtaining needles/syringes from this program in 2006.

Therefore, 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 have equaled to 0%; this result would not have fairly assessed the progress in implementing HIV prevention programs for IDUs in Georgia. Given that the problem of HIV and drug use in Georgia has been totally associated with the low awareness and other social habits (e.g. IDUs' network rules), HIV programs targeting IDUs in Georgia have placed much emphasis on awareness raising interventions and drug use prevention rather than needle exchange strategies.

Indicator 10: Support for Children Affected by HIV and AIDS

Not applicable.

Indicator 11: Life-skills based HIV Education in Schools

Since 2005, Georgia has taken initial steps to meet the Declaration target of ensuring that young people have access to critical HIV prevention services and life-skills education. Considering social and cultural context of the Georgian population, a decision was made to launch life-skills building education programs initially for students aged 16-17 (grades X-XI) and expand the program coverage incrementally. To reduce young people's vulnerability to HIV and substance abuse specific topics were incorporated into the life-skills training curriculum. Within the frames of GFATM project a manual for trainers and handbook – "Healthy Life-style – My Choice" for school students were elaborated and approved by the Ministries of Health and Education. The life-skills based HIV education program was piloted in 84 secondary schools (out of 326) in the capital city, Tbilisi in 2005-2006. During the two-year period in total 127 teachers and school psychologists were trained in HIV prevention education. Trainers spent on average 10-12 hours per school year on HIV education in each grade. In total 21 593 school students aged 16-17 underwent the life-skills building trainings in 2005-2006.

To address young people's sexual behaviors and reproductive health needs, the Healthy Women in Georgia project funded by USAID elaborated culturally sensitive training curriculum for the Healthy Lifestyle Course (HLC) targeting Adolescents in the Imereti region. The HLC aiming at increasing awareness of reproductive health and healthy lifestyle issues, as well as establishing healthy behavior, was delivered in 95 secondary schools (35 in 2006, and 65 in 2007) in all districts of the region. The target audience for the educational course has been school students aged 15-17 (IX, X, XI grades). The course includes 8 sessions on the following topics; smoking, alcohol, drugs, early

marriage, puberty, HIV/AIDS, STIs, and adolescents' reproductive health. Duration of each session is approximately 2.5 academic hours. Around 4000 students benefited from the Healthy Lifestyle carried out within the framework of Healthy Women in Georgia Project during 2006-2007. In addition, around 6000 youths were reached through various reproductive health awareness activities and IEC materials distribution.

Indicator 12. Orphans: School Attendance

No data

Indicator 13: Young People: Knowledge about HIV prevention

Knowledge about HIV Prevention among females aged 15-24

Data for this indicator are extracted from the Final Report of the Georgia Reproductive Health Survey conducted in 2005 with funding of UNFPA and USAID. The survey was a population-based probability survey consisting of face to face interviews with women of reproductive age (15-44 years) at their homes. The survey was designed to collect information from a representative sample of approximately 6000 women of reproductive age throughout Georgia.

The survey instrument included all five questions for measuring the indicator. Scores for each of the individual questions were presented in the final report. It should be mentioned that Dr. Florina Serbanescu, CDC, Atlanta, kindly agreed to run further analyses and generated the score for the composite indicator.

Knowledge about HIV among young women aged 15-24	15-19 (n=930)	20-24 (n=1079)	Overall total:
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	82.90%	85.20%	84.00%
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	70.30%	80.30%	76.00%
Can a healthy-looking person have HIV?	45.40%	52.50%	49.00%
Can a person get HIV from mosquito bites?	23.60%	28.10%	26.00%
Can a person get HIV by sharing food with someone who is infected?	31.40%	41.40%	37.00%
Gave the correct answers to all five questions	2.20%	4.80%	3.50%

Data presented in the table above report percentages of young women who correctly identify 2 ways of preventing the sexual transmission of HIV (being monogamous and

using condoms), know that HIV infection can be asymptomatic, and who reject major misconceptions about HIV transmission (from mosquito bites and sharing food with someone who is infected). It is obvious that females aged 15-24 in Georgia lack awareness of HIV; only 3.5% of all respondents could give the correct answers to all five questions, though scores for individual questions are higher.

Knowledge about HIV Prevention among males aged 15-24

The data were derived from the Male Reproductive Health Survey conducted under the UNFPA supported project “Support to Improve Reproductive Health Information and Services” in 2005. All five questions needed for construction of the indicator were included in the survey, however the database was inaccessible and constructing the composite indicator was not possible. Thus, only scores for each of the individual questions are presented for the group of young males, disaggregated by age groups 15-29 and 20-24.

