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# Georiga HIV Prevention Project

## Sustainable HIV Prevention in Georgia:

## Challenges, Opportunities, and Recommended Actions

Policy Paper

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**Final Draft**

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NCDC

INFECTIOUS DISEASES, AIDS & CLINICAL IMMUNOLOGY RESEARCH CENTER

TANADGOMA თანადგომა

BEMONI PUBLIC UNION

# Georgia HIV Prevention Project

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

Policy Paper

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# Acknowledgement (Forward)

The Georgia HIV Prevention Project team wishes first to thank the U. S. Agency for International Development (USAID), without whose support many successful initiatives aimed at strengthening HIV prevention in Georgia would not be possible. The Georgia HIV Prevention Project (GHPP), funded by USAID and awarded to RTI International and its subcontracting partners, began in February 2010 and will end in August 2014. The goal of the project is to support HIV prevention among key populations to avert the spread of HIV to the general population.

This policy paper, *Sustainable HIV Prevention in Georgia: Challenges, Opportunities, and Recommended Actions,* is the result of a lengthy and rigorous consultative process, involving key stakeholders and experts from state institutions and civil society organizations, and incorporates their substantial feedback and experience working in HIV prevention in Georgia. The document serves as a situational snapshot of the HIV epidemic in the country, presents challenges and opportunities, and offers a set of policy recommendations to strengthen HIV national response in Georgia.

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# List of Acronyms

| | |
|---|---|
| AIDS | acquired immunodeficiency syndrome |
| ART | antiretroviral treatment |
| Bio-BSS | behavior surveillance survey with biomarker component |
| CCM | country coordinating mechanism |
| CI | confidence interval |
| CIF | Curatio International Foundation, local NGO |
| CSW | commercial sex worker |
| FSW | female sex worker |
| GARPR | Global AIDS Response Progress Report |
| GHPP | Georgia HIV Prevention Project |
| HCT | HIV counseling and testing |
| HIV | human immunodeficiency virus |
| GFATM | Global Fund to Fight AIDS, Malaria and Tuberculosis |
| GoG | Government of Georgia |
| IDU | injecting drug user |
| MARA | most at risk adolescents |
| MOC | Ministry of Corrections in Georgia |
| MSM | men who have sex with men |
| NHCS | National Health Care Strategy |
| NGO | nongovernmental organization |
| NSPA | national strategic plan of action on HIV/AIDS |
| OST | opioid substitution treatment |
| PLHIV | people living with HIV/AIDS |
| PWID | people who inject drugs |
| TGF | The Global Fund |
| USAID | United States Agency for International Development |
| VCT | voluntary counseling and testing |

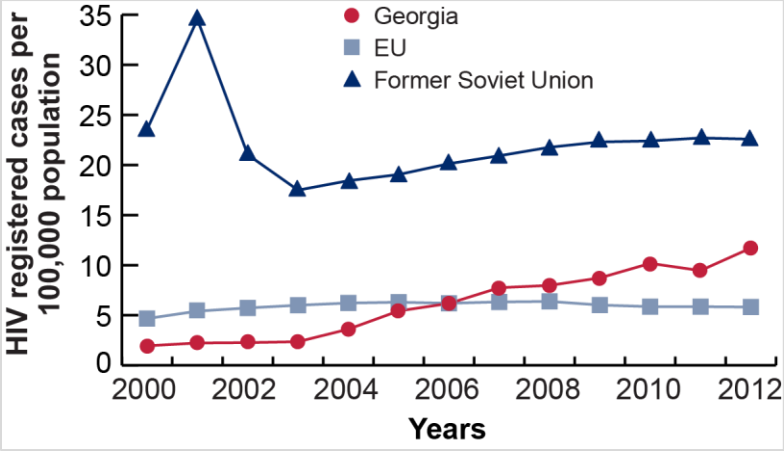
# 1. Background

## 1.1 HIV Epidemiologic Profile

Georgia is currently considered a low-HIV-prevalence country with a concentrated epidemic among key populations, specifically men who have sex with men (MSM), with a prevalence of 13% in Tbilisi,[1] and among people who inject drugs (PWID), with a reported prevalence of 5% in Batumi and 9%[2] in Zugdidi. HIV prevalence among female sex workers (FSWs) in Tbilisi and Batumi is 1%.[3]

As of April 2014, a total of 4,290 HIV cases have been registered in the Infectious Diseases, AIDS, and Clinical Immunology Research Center (IDACIRC), including 3,152 men and 1,138 women. The majority of patients belong to the 29–40 year old age group; 2,688 patients have developed AIDS; and 926 patients have died.[4]

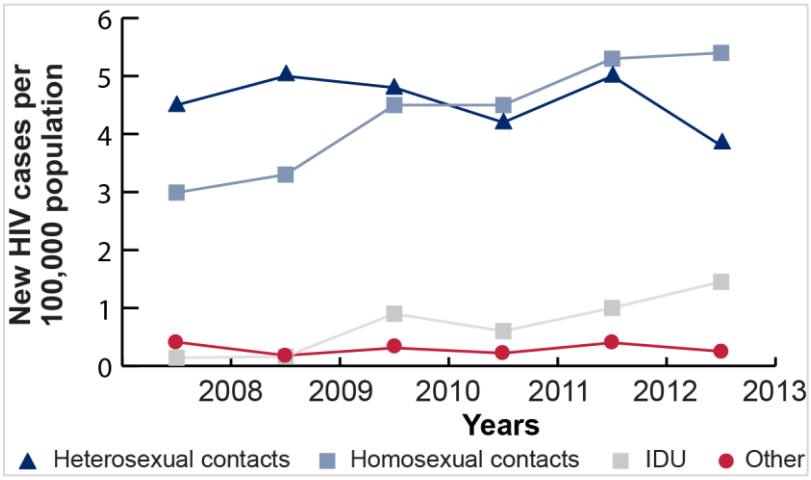
**Figure 1. Rates of HIV new diagnosis per 100,000 population[5]**




Source: WHO/Europe, European HFA Database, April 2014

HIV prevalence in the general adult population in Georgia is low (0.07%)[6]; however, HIV and AIDS remains a major public health concern given the potential for developing into a widespread epidemic. The primary risk factors attributed to HIV infection include injecting drug use (IDU) and worker migration between Georgia and its neighboring countries with higher HIV prevalence, such as Ukraine and Russia.[7] Because of the engagement in multiple HIV risk behaviors—IDU and unprotected sex—there is significant risk of HIV transmission from key populations to the general population, predominantly through heterosexual intercourse. For example, until recently the epidemic in Georgia has largely been IDU driven, and since 2011, heterosexual transmission has emerged as the main route of HIV transmission, especially among females (Fig. 2).

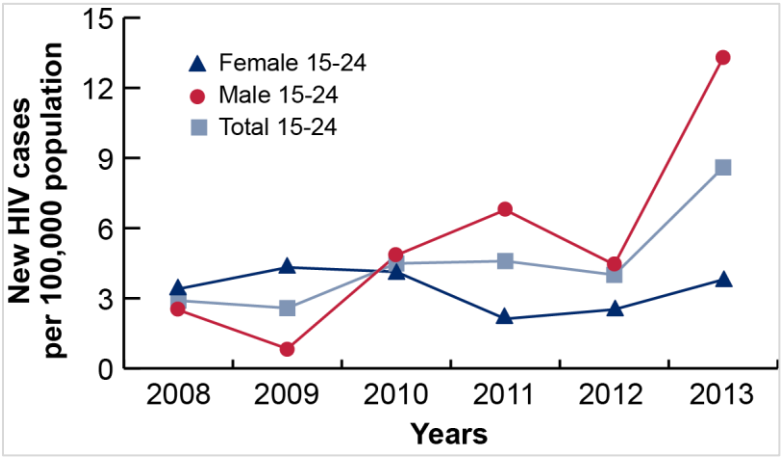
**Figure 2. Distribution of newly registered HIV cases by transmission type per 100,000 population in 2008–2012**




Source: Infectious Diseases, AIDS, and Clinical Immunology Research Center.

Data on HIV prevalence among youth are limited and somewhat unreliable; however, existing national statistics show the number of youth newly diagnosed with HIV increased notably in 2013. Since 2008, the number of annually registered HIV cases among youth has ranged from 18 to 60 in 2013. Unfortunately there is a lack of research on the rise of HIV among youth, but many experts think that these results may be due to greater awareness about HIV among youth, which leads to increased testing and/or the spread of HIV to the general youth population from key populations.

**Figure 3. Distribution of newly registered HIV cases among youth aged 15–24 per 100,000 population in 2008-2013, Georgia**




Source: Infectious Diseases, AIDS, and Clinical Immunology Research Center.

