

GEORGIA

**The Second Assessment of Public
Commitments to Ensure Sustainability
of the HIV Response Among Key Populations
in the Transition to National Funding**

EHRA

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3. Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CCM	Country Coordination Mechanism
CEECA	Central and Eastern Europe and Central Asia
CD4	CD4 [cell count] – Cluster of differentiation 4 – a laboratory indicator of immune function and predictor of HIV progression
COVID-19	Coronavirus Disease
CSO	Civil society organisation
DAA	Direct-acting antiviral
EHRA	Eurasian Harm Reduction Association
FSW	Female sex worker
GAM	Global AIDS Monitoring
GBV	Gender-based violence
HBV	Hepatitis B virus
HCT	HIV counselling and testing
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
IBBS	Integrated biological-behavioural surveillance
IEC	Information, education and communication
KP	Key population
MoE	Ministry of Education
MoIDPLHSA	Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs
MOJ	Ministry of Justice
MSM	Men who have sex with men
MTEF	Medium Term Expenditure Framework
NCDC	National Centre for Disease Control and Public Health
NGO	Non-governmental organisation

NSP	Needle and syringe programme
NSP	National Strategic Plan
OAT	Opioid Agonist Therapy
OI	Opportunistic infection
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
RITA	Recent infection testing algorithm
S&D	Stigma and discrimination
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
TG	Transgender
UHCP	Universal Healthcare Program
UIC	Unique identifier code
UNAIDS	United Nations Joint Programme on AIDS
USD	United States dollar
VL	Viral Load
WHO	World Health Organization

4. Executive Summary

Purpose and methodology: The assessment of public commitments to ensure sustainability of HIV response for key populations in the context of the transition to national funding was conducted in Georgia twice – in 2021 and 2023. The assessment aims to assist key affected communities and policy and decision makers in obtaining evidence-based information about the progress made in the transition from donor funding to national funding of HIV national response. The assessment was based on the Methodological Guide and Transition Monitoring Tool (TMT) developed in 2020 by the Eurasian Harm Reduction Association (EHRA)¹ that was tested in 2021 in nine CEECA countries, including Georgia, and was revised and updated in 2022².

Key transition achievements: The state has already achieved significant progress in certain programmatic areas, and some components have already been fully covered through public funds. The government is increasing its investment to absorb the total cost incrementally. Currently, the Government covers ARV treatment; treatment of opportunistic infections (OI), elimination of mother-to-child transmission (EMTCT) and the blood safety programme; STI diagnostics and treatment for key populations; opioid agonist therapy (OAT); pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for key populations. Starting in 2020, the state has been progressively investing some funds to support HIV counselling and testing services among people who inject drugs (PWID), sex workers (SW) and men who have sex with men (MSM) through contracting local civil society/community-based organizations. However, challenges related to transition still remain and are described in this report.

Findings of the assessment:

Domain: Results, Impact and Outcome: The assessment found that significant progress was achieved in terms of realising impact commitments such as containing HIV prevalence among the general population as well as among key population groups, containing AIDS-related mortality and containing HIV incidence through improved prevention. Georgia has successfully managed to contain the spread of the HIV epidemic not only among the general population but also among key populations. However, recent data about the high level of HIV among transgender people requires special attention. In addition, traditionally, Georgia has been very successful in providing ARV treatment to all PLHIV regardless of CD4 count, and the vast majority of people on ARV achieve viral suppression. This has contributed to containing AIDS-related mortality under 2 deaths per 100,000 populations per year³.

¹ Serebryakova L. Benchmarking Sustainability of the HIV Response in the Context of Transition from Donor Funding. A Methodological Guide. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2020.

² L. Serebryakova. Assessing Public Commitments to Ensure Sustainability of the HIV Response Among Key Populations in the Transition to National Funding. Methodological guide. – Vilnius: Eurasian Harm Reduction Association, 2022.

<https://eecaplatform.org/tmt-ru/>

³ Infectious Diseases, HIV/AIDS and Clinical Immunology Research Centre. Program data. Provided by Dr. Nikoloz Chkhartishvili; Dr. Akaki Abutidze. Email communication. April 2023.