Knowledge about HIV among young men aged 15-24	15-19 (n=533)	20-24 (n=487)	Total (n=1020)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	68.60%	72.50%	70.50%
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	90.60%	94.70%	92%
Can a healthy-looking person have HIV?	18%	31.20%	24.30%
Can a person get HIV from mosquito bites?	14%	19%	17%
Can a person get HIV by sharing food with someone who is infected?	13.80%	14.20%	14%
Gave the correct answers to all five questions		N/A	

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

Knowledge about HIV among IDUs⁶

According to the UNGASS reporting requirement, five questions were recommended for calculating this indicator. Unfortunately, the question: “Can a healthy-looking person have HIV”- was not included in the BSS questionnaire for IDUs. Scores for four questions answered by IDUs are presented in the table below; data are disaggregated by age groups.

⁶ Data Source: Behavioral Surveillance Surveys with Biomarker Component among IDUs in Tbilisi and Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

Indicator 14: HIV knowledge among IDUs	<25 (n=105)	25+ (n=364)	Total (n=469)
1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	<u>91/105</u> 86.7%	<u>294/364</u> 80.1%	<u>385/469</u> 82.1%
2. Can using condoms reduce the risk of HIV transmission?	<u>97/105</u> 92.5%	<u>317/364</u> 87.1%	<u>414/469</u> 88.3%
3. Can a healthy-looking person have HIV?	No data	No data	No data
4. Can a person get HIV from mosquito bites?	<u>56/105</u> 53.3%	<u>199/364</u> 54.7%	<u>255/469</u> 54.4%
5. Can a person get HIV by sharing a meal with someone who is infected?	<u>67/105</u> 63.8%	<u>262/364</u> 72%	<u>329/469</u> 70.1%
Gave the correct answers to all four questions	40.00% (42/105)	41.80% (152/364)	41.40% (194/469)

IDUs are well informed that having one faithful uninfected sexual partner can reduce the risk of HIV transmission. The score of correct answers to this individual question exceeds 80% for both age groups. In total 88.3% of IDU respondents know that using condoms reduces the risk of HIV. Almost half of them (46.6%) are unsure that HIV cannot be transmitted from mosquito bites. On average two-thirds of respondents know that a person cannot get HIV by sharing a meal with someone who is infected. Further data analyses showed that only **41.4%** of injecting drug users surveyed gave the correct answers to all four questions.

Knowledge about HIV among FSWs⁷

Indicator 14: HIV knowledge among FSWs:	<25 (n=50)	25+ (n=230)	Total (n=280)
1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	56% (28/50)	55.7% (128/230)	55.7% (156/280)
2. Can using condoms reduce the risk of HIV transmission?	74% (37/50)	62.6% (144/230)	64.6% (181/280)
3. Can a healthy-looking person have HIV?	72% (36/50)	76.5% (176/230)	75.7% (212/280)

⁷ Data Source: Behavioral Surveillance Surveys with Biomarker Component among Street-based FSWs in Tbilisi and Facility-based FSWs in Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

4. Can a person get HIV from mosquito bites?	32% (16/50)	23% (53/230)	24.6% (69/280)
5. Can a person get HIV by sharing a meal with someone who is infected?	30% (15/50)	21.7% (50/230)	23.2% (65/280)
Gave the correct answers to all five questions	8.00% (4/50)	3.50% (8/230)	4.30% (12/280)

BSSs data demonstrated that female sex workers lack awareness of HIV. While scores for each individual question are higher, the composite indicator on knowledge of HIV among FSWs is below 5%. Only 12 women engaged in commercial sex (out of 280 surveyed) correctly answered all five questions.

*Knowledge about HIV among MSM*⁸

	<25 (n=34)	25+ (n=36)	Total (n=70)
Indicator 14: HIV knowledge among MSM:			
1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?	2.9% (1/34)	8.3% (3/36)	5.7% (4/70)
2. Can using condoms reduce the risk of HIV transmission?	94.1% (32/34)	83.3% (30/36)	88.6% (62/70)
3. Can a healthy-looking person have HIV?	85.3% (29/34)	69.4% (25/36)	77.1% (54/70)
Gave the correct answers to all three questions	0% (0/34)	0% (0/36)	0% (0/70)

Surprisingly, men involved with same-sex activities (who are mostly well educated persons in Georgia) appeared to be least aware of HIV prevention. Only 2.9% of gay men younger than 25 years reported that having sex with only one faithful, uninfected partner can reduce the risk of HIV transmission. This indicator was relatively higher for those 25 years and older. On the other hand the majority of MSM surveyed (88.6%) acknowledged that using condoms can reduce the risk of HIV transmission. Furthermore, almost 80% are aware that a healthy-looking person can have an HIV. None of the respondents gave the correct answers to all three questions (unfortunately no more questions on knowledge about HIV were asked to MSM during the survey).