HIV infection in Georgia is primarily concentrated among the key populations: MSM, PWID and their sexual partners, and FSWs. Most-at-risk adolescents (MARA) and prisoners, because of their higher engagement in HIV risk behaviors, including IDU and

unprotected sex, have also been identified as groups at elevated risk for HIV infection in the 2011–2016 National Strategic Plan of Action (NSPA) for HIV/AIDS.[8]

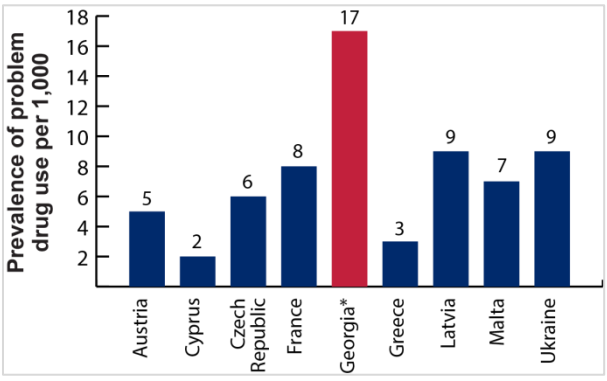
Failing to detect HIV infection at earlier stages leads to spread of the disease. According to the HIV surveillance data, approximately 45% of newly reported cases annually are diagnosed at advanced stages of the disease (with CD4 <200 and/or AIDS-defining illness), while around 65% of newly diagnosed patients already have a CD4 cell count below 350.[9] The primary reasons identified that contribute to failing to detect HIV early include, among others, low HIV awareness/risk perception and low uptake of HIV testing among key populations.

### *People Who Inject Drugs*

Based on the 2012 Estimating the Prevalence of Injection Drug Use in Georgia, prepared by Bemoni Public Union with funding from The Global Fund (TGF), the estimated number of PWID in Georgia is 45,000 (44,434–45,524) among the adult population (18–64 years), and the national prevalence estimates for IDU is 1.65% (CI: 1.63–1.67%) among 18–64 years old adult population.[10]

Problem drug use (PDU) is defined as IDU or long-term/regular use of opiates and/or cocaine-type drugs and/or amphetamine-type.[10,11] Given that the PDU Size Estimation Study in Georgia was linked to the Bio-Behavioral Surveillance Survey (Bio-BSS) among IDUs, the estimated prevalence is calculated for IDUs in Georgia.[10] Figure 4 shows that the prevalence of problem drug use in Georgia exceeds those of many European countries, even considering variations in age group—18–64 in Georgia versus 15–64 in other countries (Fig. 4).

**Figure 4 Estimated prevalence of problem drug use, 2011 (rate per 1,000 population aged 15–64)**

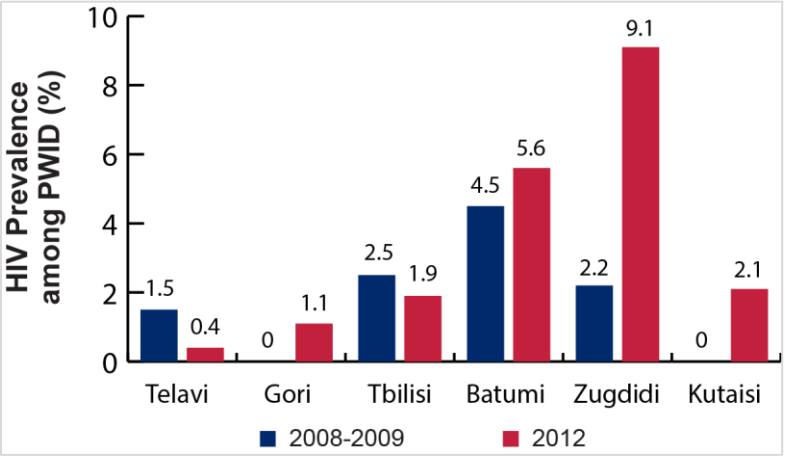



Notes: The rate in Georgia is for the population aged 18-64, year 2012, while rates for other countries is based on population aged 15-24 [10,11]

Nationwide HIV prevalence among male PWID in Georgia is estimated at 3%; data on female drug users in the country is not available. When consulting with stakeholders while developing this policy paper, key indicators were presented by city, whenever available, as these data were found useful to inform technical discussions. The combined

data set analysis of all six cities shows the HIV prevalence rate of 3% (95% CI 2.20–4.04%) among PWID. There is an increase, although not statistically significant, from 2009 where the same six cities combined prevalence rate was 2.4% (95% CI 1.56–3.46). The highest prevalence of 9.1% among PWID has been recorded in Zugdidi and 5.6% in Batumi, which confirms the concentrated epidemic level of HIV in these two major cities of Georgia (Fig. 5).[2]

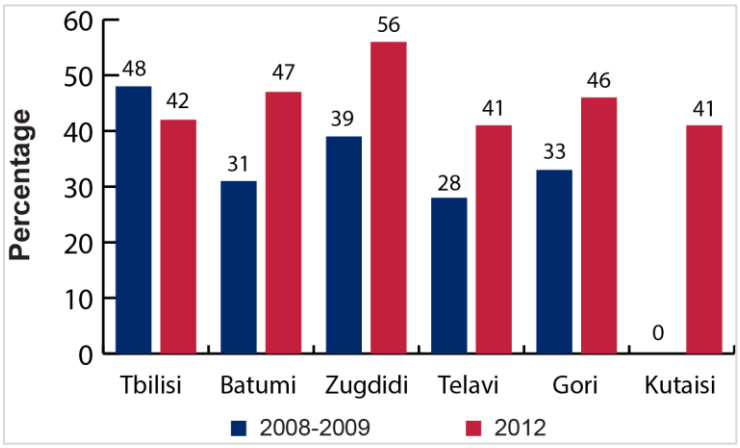
**Figure 5. Prevalence of HIV among PWID, 2008–2012**




Source: Bio-BSSs among PWID in six cities of Georgia, 2012.

The level of awareness about HIV transmission[12] among PWID has slightly increased in almost all cities participated in Bio-BSSs since 2009 (Fig. 6); however, awareness still remains low. Although PWID are aware of how the virus can be transmitted, myths and misconceptions related to HIV are still prevalent that may contribute to the stigmatization and discrimination of people living with HIV (PLHIV) that, in turn, reduces the uptake of HIV counseling and testing (HCT) and early detection of HIV positive status.

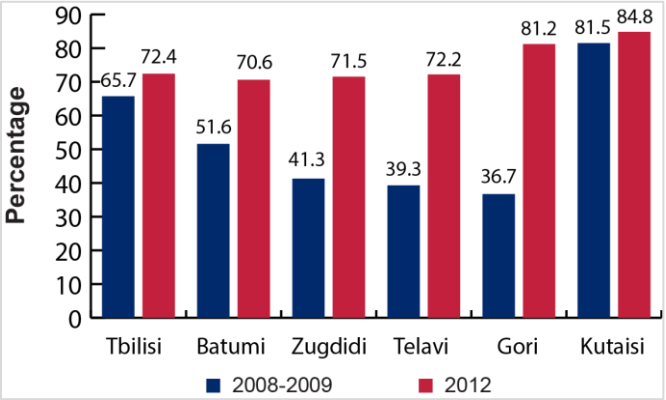
**Figure 6. Knowledge of HIV transmission and rejection of major misconceptions among PWID in 2008–2012**




Source: Bio-BSSs among PWID in six cities of Georgia, 2012.

Safe injecting behavior has improved among PWIDs since 2009 (Fig. 7); however, on average, every fourth IDU is still known to share his equipment at last injection.

**Figure 7. Safe injection at last injection by years**

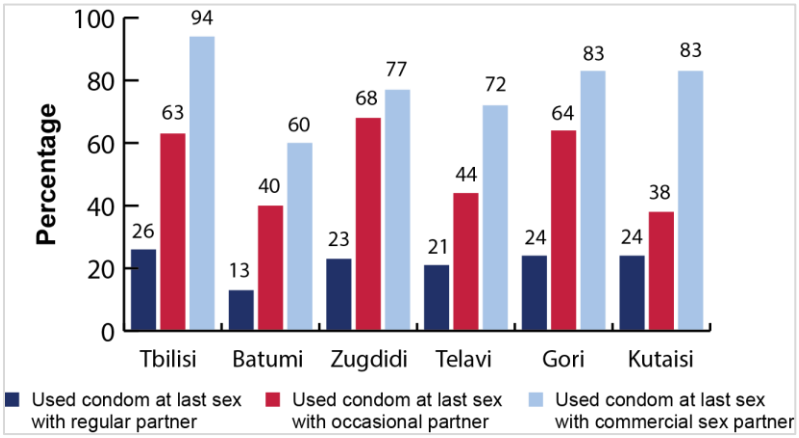



Source: Bio-BSSs among PWID in six cities of Georgia, 2012.

PWID with primary/secondary education are more likely to share injecting equipment than those with post-secondary education. Notably, the proportion of those who reported injecting in the streets dropped from 15.2% in 2009 to 2.2% in all cities,[2] which may suggest that the PWID population became more hidden because of restrictive drug policy. According to the current drug use legislation, possession and purchase drugs for the purpose of personal use is subject to administrative penalty or imprisonment. In 2006, a zero-tolerance crime policy[13] was declared by Mr. Mikheil Saakashvili, the President of Georgia, that resulted in increased imprisonment of drug users. Despite a number of advocacy initiatives, decriminalization of drug use has not happened.

Condom use by PWID with regular sex partners is low, under 40% for all cities, exposing their partners to greater risk because of IDU practices. Those who are young, not married, reached by preventive programs, and knowledgeable about HIV prevention measures are more likely to use condoms at last sex.[2] Condom use rates with commercial sex partners are relatively higher and range from as low as 60% in Batumi to 94% in Tbilisi.