Health Domain: Financing: Substantial progress (with an overall commitment compliance score of 82%) has been achieved to fulfil the government's commitment to increase HIV investment and dedicate a larger share of public spending to HIV prevention interventions targeting key populations. Out of six commitments being identified and prioritised for the assessment, five were achieved, and only one commitment was not met: HIV surveillance studies – integrated bio-behavioural surveys and population size estimation studies among each key population have still been funded by the Global Fund without the state investment. Despite this progress, there has been a significant volume of HIV prevention interventions, particularly low-threshold harm reduction and prevention services run by civil society or community-based organisations for KPs, that remain heavily dependent on the availability of donor funding.

Health Domain: Drugs, Supplies and Equipment: The government demonstrates significant progress (commitment compliance score – 100% for those commitments being identified and prioritised for the assessment within this study) in meeting its commitment to ensure universal access to ART and safeguard the uninterrupted supply of high-quality lifesaving drugs. Similarly, the Government ensures continuous supplies of substitution drugs, HIV laboratory consumables and other reagents needed for treatment monitoring. No stockouts in these supplies have been observed. Nevertheless, some concern persists among civil society that the provision of HIV prevention materials and other supplies (such as condoms, lubricants, needles and syringes, etc.) have been exclusively procured through donor funding with no indication or clear plan for smooth transitioning.

Health Domain: Service Delivery: Significant progress in fulfilling the Government's commitment to increase access to HIV prevention, treatment and care services for vulnerable populations has been documented, with an overall commitment compliance score of 87.2% for those commitments being identified and prioritised for the assessment within this study. A high degree of progress was also evidenced in terms of providing HIV prevention services to PWIDs and MSM population through introducing and further expanding not only conventional services, including OAT, but also innovative prevention services (SIGMA vending machines, community PrEP, self-tests, home delivery of HIV tests, etc.). Relatively low progress was found in expanding services for FSWs and prisoners.

Health Domain: Governance: Based on the commitments identified and monitored, only average progress was documented (commitment compliance score – 68% for those commitments being identified and prioritised for the assessment within this study) in terms of improving the components under the domain – Governance. The most critical need that remains unmet has been existing punishment-based drug legislation that will continue to pose a sustainability risk, given that HIV prevention services targeting PWIDs operate in an environment where the legality and legitimacy of harm reduction services can be confronted.

Health Domain: Data and Information Systems: Average progress has been evidenced (commitment compliance score – 58% for those commitments being identified and prioritised for the assessment within this study) in terms of fulfilling the commitments

regarding HIV research, including IBBS surveys and population size estimation studies among KPs. Only some studies were completed, although with delay. Most importantly, none of these studies were financed through public funds. Heavy reliance on donor funds to conduct research studies poses a threat to sustainability. More advocacy efforts will be needed to convince the government to allocate more resources to research. Moreover, CSO and community representatives are concerned that the budgets allocated for IBBS surveys and PSE studies have been noticeably reduced over the last several years after the NCDC started purchasing this service through state tenders. They believe the extremely low cost of studies does not allow competition, as businesses opt out of participating in tenders. Eventually, this may jeopardise the quality of research studies in the long run.

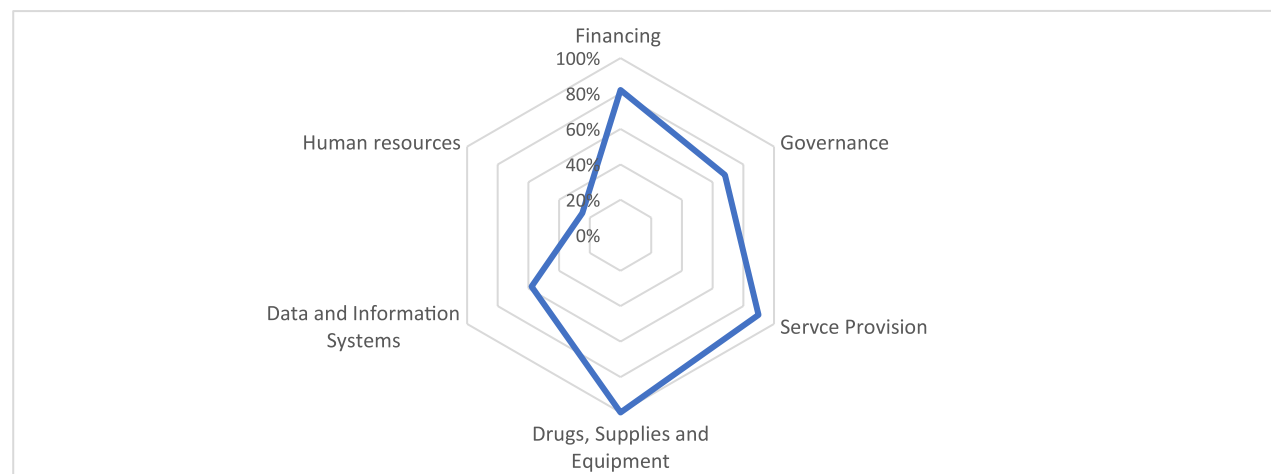
Health Domain: Human Resources: Low progress (with an overall score of 25% for those commitments being identified and prioritised for the assessment within this study) was documented in fulfilling government commitments to strengthen human resources. It seems that addressing the challenges related to human resources in the health sector has not been perceived as a priority issue by the healthcare system in Georgia. At some point in time, the Government was making public announcements about the development of a policy for Human Resources in Health (HRH), the establishment of a continuous medical education system, the institutionalisation of training programmes, the creation of functional e-learning platforms, etc. However, none of these objectives have yet been realised in general in the health sector, including in the field of HIV.