It should be emphasized that score of the correct answers to the first individual question was anecdotally low; while two other scores (questions 2 and 3) were quite high. One of the plausible explanations for this discrepancy is that MSM wanted to manifest that the number of partners is NOT the one that really matters; apparently their viewpoint is that using condoms (no matter how many partners a person has) can reduce the risk of HIV transmission. This might be a reflection of social attitudes of MSM population towards having one faithful partner. Further investigation (e.g. formative researches) to test this

⁸ Data Source: Behavioral Surveillance Survey with Biomarker Component among MSM in Tbilisi, 2005; Global Fund

hypothesis is required that would give a greater insight into the complexity of MSM perspectives.

Indicator 15: Sex before the Age of 15

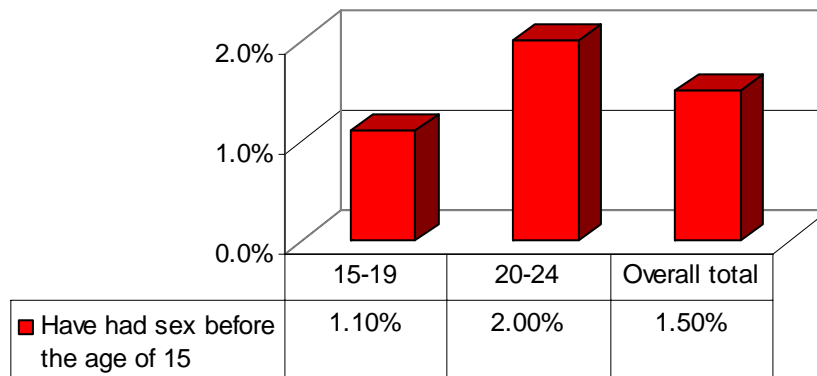
Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

No population based survey asking the question about having sexual intercourse before the age of 15 was carried out in Georgia.

Data demonstrated below are extracted from the final report of the Georgia **Women’s Reproductive Health Survey** conducted in 2005 (UNFPA and USAID funded). The survey was a population-based probability survey utilizing face to face interviews with women of reproductive age (15-44 years) at their homes. The survey was designed to collect information from a representative sample of approximately 6000 women of reproductive age throughout Georgia. The population from which the respondents were selected included all females aged 15-44 regardless of marital status, who were living in households in Georgia during the survey period.

Less than a third of respondents aged 15-24 reported being sexually experienced (defined as having ever had sexual intercourse). Young women in rural areas reported higher levels of being sexually experienced than urban women. In general, there is little or no gap between first union and first sexual intercourse. The rates of premarital sexual experience is also very low among all young women (2.5%), suggesting that almost all sexual experience occur within marriage. However, it is possible that some sexually experienced respondents were unwilling to admit their sexual activity due to social norms. Less than 2% of young women reported having sexual intercourse before the age of 15.

Percentage of young women aged 15-24 who have had sexual intercourse before the age of 15



A **Male Reproductive Health Survey** conducted under the UNFPA supported project “Support to Improve Reproductive Health Information and Services” represents the only

study on male reproductive health in Georgia. Respondents were asked a question regarding the age at first sex, however among possible categories of answers, the response “before the age of 15” was not included.

Indicator 16: Higher-risk Sex

No data

Indicator 17: Condom Use during Higher-risk Sex

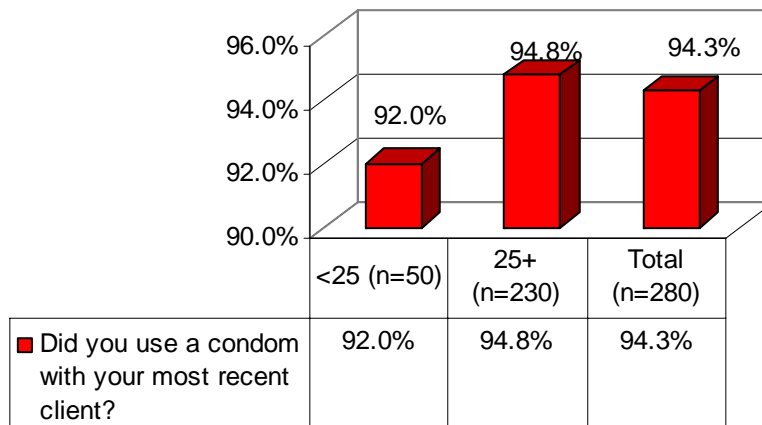
No data

Indicator 18: Sex Workers: Condom Use⁹

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

Indicator 18 :	<25			25+			Overall total (n=280)
	Tbilisi (n=28)	Batumi (n=22)	Total (n=50)	Tbilisi (n=132)	Batumi (n=98)	Total (n=230)	
Did you use a condom with your most recent client?	27/28	19/22	46/50	129/132	89/132	218/230	264/280
Total	96.4% (27/28)	86.4% (19/22)	92.0% (46/50)	97.7% (129/132)	67.4% (89/132)	94.8% (218/230)	94.3% (264/280)

Condom Use among FSWs with their Most Recent Client



⁹ Data Source: Behavioral Surveillance Surveys with Biomarker Component among Street-based FSWs in Tbilisi and Facility-based FSWs in Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

The percentages of condom use during the last sexual contact with the most recent client are very high in both age groups. These data have been almost the same during the last 5 years. Furthermore, the percentage of sex workers who report consistent condom use with clients during the last 30 days is also high reaching 89%. Most FSWs also report that use of a condom is primarily their decision, with about 40% of FSWs saying it is a mutual decision with the client.