**Figure 8. Condom use among PWID by partners**



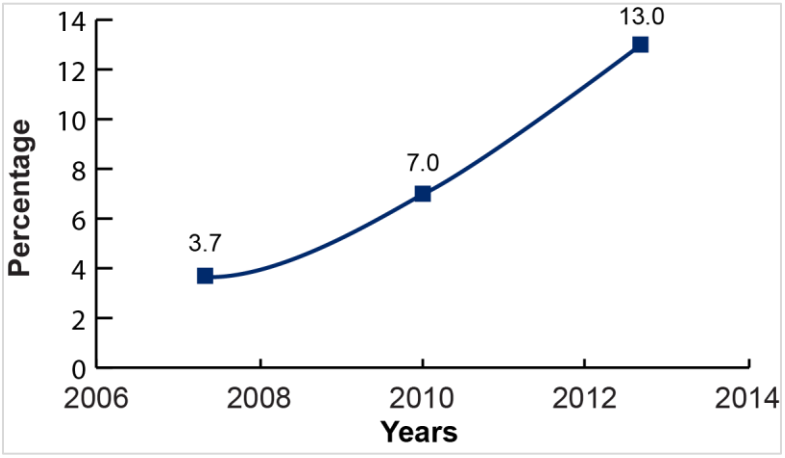

Source: Bio-BSS among PWID in six cities in Georgia, 2012.

Low condom use might explain a recent shift in major routes of HIV transmission in Georgia from injecting drug use to sexual intercourse. HIV infection has primarily been spreading from the male IDU population to their female sex partners. Having homosexual contacts was reported by only a few respondents: only 45 (2.5%) IDU men out of 1,791 respondents reported ever having sex with a male sex partner.

### *Men Who Have Sex with Men*

Data on the size of the MSM population in Georgia are limited. In 2010, a size estimation survey was conducted by Tanadgoma in Tbilisi.[14] The survey found that there were an estimated 7,900 MSM in the capital city of Georgia, and these findings were disseminated during a stakeholder consensus meeting. In 2014, under the TGF HIV grant, a broader Size Estimation Study was initiated and study findings will be available by the end of 2014. Bio-BSSs conducted among MSM[1] in only Tbilisi have shown that there is substantial increase in HIV prevalence from 3.7% in 2007 to 7% in 2010 and to 13% in 2012 within MSM, which further confirms the concentrated epidemic among this key population group and emphasizes the need for improved and targeted (MSM-friendly) prevention interventions (Fig. 9).

**Figure 9. HIV prevalence among MSM (2007–2012)**



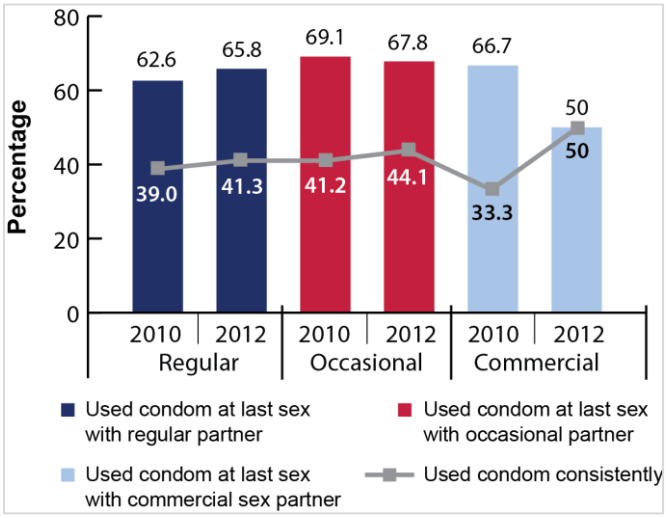

Source: Bio-BSS among men who have sex with men in Tbilisi, 2012.

According to the Bio-BSS conducted in 2012, 95.9% of MSM were aware of HIV/AIDS; however, only about one-third of respondents correctly identified the ways HIV is transmitted and rejected major misconceptions about HIV. Knowledgeable MSM are more likely to undertake HIV testing; however, this does not necessarily lead to improved safe sexual behavior. Although awareness on places where testing can be performed has improved, MSM from younger age groups are less likely to get tested.

According to the 2012 Bio-BSS, risky sexual practices are quite widespread among MSM. MSM reported a large number of different types of partners, both male and female; insufficient use of condoms, especially consistent use with any type of male and

female partners (Fig. 10); and involvement in group sexual practices. This raises concerns about the potential bridging role of MSM in HIV transmission to the general population.

**Figure 10. Condom use during anal sex by types of sex partners of MSM, 2010 and 2012**




Source: Bio-BSS among men who have sex with men in Tbilisi. 2010 and 2012

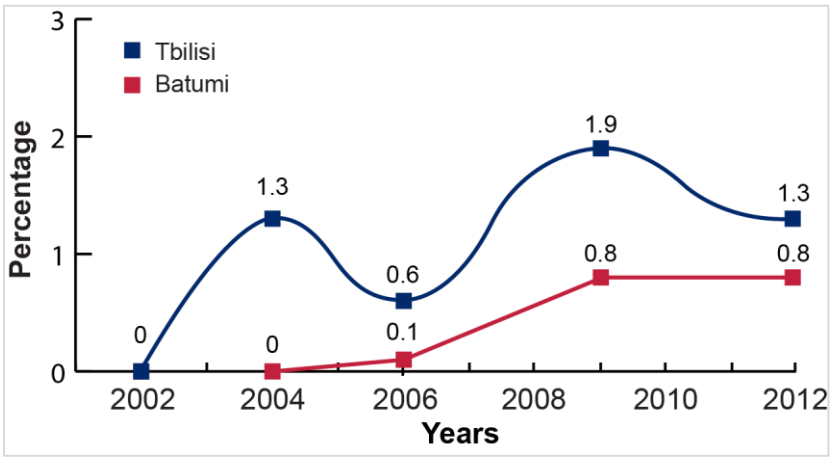
HIV preventive program coverage of MSM has increased, primarily as the result of new HIV prevention interventions (e.g., online forums, a Facebook page) introduced since 2010, and emerging lesbian, gay, bisexual, and transgender (LGBT) community organizations that are playing a positive role in increasing awareness and coverage of services. However, with regard to the growing incidence of HIV infection in this key population group, there is a real threat that HIV incidence will continue to increase further unless urgent and effective measures are taken, especially focusing on reducing HIV-associated, as well as homosexuality-associated, stigma and discrimination (See Section: HIV-associated Stigma and Discrimination related to stigma associated with MSM).

### *Female Sex Workers*

Having accurate size estimates for target populations is of chief importance for policy makers and program implementers for both program planning and monitoring purposes; however, reliable information on the size of the FSW population is not currently available in the country.

Bio-BSSs, conducted every 2–3 years over the last decade among FSWs in two major cities, Tbilisi and Batumi, have revealed that HIV prevalence amongst FSWs has remained low. In 2012, prevalence was estimated at 1.3% in Tbilisi and 0.8% in Batumi (Fig. 11).[3]

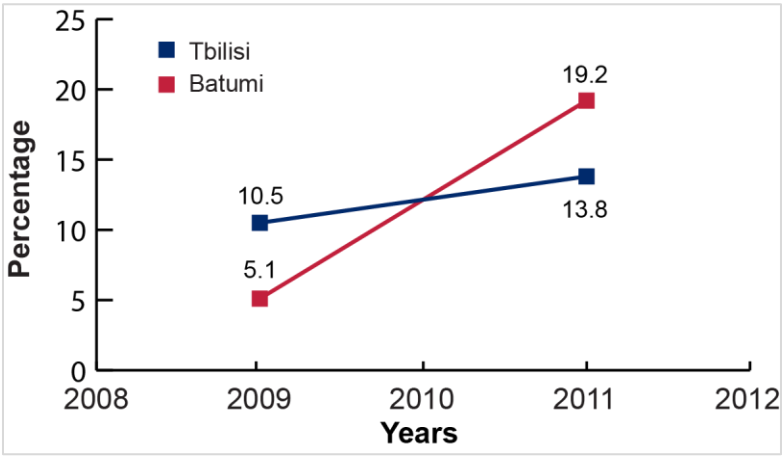
**Figure 11. HIV prevalence among FSWs in Tbilisi and Batumi, 2002-2012**




Source: Bio-BSS among FSWs in Tbilisi and Batumi, 2002–2012.

The majority of FSWs are aware of the existence of HIV/AIDS, but only small proportion of them—13.8% in Tbilisi, 19.2% in Batumi—are able to correctly identify ways that HIV is transmitted and reject major misconceptions, which actually represents a substantial increase in knowledge, especially in Batumi, compared to 2008–2009 (Fig. 12).

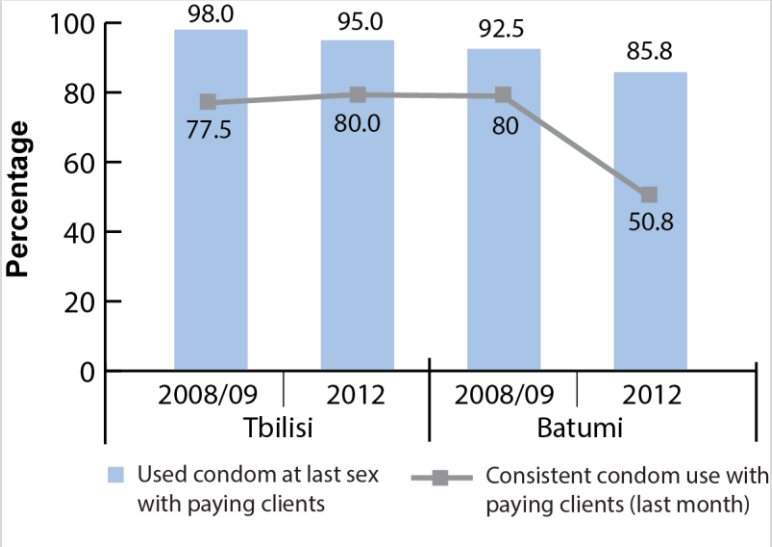
**Figure 12. Key HIV/AIDS knowledge[13] among FSWs**




Source: Bio-BSS among FSWs in Tbilisi and Batumi, 2009-2012.