Table 1 and below present summary data on the extent to which the government of Georgia has realised its declared commitments in all six health domains. Scores are presented in a pre-defined colour-coded system for better visualisation.

Table 1. Commitment compliance scores by health system domains

Total scores by health system domains		
Financing	82%	Significant progress
Governance	68%	Average progress
Service Provision	87%	Significant progress
Drugs, Supplies and Equipment	100%	Significant progress
Data and Information Systems	58%	Average progress
Human Resources	25%	Insignificant progress

Figure 1. Commitment compliance by health system domains



Transition progress in the programmatic area pertinent to key affected populations:

In the context of the transition, meeting the commitments within the programmatic areas is considered the most critical, as it will ensure the sustainability of essential services for key populations. Considering the HIV and the country context, the following programmatic areas were analysed:

- HIV prevention among PWID;
- HIV prevention among MSM;
- HIV prevention among FSWS;
- HIV prevention among prisoners;
- HIV treatment and care.

Numbers of monitored commitments are relevant to HIV prevention for all key populations – PWIDs, MSM and FSWs. These common commitments fall under three health domains: Financing, Governance and Human Resources. For instance, a total of six commitments within the 'Financing' domain, four commitments under the domain 'Governance' and one commitment under the domain 'Human Resources' are relevant to all KPs, though disaggregation of scores by key population is not possible. Therefore, progress summary scores for 'common' commitments were included while assessing the transition progress in the above-listed programmatic areas.

Apart from the 'common' commitments, specific commitments pertinent to specific KAPs were also analysed, and the average scores for the fulfilment of commitments within each programmatic area were calculated.

The overall transition progress across programmatic areas in Georgia shows varying degrees of fulfilment for prioritised transition-related commitments. Ranging from moderate progress, as seen in the programmatic area of HIV prevention among prisoners (48%), to substantial progress observed in two areas: HIV treatment and care, scoring 81%; and HIV prevention among PWIDs, scoring 73%. The differences in progress scores across programmatic areas targeting KAPs primarily stem from varying levels of achievements in expanding the scope and scale of HIV services tailored to key affected populations. Additionally, the final scores were influenced by disparities in conducting IBBS and PSE studies among KAPs, ranging from 0% for FSWs and prisoners and 50% among MSM to 100% among PWIDs.

Table 2. Overall progress in the fulfilment of the selected transition-related commitments by programmatic areas

Programmatic area		Overall progress
HIV prevention among KAPs	HIV prevention among PWIDs	73%
	HIV prevention among MSM	65%
	HIV prevention among FSWs	53%
	HIV prevention among prisoners	48%
HIV treatment and care		81%

Main recommendations:

Target: **MoIDPLHSA, Ministry of Finance, CSOs**

Integrate HIV/AIDS Programme into universal healthcare: The best way to achieve smooth transitioning and full sustainability of HIV interventions under domestic funding is to integrate the HIV/AIDS state vertical programme into universal healthcare. HIV prevention, treatment, care and support services that are sensitive to the needs of different, oftentimes marginalised, criminalised and discriminated communities should be part of the universal health benefit package.