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

Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

No data

During the BSS conducted among MSM in 2005 the question about condom use during the last anal intercourse with a male partner was not asked.

However, Tanadgoma – a local NGO that works with MSM, runs clients’ registration system where questions on behavior, knowledge and attitude are being asked to clients. The question on condom use is formulated as follows: “Out of the last five sexual intercourses, how many were unprotected?” The question does not exactly coincide with the measurement question of the indicator; still some information can be retrieved on MSM sexual behaviors.

	Mean percentage of MSM reporting having at least 1 unprotected sexual intercourse out of the last 5 sexual encounters
With partners	4.3 %
With permanent partners	40.5 %
With commercial clients	1.7 %

It is obvious that MSM tend not to use condoms with their permanent partners. The reason indicated for such behavior is mostly “being faithful to each other”. Based on the accumulated work experience with this group, it has become clear that MSM change their permanent partners quite often and relationship with them rarely lasts longer than a couple of weeks. On the other hand, MSM are more cautious with commercial clients: more than 98% reported permanent condom use during last five sexual intercourses¹⁰.

Indicator 20: Injecting Drug Users: Condom Use¹¹

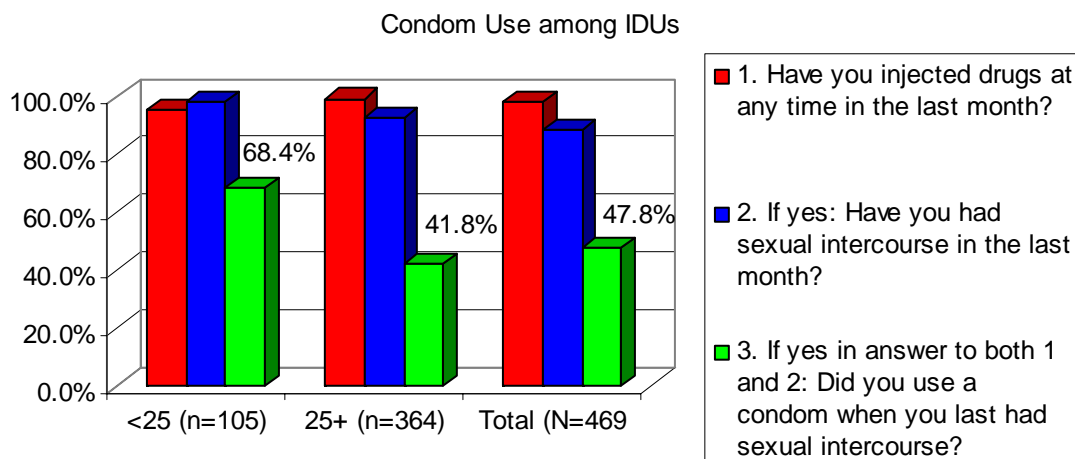
¹⁰ Data Source: Clients Registration System, 2006 NGO – Tanadgoma

¹¹ Data Source: Behavioral Surveillance Surveys with Biomarker Component among IDUs in Tbilisi and Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

Data from two BSSs conducted in 2006 in Tbilisi and Batumi have been aggregated to calculate the indicator. In total 469 IDUs participated in the surveys; of them 105 were under 25 years, and 364 IDUs were 25 years or older. Out of 469 IDUs surveyed 461 (98.3%) reported injecting drugs at any time in the last month. Of them 435 (94.4%) also reported having had sexual intercourse in the last month.

Indicator 20:	<25			25+			Overall total (n=469)
	Tbilisi (n=82)	Batumi (n=23)	Total (n=105)	Tbilisi (n=192)	Batumi (n=172)	Total (n=364)	
1. Have you injected drugs at any time in the last month?	77/82	23/23	100/105	189/192	172/172	361/364	461/469
2. If yes: Have you had sexual intercourse in the last month?	76/77	22/23	98/100	176/189	161/172	337/361	435/461
3. If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse?	58/76	9/22	67/98	76/176	65/161	141/337	208/435
Total	76.3% (58/76)	40.9% (9/22)	68.4% (67/98)	43.2% (76/176)	40.4% (65/161)	41.8% (141/337)	47.8% (208/435)

In total, 47.8% of those who injected drugs and had sexual intercourse in the last month reported using condom during the last sexual intercourse. This indicator is slightly higher among younger (<25) IDUs. Of the three types of sexual partners (regular, occasional, and sex worker) male IDUs are more likely to use condoms with sex workers, followed by occasional sex partners and regular sex partners. One of the main reasons for the difference between the two age groups is that greater proportion of male respondents under 25 years are having sex with occasional partners and prostitutes (higher condom use), whereas most respondents in the age group 25+ are having sex with regular partners (lower condom use).



