GEORGIA HIV PREVENTION PROJECT

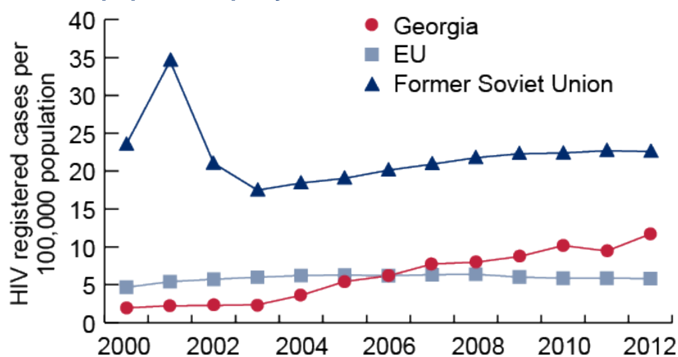
Sustainable HIV Prevention in Georgia: Challenges, Opportunities, and Recommended Actions

POLICY BRIEF NO. 1|30 JUNE 2014

HIV Epidemiologic Profile

Georgia is currently considered a low-HIV-prevalence country—the estimated prevalence in the general adult population is as low as 0.07%. However, the annual number of newly registered HIV cases per 100,000 population has been steadily increasing over the past 15 years; this increase has been steeper compared with EU and former Soviet Union countries (***Fig. 1***).[1]

Figure 1: The number of newly registered HIV cases per 100,000 population per year, 2000–2012

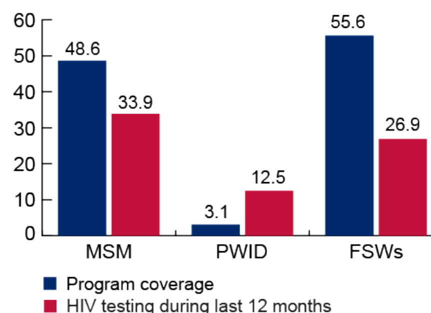


The epidemic is concentrated among key affected populations (KAP), specifically men who have sex with men (MSM), people who inject drugs (PWID), and female sex workers (FSWs). In 2012 the Behavior Surveillance Survey (BSS) reported HIV prevalence for these groups in Tbilisi as 13%, 1.9%, and 1.3%, respectively [2,3,4]; the highest HIV prevalence among PWID in Zugdidi was 9.1% and in Batumi was 5.6%.[3] Until recently the epidemic has largely been driven by injecting drug use; however, since 2011, heterosexual transmission has emerged as the leading route of HIV transmission. Furthermore, existing national statistics show that the number of newly registered HIV cases per 100,000 has been increasing among youth (15–24 years) over the past 10 years.[5]

HIV Prevention Services Among KAP

In line with the 2011–2016 National Strategic Plan of Action (NSPA) for HIV/AIDS,[6] the Government of Georgia (GoG) funds the implementation of the following programs: HIV Prevention Program Targeting KAP and Opioid Substitution Therapy, Drug Addiction Treatment and Rehabilitation for PWID. Over the last decade, funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (TGF) and the US Agency for International Development (USAID) have been critical in scaling up HIV prevention services among PWID and their partners, MSM, and FSWs nationwide. These services include rapid testing for HIV, Hepatitis B and C, and syphilis; distributing injection paraphernalia (within the framework of TGF-funded program only); and targeting behavior change communication interventions. However, despite expanding HIV prevention efforts, HIV preventive service coverage, including HIV counseling and testing (HCT), provided by the GoG and donor-supported programs remains low among all KAP(***Fig. 2***).[2,3,4]

Figure 2: HIV prevention program and HCT coverage among MSM, PWID, and FSW in Tbilisi, 2012



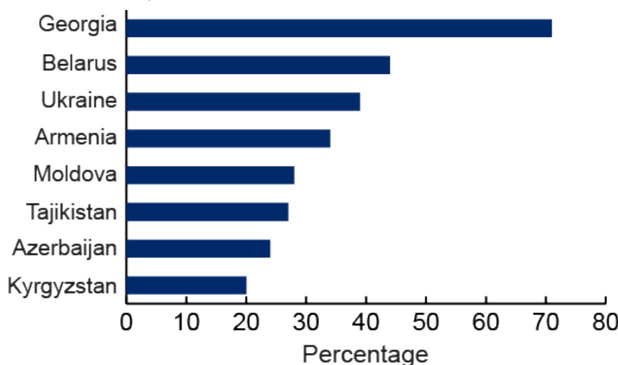
Local nongovernmental organizations (NGOs) play a critical role in providing high-quality, client-centered HIV prevention services to KAP. However, they do not readily receive GoG funding, but instead rely heavily on international donors, which poses major risks related to

their sustainability. Furthermore, there are few local NGOs that work with MSM and FSWs, and technical and organizational capacity is limited, particularly outside of Tbilisi.