Target: **MoIDPLHSA; CSOs**

HIV prevention services should be scaled up through adequate public funding. The government started investing in HIV prevention targeting KPs and began absorbing the cost related to HIV testing. However, civil society organisations believe that the funding is not adequate. An increasing trend in funding is accompanied by progressive targets for service coverage, and the funds received from the government do not leave any space to cover costs of other relevant interventions and/or administrative costs, organisational strengthening or staff professional development costs. It is recommended that the government and civil society organisations start an open dialogue about the programme budgets to understand each other's perspectives and expectations. Some service provider organisations state that without having complementary funding from the Global Fund, they may not express an interest in providing HIV services under public funding. This can be viewed as a threat to sustainability, and the government needs to be prepared for such complex challenges.

Practical use of the TMT findings to prioritise commitments: This Transition Monitoring report should guide the government to start revising its policy, programming and funding in the areas of underachievement. CSOs are encouraged to advocate with the government to convince the Ministry of Health to a) initiate long-awaited changes in drug legislation to create a conducive environment for HIV services among PWIDs, b) start investing in harm reduction services (beyond OAT) and demonstrate that the government is actually committed to low-threshold programmes through investing in syringes and needles to be distributed to PWIDs, c) ensure availability of long-term OAT services for inmates, d) ensure access to harm reduction and HIV prevention commodities in correctional settings, e) despite the availability of the GF funds, start absorbing costs of HIV-related research, such as IBBS surveys, PSE studies among KPs, RITA, etc., and f) invest in strengthening human resources in health sector and in HIV field.

Align NSP indicators and IBBS survey tool to make sure the latter is able to generate UNAIDS GAM standard indicators or indicators outlined in the national strategic plan. For instance, the HIV testing coverage indicator (measured as a percentage of people from key populations who report having tested negative for HIV in the past 12 months or who know that they are living with HIV) could not be generated from the data collected by IBBS among PWID in 2022. Having standard indicators for KPs is necessary for UNAIDS GAM reporting and, most importantly, for exploring trends in behaviours and surveillance data.

Advocacy recommendations for civil society organisations:

Commitments and indicators outlined in the HIV NSP 2023-2025 may not provide sufficient data for the next round of transition monitoring: During the 2023 TMT research and through the review of the latest approved HIV NSP for 2023–2025, it was found that some specific commitments and corresponding indicators related to transition funding are removed (e.g., share of state funding for prevention out of all public spending, % share of state funding out of all prevention spending targeting KPs, % share of public funds out of total spending for IBBSS/PSEs, etc.). Therefore, for the next round of Transition Monitoring assessment, community monitors/the national reference group may not be able to analyse financial data that are critical for transition. This may undermine the ability of civil society to monitor and demand investing in the areas that are most challenging in terms of sustainability and transition. A thorough analysis of the NSP is desired (the sooner, the better) to predict future gaps in data and advocate for taking corrective measures.

Institutionalise data validation process for the UNAIDS GAM reporting: Georgia has been committed to submitting the Global AIDS Monitoring (GAM) report to UNAIDS every year. This is a very useful resource for all interested stakeholders to monitor standard indicators. However, the quality of reporting can be further improved. Apparently, data validation of all indicators reported has not been done routinely. Not all data validation questions from UNAIDS have been answered – answering all questions would enhance the accuracy and reliability of the data. If civil society improves the monitoring of GAM reporting, the availability of HIV programme data will be enhanced.

Validation of HIV spending data and budget monitoring: More emphasis should be placed by civil society organisations on budget monitoring as well as validation and/or critical review of AIDS spending data submitted by the MoIDPLHSA to UNAIDS annually. As described in the report, some inaccuracies in spending and/or categorisation of spending have persisted over the last few years without any efforts from civil society organisations/budget monitors to seek clarification. The AIDS spending data can be a very useful tool for transition monitoring, as it provides disaggregated data about spending by financial sources (public vs external), programmatic areas, interventions and KP groups. However, the tool can be misleading if spending data's accuracy, completeness and reliability are not ensured.