The most recent Bio-BSS conducted among FSWs in Batumi in 2012 has revealed a steep decline in consistent condom use with paying clients (Fig. 13). In the 2012 BSS in Batumi and Tbilisi, client refusal was cited as the main reason for not using condoms, which shows that FSWs lack skills to negotiate safe sex practices with their clients.

**Figure 13. Consistent condom use with clients during the last 30 days and condom use at the last sex**




Source: Bio-BSS among FSWs in Tbilisi and Batumi, 2009–2012.

Despite high awareness of the dangers of sex trafficking, half of FSWs (50.8%) in Batumi said that they had voluntarily traveled abroad for sex work and one-third of respondents state they would again go abroad to earn money.[3] This can be explained by the fact that 89.1% FSW in Tbilisi and 85.0% FSW in Batumi reported that commercial sex represents their only source of income. Notably, FSWs report low rates of condom use while living/working abroad, and approximately one-third of FSWs with a history of engaging in sex business abroad, said they never using condoms while abroad.[15][16]

### *Prisoners*

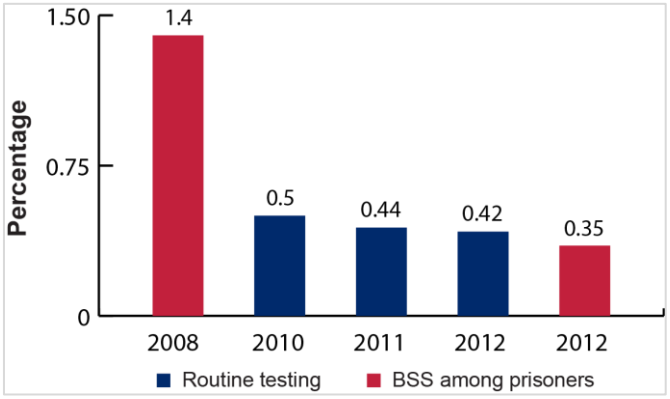
Prisoners are at a higher risk of HIV infection compared with the general population, which is attributable to a number of behavioral and external factors, such as having a history of injecting drug use, poverty, and alcoholism; living in isolated communities with limited access to health care; having unprotected sex, being treated with incorrectly sterilized medical and dental instruments; sharing blood during "brotherhood" rituals; and sharing piercing and tattoo equipment and shaving tools.[16]

In July 2012, there were approximately 23,000 (21,800 males and 1,200 females) prisoners in the Georgian penitentiary system, which is composed of 17 establishments managed by the Ministry of Corrections (MOC). After the parliamentary elections in October 2012, several rounds of massive amnesty took place, and by the end of 2013, the number of prisoners has drastically reduced to just over 10,000. In addition, few prisons were closed either permanently due to unacceptable conditions or temporarily due to renovation. By the end of 2013, HCT cabinets were operational in all 12 establishments in the penitentiary system.

According to the statistical data from the MOC, as of May 2013, there were 10,202 prisoners in the penitentiary system; of those prisoners, 45 were HIV positive, which represents a prevalence rate of 0.44%, which is 9 times higher than among the general population. Out of the 45 HIV positive prisoners, 38 have developed AIDS; 35 are on antiretroviral treatment (ART); and 3 have declined treatment.

In 2010, 6,095 prisoners underwent HIV testing, and out of those prisoners 33 new cases (0.5%) were detected; in 2011, among 5,626 tested prisoners, 25 new cases were detected (0.44%); in 2012, out of 7,872 tested prisoners, 33 (0.42%) new cases were detected. Two Bio-BSSs, conducted among prisoners in Georgia in 2008 and 2012, generated data on prisoners' knowledge about HIV and risky behaviors. HIV prevalence among prisoners derived from programmatic and BSS data is presented in the Fig. 14.

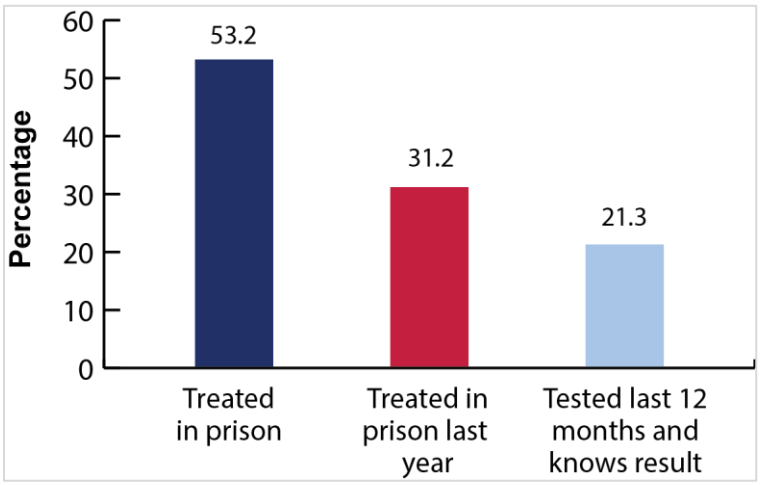
**Figure 14. HIV prevalence among prisoners (VCT program data vs. Bio-BSS data)[15]**




The majority of prisoners are aware of HIV/AIDS, but only 24.6% are able to correctly list ways of HIV transmission and reject major misconceptions about HIV.

Even though HCT cabinets are operational in all establishments of the penitentiary system, and according to the MOC, approximately 5,600[6] prisoners are tested annually. The Bio-BSS among prisoners conducted in 2012 revealed that HIV testing uptake is not high: only 21.3% of inmates reported they were tested for HIV during last 12 months and knew their test results.

**Figure 15. HIV testing among prisoners, 2012**




Source: Bio-BSS among prisoners, 2012.

There is a high concentration of drug users in prisons; however, Bio-BSS findings suggest that in 2012 drug use does not take place in Georgian prisons.

Due to special conditions imposed by incarcerations, it is vitally important to ensure that Georgia has a clearly elaborated strategy to scale-up access to HCT and, more broadly, to achieve universal access to comprehensive prevention programs, treatment, care, and support in closed settings. Since 2012, reforms have been initiated by the new administration of the MOC to improve conditions in prisons. With increased focus placed by the MOC on protecting the rights of prisoners, the USAID-funded GHPP, in partnership with the MOC, developed the HIV Counseling and Testing Policy in Penitentiary System. The national policy will serves as the basis for a position statement that promotes access to HCT, mitigates the stigma and discriminations related to HIV, and protects the rights of prisoners by upholding standards of informed consent and confidentiality.

### *Youth*

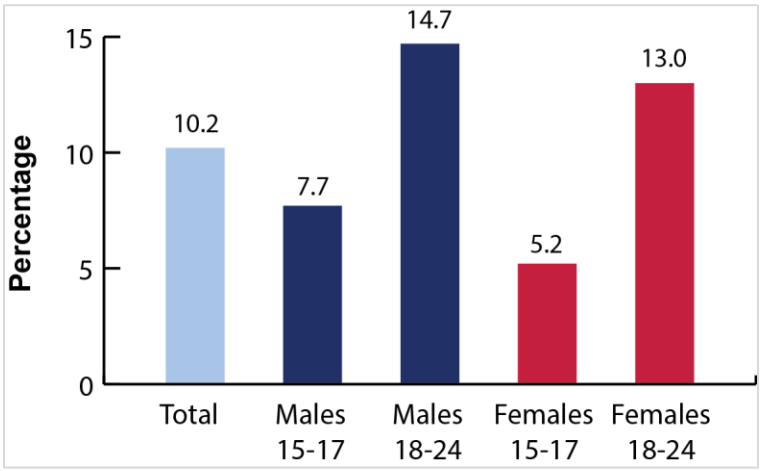
The 2011–2016 NSPA identifies HIV prevention among youth as one of the national priorities. It highlights the importance of conducting Bio-BSSs among youth to generate valid and reliable data on youth and better understand the patterns of behaviors that put young people at risk.

Youth Behavioral Surveillance Survey: HIV/AIDS Knowledge, Attitudes, and Practices among School Pupils and University Students (aged 15-24) in Tbilisi, Georgia conducted within the framework of the USAID-funded GHPP[17] revealed that 69.9% of males reported having had sex compared to 5.9% of females. Among sexually active respondents, 30.8% (33.4% males and 1.8% females) are sexually active before 15 years of age. Among males reporting early sexual debut, 41.1% said their first-time partner was a FSW; 72.7% of them reported using a condom. Among males who had multiple sex

partners, 58.2% reported consistent condom use.[18] In contrast, female youth are far less likely to have early sexual activity due to social norms that place high value to keeping female virginity until marriage.