Access to ARV Treatment

ARV drugs, through inhibiting viral replication, significantly reduce the likelihood of transmitting HIV.[7] Since 2004, Georgia has implemented a policy of universal access to antiretroviral therapy (ART) for all people living with HIV (PLHIV). The UNAIDS 2013 Global Report on AIDS shows that Georgia has the highest estimated ART coverage in the Eastern European region (***Fig. 3***).[8]

Figure 3: Estimated ART coverage in Eastern Europe and Central Asia, 2012



However, late presentation of HIV cases to clinical services remains a serious problem; approximately 45% of newly reported cases annually are diagnosed at advanced stages of the disease (with CD4 count of <200 and/or AIDS-defining illness), and around 65% of newly diagnosed patients already have a CD4 cell count below 350.[9] Failing to detect HIV infection early may increase the onward transmission and decrease ART effectiveness to save lives and improve quality of life for PLHIV.

HIV-Associated Stigma and Discrimination

Stigma and discrimination directed at KAP (especially MSM) and PLHIV presents a major challenge, hindering the successful scale-up of HIV prevention. According to the results of BSS among youth in 2010, 28.2% of Georgian students expressed at least two of the following discriminatory attitudes: (1) if a teacher has HIV, s/he should not be allowed to teach in school; (2) PLHIV should be isolated; and (3) a student with HIV should not be allowed to attend school.[10] On May 2, 2014 the Georgian Parliament took a major step and passed an antidiscrimination law that aims to eliminate all forms of discrimination.

HIV Policy and Legal Environment

The existing national drug policy prioritizes reducing supply by fighting import of illegal drugs. In parallel, GoG has intensified drug testing and punitive strategies toward drug users, including high fines and imprisonment.[11] These antidrug regulations, which apply administrative and criminal penalties for personal use and possession of illicit drugs, impede effectively implementing HIV prevention interventions among PWID. At the same time, drug addiction treatment and rehabilitation programs have very limited budget and coverage. In 2013, under the leadership of the Interagency Drug Council, the National Anti-drug Strategy and 2014–2015 Action Plan was adopted,[12] which is trying to promote a more balanced public health–oriented approach, particularly to amend criminal liability. In its 2009 Fall Session, the Parliament adopted the HIV/AIDS State Law, which aims to protect PLHIV against discrimination and improved the overall legal environment for national response. However, by-laws regulating HIV testing policy details (e.g., partner notifications, employment restrictions) have not been endorsed by the GoG yet.

Strategic Information

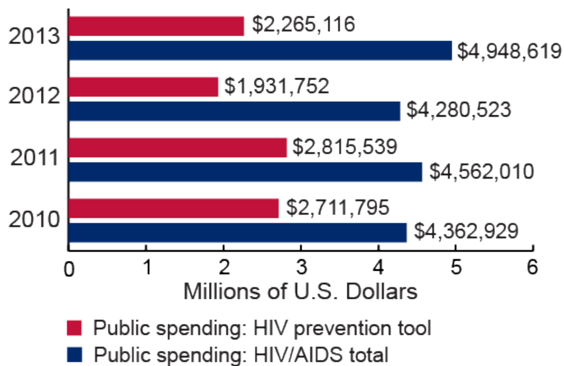
Knowing the size of KAP is of chief importance for policy makers and program implementers for planning and monitoring purposes. Within the framework of TGF projects in Georgia, PWID population size estimation studies have been conducted, generating national estimates for this group.[7,13] The MSM population size estimation study is anticipated to be completed in 2014, but reliable information on the size of FSWs is not available yet and no size estimation studies are being planned. Starting from 2002, BSS studies among KAP have been regularly conducted (every 2–3 years) through USAID and TGF projects. There is a risk to the sustainability of these efforts, however, related to the available funding through the GoG budget beyond the end of donor support. The National HIV/AIDS Surveillance Plan, has been developed.[14] The National Center for Disease Control and Public Health (NCDCPH) is responsible for routine HIV/AIDS surveillance and operates the National HIV/AIDS database in line with HIV/AIDS routine surveillance guidelines.[15] The database is used to store and analyze routine surveillance data from all contributors to the system and is based on an anonymous unique code composed of 15 characters. Following the 2011changes in the state program administration rules, state program beneficiaries are now required to present their personal

photo national ID card to receive prevention services, which creates a barrier for KAP since most are reluctant to disclose their ID and thus refuse to access services.