Indicator 21: Injecting Drug Users: Safe Injecting Practices¹²

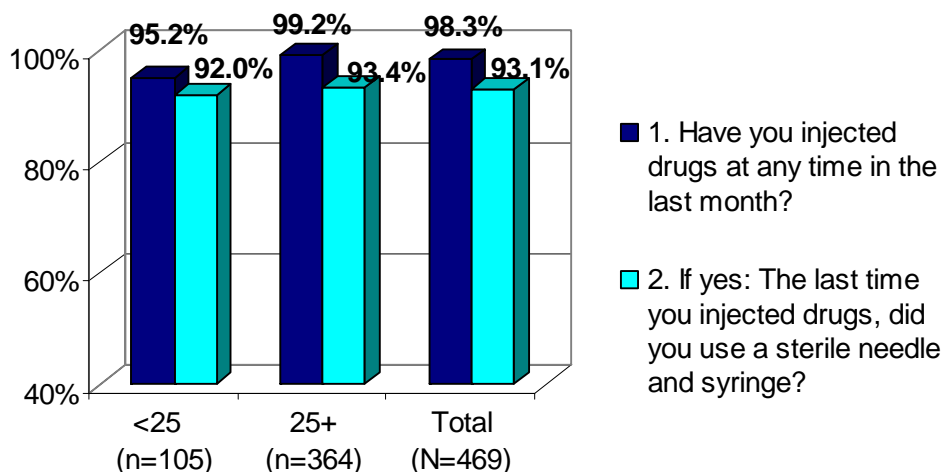
Injecting drug use is the predominant mode of HIV transmission in Georgia. The risk of HIV transmission through contaminated injecting equipment is extremely high. In addition, injecting drug users can spread HIV through sexual transmission to the wider population. Considering all above mentioned assessing safe injection practices is one of the most valuable indicators for Georgia.

According to the BSSs data 93.1% of all surveyed IDUs reported that they had injected drugs in the last month and they used sterile needles and syringes during last injection. This indicator is quite high and was similar for both age groups.

Indicator 21:	<25			25+			Overall total (n=469)
	Tbilisi (n=82)	Batumi (n=23)	Total (n=105)	Tbilisi (n=192)	Batumi (n=172)	Total (n=364)	
1. Have you injected drugs at any time in the last month?	77/82	23/23	100/105	189/192	172/172	361/364	461/469
2. If yes: The last time you injected drugs, did you use a sterile needle and syringe?	70/77	22/23	92/100	169/189	168/172	337/361	429/461
Total	90.1% (70/77)	95.7% (22/23)	92.0% (92/100)	89.4% (169/189)	97.7% (168/172)	93.4% (337/361)	93.1% (429/461)

¹² Data Source: Behavioral Surveillance Surveys with Biomarker Component among IDUs in Tbilisi and Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

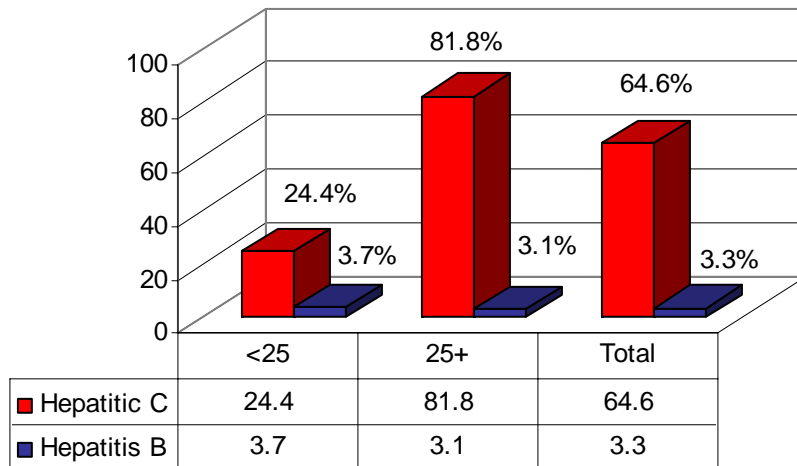
Safe Injecting Practices



Several rounds of behavioral surveillance surveys among IDUs have demonstrated that the rate of using sterile needles and syringes is on the rise that could be interpreted as a good sign. However, recent data on the prevalence of hepatitis C among injecting drug users seems to be quite alarming. Acknowledging the magnitude of hepatitis C virus infection among IDUs, free-of-charge testing for hepatitis B and C viruses were offered to all IDU respondents during the BSS in 2006. It was found that out of 274 IDUs tested in Tbilisi 64.6% is infected with hepatitis C virus; this indicator for older drug users was considerably higher than for younger injectors (81.8% vs. 24.4%)¹³. That seems reasonable as anti-HCV-positivity is in direct correlation with longer injecting practices.