According to the survey, the majority of pupils and students are aware of HIV. Although results showed a statistically significant difference in HIV awareness between age groups (15–17 vs. 18–25), they did not reveal the same for gender. Only 10% of youth were able to correctly identify ways to prevent sexual transmission of HIV and reject major misconceptions about HIV transmission (Fig. 16).[13]

**Figure 16. Percentage of school pupils and university students who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**




Source: BSS among school pupils and university students in Tbilisi, 2011

A few young respondents (4%) reported smoking marijuana at least once in last 12 months, while only 2 male students out of 462 reported injecting drugs in last 12 months; 4 male students (0.9%) disclosed ever having had sex with a male partner.

Lack of sex education among youth, early sexual debut among boys and mostly with sex workers, and unprotected sex with FSWs may put youth, and particularly young boys, at elevated risk for contracting HIV.

In light of the aforementioned risk factors being observed among the general youth population and the potential for HIV transmission among this group, there is greater risk for HIV transmission among MARA, who are more prone to risky behaviors.

MARA have been identified as one of the key target groups in the 2011–2016 NSPA. This group was not specifically defined in Georgia until 2013. The first definition of MARA was presented by the European Council -funded program being implemented by BPU in partnership with UNICEF, Strengthening Capacity of NSA for HIV Testing and Counseling of Most-at-risk Adolescents and Young People, which declared that MARA consists of young people who live without parental care, on the streets or institutions;

represent national minorities or displaced persons; and boys having sex with men, who are IDUs or in conflict with the law. Specific data pertaining to this group are limited. The first efforts to generate evidence-based data on this group were taken by GHPP. The project conducted a qualitative study investigating the initiation of injecting drug use and unsafe sex practices among MARA. Study findings suggest there are some social, community, and behavioral factors, such as easy access to certain drugs and alcohol, excessive amounts of free/leisure time, peer pressure/influences, lack of knowledge about the risks of drug use and unprotected sex that should be addressed to improve existing HIV prevention efforts among MARA. Based on the study results, GHPP designed and piloted a MARA prevention intervention program among incarcerated youth, youth on probation, and at-risk youth outside of the penitentiary system. The intervention consisted of 7 Cognitive Behavior Therapy sessions focusing on healthy lifestyle topics. Overall, the pilot interventions have had a positive effect on participants' knowledge, which can be applied by MARA to protect their own health and well-being. Specifically, the proportion of respondents reporting knowledge about harms related to smoking increased from 47% to 72% (p=0.040); the proportion reporting increased knowledge of risks of injecting drug use increased from 39% to 90% (p=0.000); and the proportion reporting increased knowledge of HIV risk behaviors increased from 25% to 90% (p=0.000).[19]

# 2. Progress and Challenges

## 2.1 HIV Prevention Services in Georgia

The national response has failed to place equal importance on each component of the core packages of HIV prevention. State-funded programs include the following: HIV Prevention Program among Key Populations; Post-Exposure Prevention; Opioid Substitution Therapy (OST) for PWID; Drug Addiction Treatment and Rehabilitation. In addition, the Government of Georgia (GoG) supports the Safe Blood Program and Prevention of Mother-to-child Transmission Program, offering routine testing of blood donors and pregnant women on HIV and other blood borne infections.

From 2011 to 2013, the GoG did not provide funds for key populations screening components of the state program. It should be highlighted that the state program does not procure 4$^{th}$ generation HIV tests, which identify HIV positive cases earlier.

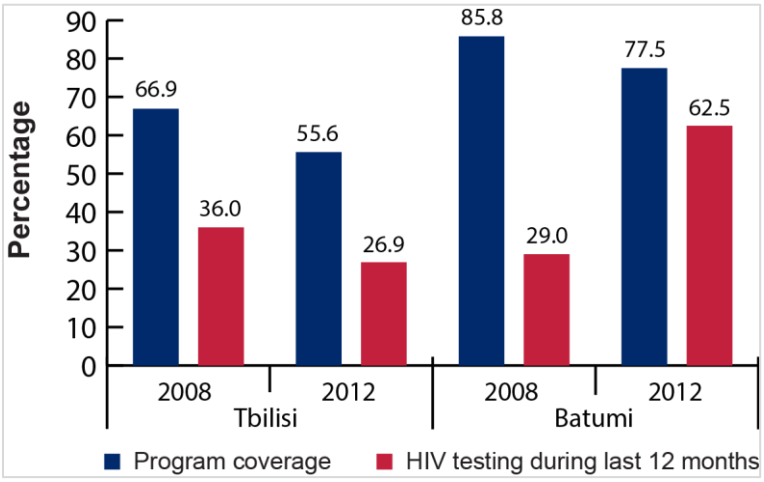
HCT, needle and syringe programs (NSP), OST, ART, HIV education, provision of safe sex, and safe injection commodities represent a core package of HIV prevention among key populations at high risk of HIV.

Over the last decade, funds mobilized through TGF and USAID have been critical for scaling up the national response for HIV prevention among key populations (PWIDs and their partners, MSM, and FSWs). TGF Round 10 project continues to support HCT in 10 cities throughout the country: Tbilisi (4 sites), Gori, Zugdidi, Batumi, Sokhumi, Telavi, Kutaisi, Samtredia, Ozurgeti, and Poti. The services include rapid testing for HIV,

Hepatitis C and B, and syphilis and distribution of injection paraphernalia. From 2010 to 2014, the USAID-funded GHPP offered HIV preventive services to key populations in the following cities: Tbilisi, Kutaisi, Batumi, Zugdidi, Telavi, Rustavi, and Marneuli. As a part of behavior change communication (BCC) strategies-targeted Information Educational Communication (IEC) materials as well as free condoms are available for key populations through donor-funded HIV prevention programs. However, lubricants were of limited access until 2014 when the TGF project procured lubricants for anal sex to be distributed among MSM.

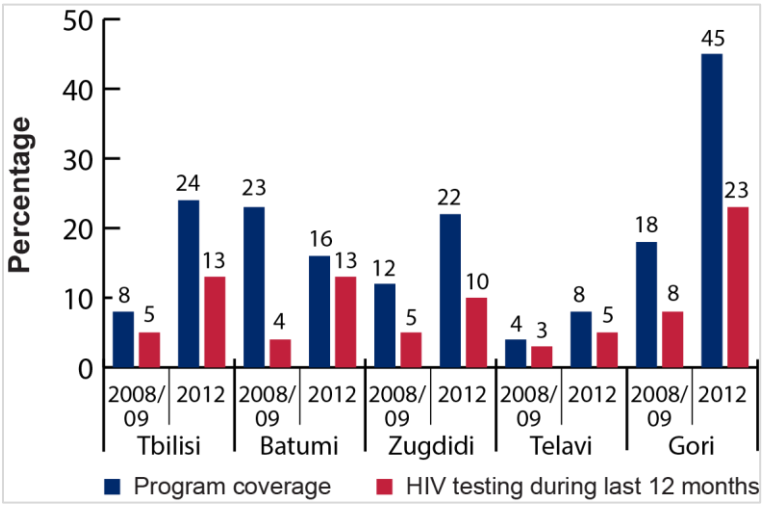
Despite the impressive expansion of HIV prevention efforts over the last several years, coverage of key populations with preventive services and HIV testing remains low for all key populations. According to the Bio-BSSs conducted among PWIDs in six cities, among FSWs in Tbilisi and Batumi, and among MSM in Tbilisi, coverage of prevention programs among FSWs in Tbilisi and Batumi has decreased with statistically significant change compared to the previous survey (Fig. 17),[3] while the coverage of PWIDs and MSM with services has increased (Fig. 18 and 19).

**Figure 17. HIV prevention program coverage and HIV testing uptake among FSWs**



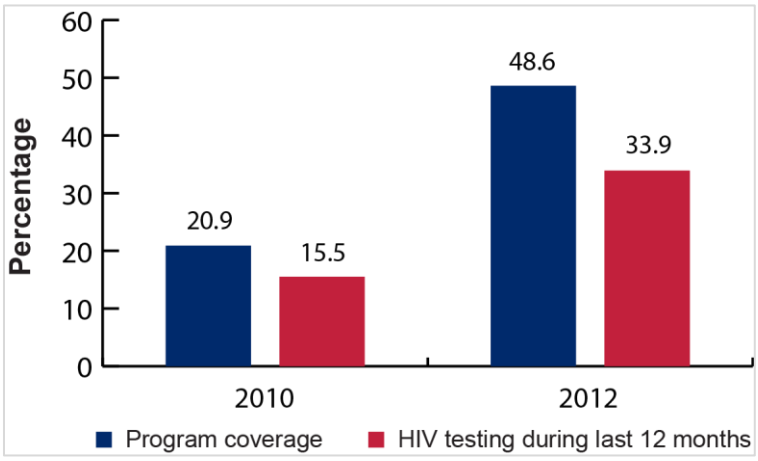

Source: Bio-BSS among FSWs in Tbilisi and Batumi, 2008–2012.

**Figure 18. HIV prevention program coverage and HIV testing uptake among PWIDs**




Source: Bio-BSS among PWID in six cities in Georgia, 2008–2012.

**Figure 19. HIV prevention program coverage and HIV testing uptake among MSM in Tbilisi**




Source: Bio-BSS among men who have sex with men in Tbilisi. 2010 and 2012.