Funding

The GoG has progressively allocated financial, human, and infrastructural resources to control the HIV epidemic and yet there are significant financial gaps, particularly in the area of HIV prevention targeting KAP and advanced HIV/AIDS treatment. In 2013, the GoG allocated $640 million GEL ($388 million USD) from the state budget for health care, of which $3.5 million GEL ($2.1 million USD), or 0.5%, of the total budget has been designated for the National HIV/AIDS Prevention and Treatment program.[16] A breakdown of total public spending for HIV/AIDS and the spending specifically for HIV prevention for the last 4 years (***Fig. 4***) demonstrates that public spending in support of the HIV/AIDS national response has not changed significantly since 2010.[17]

Figure 4: Public spending in US dollars, 2010–2013



TGF has provided the largest portion of external support since it historically has covered approximately half of all country expenses for HIV/AIDS (57.9% in 2012 and 47.8% in 2013). The share of TGF financial support in all external (nonstate) funding reached 85% in 2012 and 82% in 2013. USAID is the second largest donor in the country, supporting HIV prevention activities through its $5 million USD Georgia HIV Prevention Project (GHPP). The portion of USAID funds in all international funds reduced drastically from 22.3% in 2011 to 9.6% in 2013. GHPP will end in August 2014, after which time USAID will no longer provide funds for HIV prevention in Georgia, which may further exacerbate the financial gap for HIV prevention, unless the state increases its funding to replace it.

According to the NSPA financial gap analysis study, HIV prevention and treatment services were underfunded in 2012; the funding gap was estimated at $1.1 million USD for prevention and $1.7 million USD for treatment services (***Fig. 5***).[16]

Figure 5: NSPA funding gap by strategic objective in 2012 (million USD)

Categories/Strategic Objectives of NSPA	2012 (Million USD)		
	Budgeted for NSPA	Actual Spending	Gap
Prevention	7.5	6.4	1.1
Treatment	8.64	6.9	1.74
Care and Support	0.45	0.39	0.06
Health System Strengthening	3.48	2.12	1.36

Opportunities and Recommendations for Enhancing HIV Prevention

Scale-up comprehensive HIV prevention for KAP. Prevention interventions should be scaled up to achieve sufficient coverage levels through strengthened outreach, peer-driven, and community-level interventions. Preventive services should be expanded to other geographic areas, specifically to the cities with larger populations of KAP. Community empowerment is vital for these groups and efforts should be expanded to improve reach of MSM and PWID with HIV prevention services through representatives of the community groups. NGO capacity should be strengthened, and their critical role in the HIV response recognized, through targeted training, increased grant opportunities (from international donors, but primarily from GoG), and advocacy initiatives.

Improve early detection and timely initiation of ART. Given the GoG's commitment to universal ART access, special emphasis should be placed on improving early detection and strengthening referrals to treatment services. Early detection recommendations are

- Improve HCT coverage among KAP through community-based rapid testing and referral to relevant confirmatory testing services as needed.
- Expand provider initiated HCT at health facilities countrywide.
- Promote the use of 4th generation HIV tests (including rapid tests).

Reduce stigma and discrimination to create a supportive environment. Given rampant HIV-, drug use-, and homosexuality-associated stigma and discrimination in Georgia, the GoG, law enforcement agencies, human-rights advocates, and NGOs are needed to monitor that human rights are not violated and address every occasion of harassment and violence against KAP

everywhere. Advocacy initiatives, such as public awareness campaigns involving mass media, vulnerable populations, and human rights activists, should be widely implemented to reduce HIV-associated stigma and discrimination and create a supportive environment for responding to HIV.

Foster policy reform and legal change to create an enabled environment for HIV risk reduction. The Anti-drug Interagency Council should advise Georgian Parliament on the alignment of drug control legislation with international drug control treaties and international best practices, with an emphasis on prioritizing public health goals. Concurrently, the HIV/AIDS State Law—adopted by the Parliament of Georgia in 2009—protects PLHIV against discrimination. However, the Ministry of Labor, Health, and Social Affairs should resume working on the by-laws regulating the specifics of HIV testing policies, partner notifications, employment restrictions, etc., and foster the process of their endorsement.

Develop/upgrade information systems to better guide effective HIV prevention efforts among KAP. The GoG should ensure that up-to-date information is available through well designed and implemented size estimation studies for all KAP in respective geographical regions. This requires adequate planning and budgeting to ensure that repeated studies are conducted with GoG financial support, particularly as donor funding dwindles. BSS studies among KAP should be conducted regularly to monitor both biological and behavioral dynamics of the HIV epidemic in Georgia. The GoG should refine and adapt existing procedures for collecting HCT data to ensure that state program beneficiaries can access free HCT services without presenting their personal photo ID cards.

Secure funds for comprehensive HIV prevention. The Financial Gap Analysis study conducted in 2013 suggests that to minimize the country's reliance on external funding sources, substantial increases in national/public expenditures on HIV/AIDS should be planned and mobilized in coming years. Specifically, there is a need have an adequate amount of annual funding to abolish the funding gap observed in 2011 and 2012 and to be able to pay for necessary HIV prevention activities. It is recommended to carry out long-term financial sustainability analysis/planning to develop the best potential sources for mobilizing needed resources.

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