¹³ Data Source: Behavioral Surveillance Surveys with Biomarker Component among IDUs in Tbilisi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office

Hepatitis B and C Prevalence among IDUs in Tbilisi BSS-2006



However, it should be emphasized that one out of every four IDUs aged under 25 tested positive for anti-HCV antibodies suggesting that younger IDUs with shorter injecting histories have been recently infected with hepatitis C virus. Thus, even though the vast majority of IDUs reported having used sterile needles and syringes the last time they injected drugs, there is some concern that this high percentage of self-reported safe injection practices may reflect “social desirability bias.” If the indicator were indeed correct then the prevalence of hepatitis C among young people would be much lower. Thus, it might be possible that unsafe injection practices still persist among drug users in Georgia and it requires further attention.

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 workers¹⁴

In total five Behavioral Surveillance Surveys with biomarker component among FSWs conducted in two cities in 2002, 2004 and 2006 have evidenced that HIV prevalence remains low among women engaged in commercial sex.

The table below represents data for capital city only. In 2004 the prevalence of HIV was 1.3% (2/158). Both cases of HIV were found in the age group above 25 years. In 2006, only one FSW tested positive for HIV out of 160 women tested; thus the prevalence was 0.6% (1/160). It is worth mentioning that the only woman who tested positive in 2006 appeared to have participated in the BSS-2004 as well and she was one of those two women who were diagnosed with HIV.

Indicator 23 for Female Sex Workers:	<25		25+		Overall total	
	BSS 2004	BSS 2006	BSS 2004	BSS 2006	BSS 2004	BSS 2006
1. Number of FSWs test positive for HIV	0	0	2	1	2	1
2. Number of members of the most-at-risk population tested for HIV	37	28	121	132	158	160
Total	0.0%	0.0%	1.7%	0.8%	1.3%	0.6%

HIV prevalence among MSM

As it was mentioned previously, MSM population is one of the worst affected groups in Georgia. The highest HIV prevalence was observed among men who have sex with men the country, though HIV prevalence remains to be under 5%.

To assess progress in reducing HIV prevalence among MSM the data from BSSs conducted in Tbilisi in 2005 and 2007 were used. It should be noted that BSS 2007 was conducted within the USAID funded STI/HIV Prevention Project that is being implemented by Save the Children in partnership with two local NGOs – Tanadgoma and Bemoni Public Union. Behavioral and biomarker data collection process ended in December 2007 and data analyses are in progress. The baseline BSS in 2005 was conducted by the Global Fund project and used the same sampling methodology – respondent driven sampling.

¹⁴ *Data Source: Behavioral Surveillance Surveys with Biomarker Component among Street-based FSWs in Tbilisi and Facility-based FSWs in Batumi, 2006; USAID funded STI/HIV Prevention Project; Save the Children Georgia Country Office*

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.

A total of 140 MSM participated in the BSS in 2007. None of them refused to get tested for HIV. Out of 140 MSM tested, 5 respondents were found to be HIV positive (confirmed with Western Blot test). In addition, indeterminate test results were found among 4 MSM. It is known that interpretation of Western Blot can be complicated if only one or two bands appear. In order to have solid evidence that antibodies to HIV have been detected at least three bands should be found (so called “3 band rule”). As a rule, if a patient with an indeterminate test has engaged in high risk behaviors, another test is recommended to be performed within 4-6 months. Therefore, the number of HIV positive MSM (as well as HIV prevalence) might increase for the time BSS-2007 report is finalized.

Based on the above mentioned, HIV prevalence among MSM in 2007 is equal to 3.6% (with potential to increase). New findings from the latest BSS will be reflected in the next UNGASS report.

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

Men Who Have Sex with Men in Tbilisi	<25		25+		Overall total	
	BSS 2005 (n=34)	BSS 2007 (n=57)	BSS 2005 (n=36)	BSS 2007 (n=83)	BSS 2005 (n=70)	BSS 2007 (n=140)
1. Number of MSM who test positive for HIV	1	2	2	3	3	5
2. Number of MSM tested for HIV	34	57	36	83	70	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)