Since 2010, the two projects, the USAID-funded GHPP and TGF project implemented by Georgian Harm Reduction Network (GHRN), have been offering an expanded package of HIV intervention to PWID that, in addition to HIV services, include free-of-charge testing of PWID on Hepatitis B and C. In addition, Medicines du Monde (MDM) has been running a harm reduction program in Tbilisi in partnership with New Vector, a Georgia self-support association. The MDM program in Georgia offers free diagnostics for liver fibrosis (through fibroscan), dental services, and psychological and legal counseling to PWID.[20]

Data from GHPP, TGF, MDM programs show that providing diversified, free-of-charge, and user-friendly services has attracted more beneficiaries, and the number of PWID

using HIV prevention services increased significantly. However, availability of services in regions has been limited and comprehensive packages should be expanded to other cities and regions, at least to the cities with a high number of problem drug users and HIV prevalence (Zugdidi, Batumi).

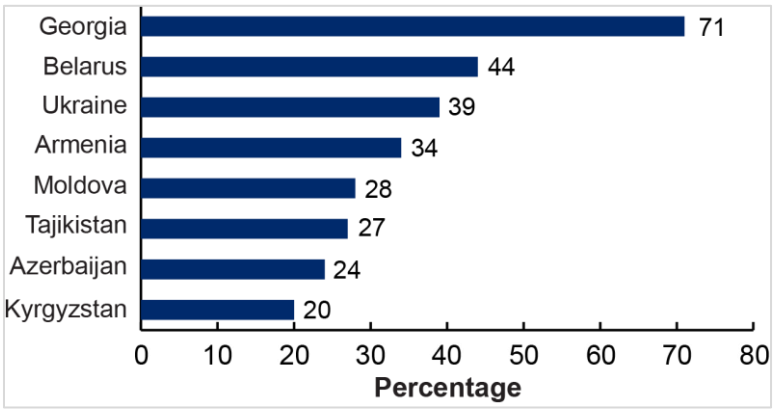
The demand for OST and detoxification therapy is on the rise as the services are being offered to broader geographic areas and the number of patients is increasing. When the state OST program was launched by the Georgian government in 2008, there were 12 OST sites in different regions of Georgia. The OST program is based on a co-funding principle; however, HIV/AIDS patients are offered services for free. By the end of 2013, TGF operated five civil sector OST sites (three sites in Tbilisi, one site in Gori, and Batumi). OST sites have the capacity to provide methadone substitution therapy to 450 clients and approximately 700 patients during the course of a year. There is also one private OST program in Tbilisi that offers buprenorphine and naloxone treatment. In 2013, therapy programs served a total of 4,261 patients (802 under the TGF program and 3,161 under the state program); among them, 49 were female[21].

There are two sites for long-term detoxification with methadone in penitentiary systems located in Tbilisi and Kutaisi, with the capacity of providing service to 100 inmates simultaneously. The two OST sites operating in penitentiary institutions provided detoxification treatment with methadone to 107 drug-addicted prisoners in 2011, 135 in 2012, and 352 in 2013. Harm reduction services have been very limited in the Georgia penitentiary system: Methadone substitution therapy is not available in most prisons; needle exchange programs do not exist in the penitentiary system; and condoms are not available for prisoners. In 2013 high-level officials from the MOC demonstrated unprecedented political will, and launched a state-funded Hepatitis B and C Diagnostic and Treatment Program in the penitentiary system. In May 2014, MOC[22] made an official announcement acknowledging existing needs for scaling up harm reduction services (including needle exchange programs) targeting incarcerated persons in closed settings.

### *Access to Antiretrovial Treatment*

Universal access to antiretroviral (ARV) drugs may be an effective tool for HIV prevention since scientific evidence suggests that ARV drugs, through inhibiting viral replication, significantly reduce the likelihood of transmitting HIV. Since 2004 Georgia has ensured universal access to ART for all PLHIV. The country has realized the principle of equitable access, and treatment is provided to eligible patients regardless of social, demographic, or risk behavior status. By the end of 2013, 91% of eligible diagnosed PLHIV were enrolled in treatment. UNAIDS' 2013 Global Report on AIDS shows that Georgia has the highest estimated ART coverage in the Eastern European region (Fig. 20).

**Figure 20. Estimated ART coverage in Eastern Europe and Central Asia**

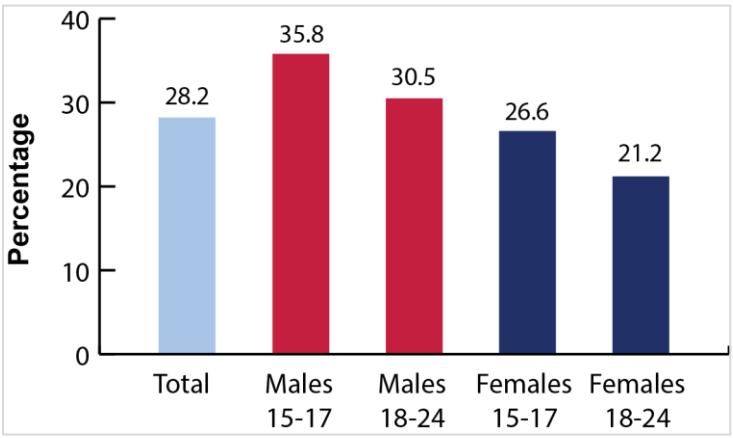



Source: Infectious Diseases, HIV/AIDS and Clinical Immunology Research Center

### *HIV-Associated Stigma and Discrimination*

HIV-related stigma and discrimination includes prejudice, negative attitudes, violence and verbal abuse, and poor treatment directed at PLHIV. Stigma and discrimination directed at high-risk groups as well as at HIVpositive persons remains a major challenge hindering scaling up of HIV prevention interventions. Stigma is fed by poor awareness and lack of understanding among the general population, as well as between and among high-risk groups. Stigmatized and discriminatory attitudes towards PLHIV are prevalent among school pupils and university students in Tbilisi. According to data obtained during Bio-BSS among Youth in Georgia, pupils and students expressed discriminatory attitudes by responding that, theoretically, if a teacher was HIV infected, s/he should not be allowed to teach in school; people with HIV should be isolated; and a student with HIV should not be allowed to attend school. Overall, 28.2% of pupils and students expressed two and sometimes three of the discriminatory attitudes represented by the scenarios presented.

**Figure 21. Percentage of school pupils and university students with a discriminatory attitude toward people living with HIV[17]**




Source: BSS among school pupils and university students in Tbilisi, 2011

Poor awareness about HIV transmission among youth makes teens highly vulnerable to HIV infection and also shapes stigmatized and discriminatory attitudes toward PLHIV.

Stigma and discrimination of PLHIV as well as negative societal attitudes and low public awareness have been identified in 2011–2016 NSPA as important barriers to HIV prevention and service utilization.

Negative social attitudes toward MSM population and low public awareness about HIV remain serious obstacles to strengthening HIV prevention efforts for men engaging in male-to-male intercourse. Crowds demonstrated extremely judgmental, stigmatizing, and discriminatory attitudes toward MSM on International Day Against Homophobia, May 17, 2013. There were massive demonstrations, led by church representatives, against a small group of LGBT activists who "dared" to organize a flash mob and silent walk in the capital city. Although police tried to provide some support, they were unprepared and ultimately were unable to protect activists from approximately 10,000 aggressive and violent protesters. This event is a staunch reminder of the level of homophobic attitudes that exist toward LGBT in Georgia. Stigma and discrimination have been hindering HIV prevention among vulnerable, marginalized groups, and will continue to deter MSM from seeking HIV prevention services unless effective steps are taken to reduce stigma.

## 2.2 Policy and Legal Environment Pertinent to HIV Prevention

Control of HIV/AIDS was identified as one of the public health priorities by the National Health Care Strategy 2011–2015 (NHCS) endorsed by the GoG in 2010, thereby reaffirming country's commitment to control the epidemic.

HIV prevention and care activities have been implemented in Georgia since 1994. The first NSPA on HIV/AIDS was developed in 2002 for the period of 2003–2006, and the latest NSPA 2011–2016 was endorsed in 2010. The goal of the plan is to stabilize the epidemic growth and improve health outcomes for PLHIV. The National HIV/AIDS Monitoring and Evaluation System framework and Action Plan was endorsed by the Georgian Country Coordinating Mechanism (CCM) in June 2011. However, institutional mechanisms for effective functioning of the national monitoring and evaluation (M&E) system are not in place.

The major responsibilities for providing an effective HIV/AIDS response, including HIV prevention, have been divided among various state institutions: the CCM; the Ministry of Labor, Health, and Social Affairs; the National Center for Diseases Control and Public Health; and the Infectious Diseases, AIDS, and Clinical Immunology Research Center. HIV prevention interventions targeting key populations are mostly provided by the NGO sectors under TGF and donor-funded programs.

Importantly, participation of civil society in planning, budgeting, and delivering HIV preventive and supportive has been increasing over the years. Since 2002, a sexually transmitted infection (STI)/HIV Prevention Task Force (PTF) has been operational in Georgia. The PTF is a results-oriented professional network that unites leading government institutions, NGOs, UN agencies, and international donor organizations engaged in HIV prevention and drug addiction in the country. PTF has taken a considerable role in HIV policy and advocacy. The PTF has its representation on the CCM and is involved in all policy and advocacy initiatives. Special emphasis has been placed by donor-funded programs (TGF and USAID/GHPP) to strengthen institutional and technical capacity of civil society organizations through providing training sessions and small grants to implement HIV prevention programs among key affected populations. In 2012–2013 several community based-organizations (CBOs) representing ex-prisoners, female IDUs, and FSWs were established in Georgia and serious efforts were undertaken by donor-funded programs (TGF; EU; Open Society Georgia Foundation [OSGF]; USAID/GHPP) to strengthen organizational capacity of newly incubated CBOs to ensure their participation in HIV advocacy and service provision.

### *HIV/AIDS Law*

In its 2009 fall session, the Parliament of Georgia adopted new a law on HIV/AIDS, which improved overall legal environment for national response. The HIV/AIDS State Law protects PLHIV against discrimination. However, by-laws regulating specifics of HIV testing policies, partner notifications, employment restrictions, etc., that were prepared in early 2010 have yet to be endorsed by the Government.

### *Drug Policy*

Despite the fact that Georgia is not considered to be a drug producing country, there are certain concerns about it becoming a transit route for drugs from Asian countries into Europe. Therefore, law-enforcing agencies have been prioritizing supply reduction by fighting import of illegal drugs. In parallel, GoG has intensified drug testing and punitive strategies toward drug users, including high fines and imprisonment.[23] These current antidrug regulations, which apply administrative and criminal penalties for personal use and possession of illicit drugs, impede implementation of effective prevention interventions in IDUs.

According to the Article 6 of the law of Georgia on HIV/AIDS, all individuals have the right to undergo voluntary consultation and testing, including anonymous and confidential testing on HIV. Nevertheless, changes were endorsed in 2011 in the state program administration of the HIV/AIDS component, where each beneficiary is required to submit his/her identity card to a service provider to receive free testing. The new regulation has hindered access to free HIV testing services for key population groups, not only PWIDs, but also MSMs and FSWs due to social stigma and fear of disclosure.

Since 2008, there have been several advocacy and policy initiatives to amend national drug legislation, including amendments for the Drug Control Law and the Law on Narcotics, Psychotropic Substances, Precursors, and

Drug assistance. However, none of the packages submitted to the Parliament were successful. Legal sanctions remain especially strict and oriented on criminal penalties, where a more balanced public health–oriented approach is essential, particularly to amend criminal liability.

In 2011, policy debates around the country's anti-drug strategy and drug legislation resumed by an Interagency Drug Council established under the Presidential decree #751, November 22, 2011. The Interagency Council unites representatives of line ministries (the Ministers of Internal Affairs; Justice; Education and Science; Labor, Health, and Social Affairs; and Corrections;) and representatives of General Prosecutor's office; experts from relevant medical institutions (Institute of Mental Health and Drug Prevention; NCDCPH; the National AIDS Center); local NGOs (Alternative Georgia; Psycho- social Center "Kamara"; Open Society Georgia Foundation; Georgia Harm Reduction Network); and international and bilateral donors.

In May 2012, part of legislative changes proposed in the amendment package submitted to the Parliament in 2008 (by then vice speaker of the Parliament) was adopted. With the adopted bill, the *Law on Narcological Aid* was refined: the list of new psychoactive substances was added, additional norms for legal turnover of drugs as well as the rules for mandatory randomized drug testing of public servants were adopted; in addition, so called "small amounts" for heroin and methadone were defined and added to the list of quantities of controlled substances.

Since 2011, the Interagency Council has been working on developing a national antidrug strategy and an action plan 2013–2015. Given the change in the government in 2012, the process was prolonged, but in late December 2013, a national antidrug strategy as well as an action plan for 2014–2015 were adopted.[6]

## 2.3 HIV Surveillance System in Georgia

The HIV/AIDS Surveillance function in the country is the responsibility of the National Center for Disease Control and Public Health (NCDC).[6] The National HIV/AIDS Surveillance Plan was developed by the national working group in the frame of the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM)-supported project in 2010. The national plan describes the organizational arrangement of the system, major functions, responsible bodies, surveillance system target groups, surveillance methods and tools, indicator passports, and the system outputs. HIV/AIDS routine surveillance guidelines for service providers and data users were developed and approved by the ministerial decree #217/o, July 23, 2010. The national HIV/AIDS surveillance system database housed in the NCDC was also developed and became fully operational in 2010. The database ensured collection and analyses of routine surveillance data from all players of the system and was based on anonymous unique identifier composed of 15 codes. Following the changes in the state program administration rules in 2011, state program beneficiaries are now required to present their personal photo ID to receive prevention services. This has created obstacles for service providers who are now forced to collect

15 codes and personal information simultaneously. The database was further modified; however, NCDC could not maintain full-scale operations and the database stopped functioning in late 2011. Currently the NCDC runs an Excel-based database to generate routine surveillance data.

Surveillance studies (e.g., Bio-BSSs among key populations, size estimation studies) have been conducted by NGOs with the USAID and TGF financial support. Hence, there is a risk of sustainability of these efforts in terms of availability of necessary funding through the GoG budget beyond the end of the donor's support. There is also considerable need for technical assistance to support revitalization and strengthening of the HIV/AIDS surveillance system.

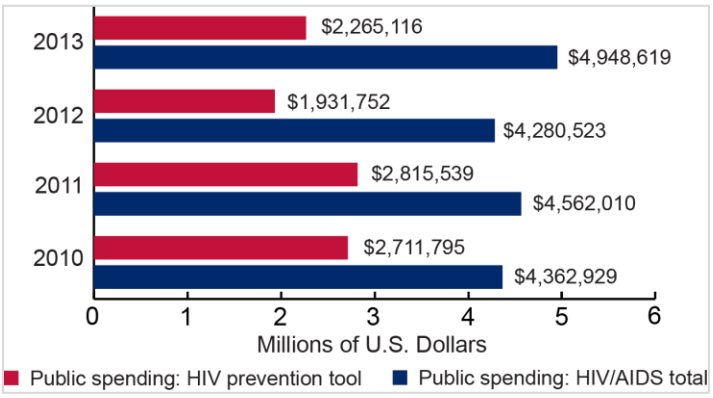
## 2.4 Funding

The GoG is committed to controlling the HIV epidemic and has been progressively allocating financial, human, and infrastructural resources for this purpose. However, there are significant financial and programmatic gaps, particularly in the area of HIV prevention activities among key population groups as well as complex interventions in HIV/AIDS treatment.

The new GoG appointed after the last parliamentary elections of October 1, 2012 has further increased the state budget allocations for health to $640 million GEL ($388 million USD) in 2013, from which $3.5 million GEL ($2.1 million USD) as 0.5% of total budget has been designated for the National HIV/AIDS Prevention and Treatment program.[24]

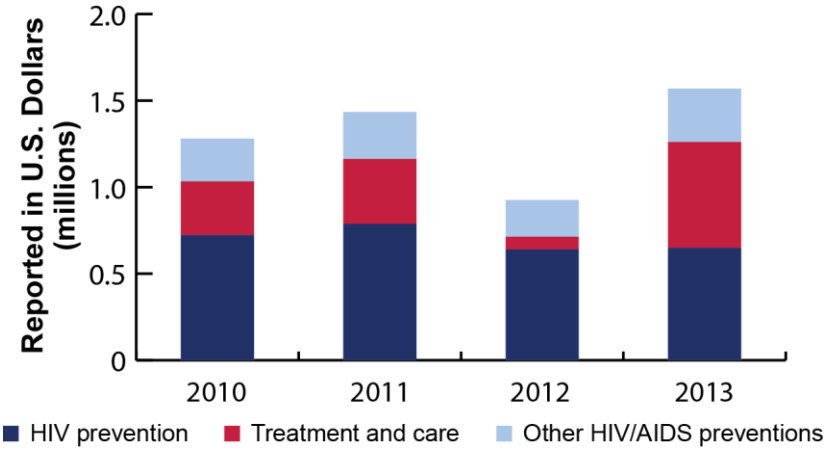
A breakdown of total public spending for HIV/AIDS national response and the spending specifically for HIV prevention for the last 4 years is presented below. Of note, public spending for strengthening HIV/AIDS national response has not changed significantly since 2010, and has varied from $4.3 million USD to $5 million USG. In 2013, total public spending for HIV/AIDS, as well as spending for HIV prevention, increased slightly compared with the previous year.

**Figure 22. Public spending in US dollars, 2010–2013 [25]**




Source: National Funding Matrix, 2009-2012 and 2013 (prepared by the MoHLSA for the Georgia Progress Report for the GARPR); unpublished

**Figure 23. HIV/AIDS spending by categories, 2010–2013[25]**




Source: National Funding Matrix, 2009–2012 and 2013 (prepared by the MoHLSA for the Georgia Progress Report for the GARPR); unpublished

TGF has provided the largest external support as it 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. Other international organizations support the national response to HIV/AIDS Georgia as well, particularly USAID, WHO, UNAIDS, United Nations Population Fund (UNFPA), OSGF, EU, and others. USAID is the second largest donor supporting HIV prevention activities through its GHPP in the country. However, the share of the USAID funds in all international funds reduced drastically from 22.3% in 2011 to 9.6% in 2013. GHPP will end in August 2014, and USAID will no longer provide funds for HIV prevention in Georgia, which may further exacerbate the financial gap, unless the state increases its funding significantly.

The largest share of public funding and TGF funds are focused on treatment and care services, while the USAID funds are allocated for solely HIV prevention interventions.