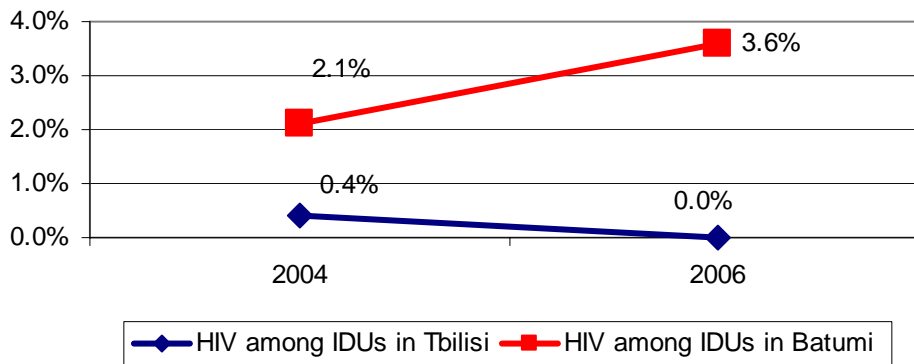
HIV Prevalence among IDUs

In total 274 IDUs were tested for HIV during the third round of BSS in 2006 in Tbilisi. Of them 82 were under 25, and 192 were aged 25 and older. No HIV positive cases were identified. It should be noted that a total of 278 IDUs were tested for HIV for the second round BSS in 2004. Of them only one tested positive for HIV. Thus the prevalence of HIV among IDUs in the capital city was 0.4% in 2004 and the indicator equaled 0% in 2006.

IDUs in Tbilisi (BSS -2006)	<25 (n=82)	25+ (n=192)	Total (N=274)
1. Number of IDUs who test positive for HIV	0	0	0
2. Number of IDUs tested for HIV	82	192	274
HIV Prevalence among IDUs	0%	0%	0%

Slightly different picture was found in terms of HIV prevalence in the port city, Batumi (the Black sea coastal region). So, even though it was requested to report this indicator for the capital city only, we decided to bring the issue to your attention. In 2004, out of 192 tested for HIV four IDUs appeared to be HIV positive (2.1%); follow-up BSS in 2006 revealed an increase in HIV prevalence among IDUs in Batumi. Out of 195 IDUs tested for HIV 7 drug users tested positive (3.6%). Luckily, none of these HIV seropositive cases was among IDUs under 25 years. Thus, taking into account the data from Tbilisi only HIV prevalence among IDUs has decreased from 0.4% in 2004 to 0% in 2006; however an increase in HIV prevalence among IDUs in Batumi was observed over the last two years (from 2.1% to 3.6%).

**HIV Prevalence among IDUs in Tbilisi and Batumi,
2004 - 2006**



Impact Indicator 24:

HIV Treatment: Survival after 12 Months on Antiretroviral Therapy ¹⁵

In total 130 patients initiated ART during the twelve months prior to the beginning of the reporting period (from January 31 to December 31, 2005). Among them 95 were male, and 35 female patients.

Out of 130 patients:

- two male patients stopped therapy
- 31 died; 26 males (one <15yrs.) and 5 females (one <15yrs.)
- 97 patients (67 males, 30 females) were alive and still on treatment 12 months after initiation of therapy

¹⁵ Data Source: AIDS patients registers; ART registers; Infectious Diseases, HIV/AIDS and Clinical Immunology Research Center

Thus, the percentage of adults and children with HIV known to be on ART 12 months after initiation of therapy is 74% (97/130).

AIDS patients by sex and age	Alive and on treatment 12 months after initiation of ART
All adults and children	74% (97/130)
Female patients	86% (30/35)
Male patients	70.5% (67/95)
All adults (+15)	74.6% (91/122)
Adult females (+15 yrs)	87.9% (29/33)
Adult Males (+15 yrs)	69.7% (62/89)
All children (<15yrs)	75% (6/8)
Female Children (<15yrs)	50% (1/2)
Male children (<15yrs)	83% (5/6)

The survival rate after 12 months of ARV therapy has been found slightly higher among female patients than among male patients (86% and 70.5%, respectively). This could be due to the fact that female patients show better adherence to ART regimens than males.

Challenges Faced and Actions Needed

Limited National Budget allocations

Although annual spending to combat HIV/AIDS in Georgia has increased significantly, it is largely due to GFATM and international donor organizations. Donor aids constitute a large influx of funds to Georgia for HIV/AIDS and the national spending accounts for only 11% of the total expenditure. Such a heavy reliance on donors' support may undermine long-term sustainability and state's ability to develop solid and comprehensive response to HIV/AIDS. A major increase in long-term financial investments from the government will be necessary to meet fast-growing demand for HIV prevention, treatment and care services in Georgia.

Absence of National Monitoring and Evaluation System

Rapid growth in resources for HIV/AIDS is accompanied by increase recognition of the importance of establishment of a coordinated M&E national system. However, until 2007, little focus has been given to establishment of M&E system in Georgia. Initial steps were taken by the CCM recently. An experts' group was created to facilitate this process. Key steps towards an effective M&E system must be taken to develop an M&E framework, with key indicators, aligned to the National Strategies. The country should prepare a detailed M&E operational plan and budget. Availability of adequate funding sources will be essential for proper functioning of the national M&E system in the nearest future. In addition, much emphasis should be placed on building capacity (institutional, technical, HR) to ensure implementation of M&E system in the country.