Private spending only represents out-of-pocket payment from drug addicts enrolled in state-supported Methadone Substitution Treatment Program that involves patients copayment ($150 GEL/month before 2013; reduced to $110 GEL/month in 2013).

Local NGOs heavily rely on international donors for financial support due to the fact that they do not receive funding from the state budget except for OST programs. The important role of NGOs in providing client-oriented, high-quality HIV prevention services should not be underestimated. Therefore, financial support of NGOs requires utmost consideration to sustain their activities in priority areas as well as strengthen their capacity for delivering accessible services with human rights perspective, to all those key populations in need.

According to the NSPA financial gap analysis study during the period of 2011 and 2012, a total of $18.4 and $20.7 million USD were budgeted for successful national response to the HIV/AIDS epidemic. However, the actual spending in 2011–2012 years accounted for $14.3 and $15.8 million USD only; thus the financial gaps between the projected and actual spending reached around $4 million and $5 million USD in 2011 and 2012, respectively. In 2012, HIV prevention and treatment services were underfunded; the funding gap was estimated at $1.1 million USD for prevention and $1.7 million USD for treatment services.

**Table 1. NSPA funding gap by each 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 |

# 3. Opportunities and Recommendations for Enhancing HIV Prevention

## 3.1 Scale-up Comprehensive HIV Prevention in Georgia for the Key Populations at Higher Risk of Being Infected, including MSM, PWID and Their Sexual Partners, FSWs, and Prisoners

It is proven that when core HIV prevention services are delivered in combination, a sufficient coverage level can be reached that will ultimately help reduce HIV incidence in target groups. Prevention interventions should be scaled up through enhanced outreach

and peer-driven and community-level interventions. Preventive services should be expanded to other geographic areas, specifically to the cities with higher problem drug use prevalence rates. Scaling up activities should be promoted pertaining to STI tests and treatment among FSWs and MSM as well.

Community empowerment is vital for this group since HIV prevention coverage remains low, and efforts should be expanded to improve reach of MSM and PWID with high-impact interventions. HIV prevention interventions and behavior change communication should be accompanied by distribution of safe injection commodities as well as condoms, including providing lubricants to MSM. The role of civil NGOs in community empowerment and advocacy is immense, although funding opportunities remain to originate mostly from international donors without any financial support from state funds. Strengthening of CBOs should be done through advocacy initiatives, targeted training, and increased grant opportunities provided not only from international donors but also from the state.

Given the barriers to HIV prevention services, a more diversified and attractive package of services should be offered to vulnerable populations. Comprehensive packages of HIV prevention targeted to each key population should be defined and endorsed by the GoG at the national level. Services that will attract PWID, such as Hepatitis B and C testing, Hepatitis B vaccination, Hepatitis C treatment, STI testing and Treatment, should be integrated into the comprehensive package.

Harm reduction services should be strengthened not only in the civil sector but also in the penitentiary system. MOC and Ministry of Labour Health and Social Affairs of Georgia (MoLHSA) should ensure that Agonist Maintenance Therapy and needle exchange program is available in all penitentiary establishments throughout the country. Drug treatment and rehabilitation services, including residential-type services, should be scaled up to become effective care and social reintegration programs available and accessible to target groups.

The GoG should consider initiating policy dialogue to increase availability and affordability of hepatitis treatment for PWID in Georgia.

## 3.2 Fostering Policy Reform and Legal Change to Create Enabling Environment for HIV Risk Reduction

The HIV/AIDS State Law adopted by the Parliament of Georgia in 2009 protects PLHIV against discrimination. However, to ensure that effective mechanisms for the law enforcement are in place, the MoLHSA should resume working on the by-laws regulating specifics of HIV testing policies, partner notifications, employment restrictions, etc., and foster the process of their endorsement.

Legal changes and policy reforms are particularly important in Georgia due to the current, overly restrictive and punishment-based drug policy that results in decreased utilization of harm reduction services, especially among PWIDs. Anti-drug Interagency

Council should advise Georgian Parliament on the alignment of drug control legislation with international drug control treaties and international best practices, keeping in mind public health goals being a priority. The council should continue working with line ministries, key stakeholders, and civil society organizations to foster policy reform, and ensure the amendment package that has been proposed by the Interagency Council is adapted by the Parliament of Georgia.

## 3.3 Reducing Stigma and Discrimination to Create a Supportive Environment

Creating a supportive environment and fostering social change should not be overlooked. 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.

Notably due to existing stigma and fear of disclosure and further violations, many cases of assault and extortion in Georgia remained unreported and unrecognized. After fierce debate with the Orthodox Church,[26] on May 2, 2014 the Georgian Parliament passed the antidiscrimination law on the elimination of all forms of discrimination. Due to wide HIV-associated stigma, as well as drug use and homosexuality-associated stigma and discrimination in Georgia, the GoG, law enforcement agencies, human-rights advocates, and civil society organizations should be watchful and address every occasion of harassment and violence of key groups on all levels of society.

## 3.4 Improving HIV Prevention among MARA

The NSPA 2010–2016 identifies MARA as one of the top priority groups. The targeted prevention program for MARA that was successfully pilot tested within the USAID/GHPP should be institutionalized within respective institutions. Namely, the intervention consisted of seven cognitive behavioral therapy sessions focusing on healthy lifestyle topics, which proved to be effective through the pilot intervention, should be delivered to targeted youth on a routine basis through relevant programs and activities of MOC and MOES. More rigorous studies, including BSS among MARA, should be conducted to inform stronger, evidence-based strategies for improving HIV prevention and promoting healthy lifestyles among at-risk youth.

## 3.5 Strengthening Health Information Systems to Improve HIV Prevention Through Effective M&E, Surveillance, and Research

Regular, anonymous, and systematic surveillance studies of both behavioral and selected biological markers among key populations should be conducted every 2 years to monitor the prevalence dynamics of HIV infection in Georgia. Reliance on donor funding for surveillance studies might pose a risk of sustainability of these efforts unless the GoG starts planning and allocating adequate funding to ensure that repeated studies are carried out through financial support of the government.

Regular collection and use of routine monitoring data through Bio-BSSs carried out among at-risk groups allows for establishing trends of HIV transmission and early detection of alarming trends, especially considering the concentrated HIV epidemic among MSM and increasing HIV prevalence trends among PWID in certain regions. The GoG should demonstrate its commitment and establish effective funding mechanisms for repeated surveys after TGF program ends.

NCDC, the responsible agency for HIV surveillance and the M&E system in the country, should advocate to secure state funds for implementing all interventions outlined in the national HIV/AIDS surveillance plan approved in 2010 by the ministerial decree #217/o, July 23, 2010.

The MoLHSA should ensure adequate financing to establish an effective M&E unit at the NCDC and provide training opportunities to strengthen staff technical capacity. NCDC should refine and adapt existing HIV/AIDS national database to enable collection and analyses of reliable routine surveillance data from all players throughout the country. Routine data on the delivery of core interventions should be collected and analyzed on a regular basis to inform effective prevention policy in the country. As outlined in the NSPA 2011–2016, operational research studying the effectiveness and impact of HIV prevention services should be conducted at a national level.

Civil society organizations and human rights activists should continue working closely with the MoLHSA/NCDC to ensure that state program beneficiaries can access free HCT services without presenting their personal photo ID cards.

## 3.6 Sustain/Achieve Universal Coverage of ART in PLHIV to Enhance HIV Prevention Effect

Maximizing the coverage of ART among PLHIV is one of the strategic interventions in the scope of combination HIV prevention. Effective ART regimens save lives, improve quality of life, and most importantly prevent transmission of HIV by reducing viral load to untraceable levels. Therefore, wider access to ART should be proposed and adopted for clinical and prevention benefits.

## 3.7 Early Detection—Provider-initiated Testing

As discussed previously, the majority of new HIV cases in Georgia are diagnosed at a late stage, posing challenges to ceasing HIV transmission and diminishing chances of successful treatment. Special emphasis should be placed on improving earlier detection of HIV as it improves survival and quality of life; people aware of their HIV positive status reduce risk behavior and receiving ART further reduces risk of HIV transmission. Improving earlier detection should be done through:

- Improving HCT coverage in most at-risk populations through community-based HCT

- Expanding health system–based HIV indicator disease guided HCT (can be referred to as provider-initiated HCT) countrywide
- Use 4th generation HIV tests (including rapid tests) to ensure earlier HIV diagnosis.

### 3.8 Securing Funds for Comprehensive HIV Prevention

The Financial Gap Analysis study conducted in 2013 suggests that a substantial increase in national/public expenditures on HIV/AIDS should be planned and mobilized in the coming years to minimize the country's reliance on external funding sources. Namely, there is a need to mobilize approximately $1.1 million additional funding (this amount was defined by the Financial Gap Analysis study for 2012, which can be still considered a good approximation for 2014 and beyond) to ensure an adequate HIV prevention response in the country. It is recommended to carry out a long-term financial sustainability analysis/planning to find the best potential sources for mobilization of needed resources.

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[12] Respondents correctly answering all five standard questions: (1) Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? [correct answer: yes]; (2) Can using condoms reduce the risk of HIV transmission? [correct answer: yes]; (3) Can a healthy looking person have HIV? [correct answer: yes]; (4) Can a person get HIV from mosquito bites? [correct answer: no]; (5) Can a person get HIV by sharing a meal with someone who is infected? [correct answer: no].

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