Blood Safety

The development of SOP for use in blood centers would ensure the consistency in guaranteeing the safety and quality of blood and blood products. SOP should be validated and authorized by the top management. Review of the SOP should take place periodically to ensure adjustments are made according to the methodologies and reagents used. Quality management structure should be created to establish, implement and maintain External Quality Assurance Schemes.

Specific trainings will be needed to orient blood transfusion professionals on the importance of SOP and quality assurance system. This is especially important for the country where the share of the blood collected from non-remunerated blood donors does not exceed 4%. More aggressive public awareness raising campaigns for recruitment and attainment of voluntary donors should be an integral part of Blood Safety Programs.

Scaling up prevention and treatment programs for IDUs

Acknowledging that injecting drug use is widespread in the country many NGOs and health institutions are working hard to reach IDUS and help them to change their

behaviors aimed at reducing the risk of both acquiring and transmitting HIV and other blood borne infections.

The current anti-drug policy in Georgia creates barriers and impedes IDUs access to HIV prevention and harm reduction services. Until recently, more emphasis was placed on criminal penalties, rather than treatment. HIV Prevention and harm reduction programs do not adequately cover prisoners. The coverage of drug addicts with the Substitution therapy provided through the GFATM, is extremely deficient. Very few centers are authorized and capable of providing detoxification services. Post-treatment rehabilitation and social integration programs are receiving very little (if any) attention in the country.

In the reporting year no funds were allocated for treatment services from domestic budget. However, it should be noted that the Government of Georgia has devoted some (though scarce) funds to offer treatment services to IDUs in 2007. Considering the magnitude of health, social and economic consequences of drug abuse in Georgia, a significant increase should be achieved in the uptake of detoxification services. Supplemental funding sources should be explored to address unmet needs.

HIV Surveillance

Sentinel surveillance sites should be extended to generate reliable behavioral, epidemiological and statistical data that should help the GoG form effective and streamlined national policies. Over the last years, the volume of collected epidemiological and programmatic data has been significantly increasing in the country. However, available data are disunited and are not being analyzed and synthesized to help experts to better understand the epidemic trends in the country and promote development of sound, evidence based policies.

Access to VCT

Voluntary Counseling and Testing services should be made accessible and affordable to public. Available data in Georgia suggest that demand in counseling and testing services should significantly increase that will be achieved through rising public awareness of HIV and potential psycho-social benefits of knowing HIV status. Barriers to greater use of VCT should be addressed: these barriers include low awareness, fear of stigma and rejection, and low access to high quality and trusted services. Anonymous, client centered, HIV counseling and testing services need to be extended to rural areas to cover populations in regions.

Private and business sector engagement in HIV/AIDS

As HIV infection especially affects the working population, the involvement of business and private sectors is vital. Thus far, private contributions to HIV/AIDS are extremely limited; no steps were taken for establishment of HIV/AIDS policies in workplaces in Georgia. Sensitization and advocacy campaigns for union leaders and top management can be a good start to discuss the important role of private and business sectors and their

commitments in mitigation of AIDS impact. Trainings of leaders on ILO Code of Practice on HIV/AIDS should be launched. Concrete initiatives should be undertaken to help employers in elaboration of HIV/AIDS policies in workplaces that shall envisage information and training activities for employees and their family members, care and human rights protection of infected workers, interventions aimed at reducing stigma and discrimination.

Lack of comprehensive response targeting young people (including life-skills based HIV education programs)

Limited resources are being allocated to implement wide-scale prevention programs targeting young people in Georgia. Reliable country data on youth's knowledge, behavior, and attitude are scarce and need to be updated. As no surveys were conducted among young people some statistics for relevant indicators were extracted from the population based reproductive health surveys conducted in 2005. To empower young people, life skills-based HIV education programs in schools should be scaled up. Age specific and culturally sensitive Behavioral Change and Communication (BCC) strategies are to be developed. More aggressive awareness raising campaigns should be conducted through various media channels, including TV, radio, print media.

Absence of palliative care and social services

There is no palliative care service in place to achieve optimal quality of life for PLHA and their families. No efforts are being taken for initiation of social integration and/or income generation assistance programs.

Lack of HIV/AIDS services (complete absence of ARV therapy) in the two separatist regions Abkhazia and South Ossetia

There is very limited access to HIV/AIDS prevention services in these two regions of Georgia due to difficult political situation and security concerns. ARV therapy is completely absent there and AIDS patients travel to the capital Tbilisi for this treatment in very advanced stages of the disease.

Recommendation to UNGASS:

Two indicators could be added (at least for countries where injecting drug use remains to be the major transmission route) such as:

- IDUs coverage with substitution therapy (**numerator:** number of drug addicts who started therapy during the reporting period/**denominator:** estimated number of drug addicts by the end of the reporting year);
- Hepatitis C patients coverage with specific antiviral therapy (**numerator:** number of Hepatitis C patients who started specific antiviral therapy during the reporting period/**denominator:** estimated number of Hepatitis C patients in need of specific antiviral therapy by the end of the reporting year).