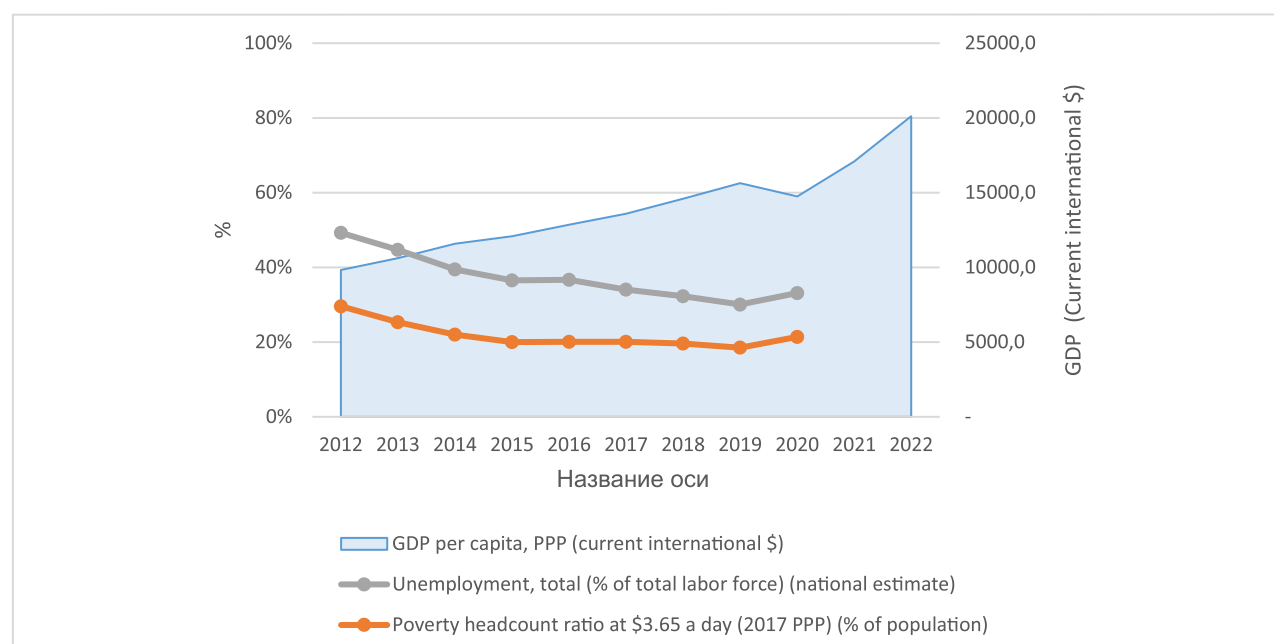
Obtaining data and key documents from state agencies has become more formalised than ever: As described in the report, most HIV programmatic data and financial reports are not uploaded to domains that are accessible to the public. While there is no indication that the government is withholding public information, civil society should be aware that the process of collecting data from state agencies has become formal and advance planning will be needed, as a prompt response from state agencies cannot always be guaranteed.

Civil society and community activists are encouraged to use the transition monitoring assessment report as a guide that helps them be informed and engaged in community monitoring of the transition process. Data and findings of the assessment can be used as an advocacy instrument for addressing remaining gaps in commitment fulfilment.

5. CONTEXT

Country context: Georgia is situated in the South Caucasus region bordering Russia, Azerbaijan, Armenia, Turkey and the Black Sea. The country covers an area of 69,700 square kilometres and has a population of 3.7 million people. Tbilisi is the capital and largest home to roughly a third of the Georgia population. After regaining independence, Georgia faced substantial political challenges and economic collapse. However, since the early 21st century, visible positive developments have been observed in the country. Currently, Georgia is classified as an upper-middle-income country by the World Bank. Gross domestic product has been rising, reaching its maximum in 2022. The total debt of the central government as % of GDP⁵ was alarmingly increasing from 29% in 2012 to 66% in 2020; however, in 2021, it declined to 55% due to positive developments in the country's economy. The National Statistics Office claims that the unemployment rate declined from 23% in 2014 to 17% in 2023⁴.

Figure 2. Georgia – Country economic data



Georgia healthcare system overview: Since Georgia re-gained its independence, dramatic changes have been introduced in the healthcare system. One of the most substantial waves of the reform occurred in 2007, and it was characterised by deregulation and decentralisation of the healthcare system⁵. The majority of health institutions, including primary healthcare institutions and hospitals, were extensively privatised from 2007 to 2012. Currently, most healthcare providers are private, including approximately 80% of hospital beds. In 2013, the newly elected government enacted a universal healthcare programme (UHCP), which aimed at covering almost the whole population, most of whom had no health coverage before 2013. Since then, Georgia has been striving to provide universal health coverage through a package

⁴ National Statistics Office of Georgia. www.geostats.ge

⁵ World Bank. Georgia Country profile. <https://data.worldbank.org/country/georgia?view=chart>

of publicly funded benefits and increased public investment in health. In 2021, the UHCP provided 94.3% of the resident population with some degree of coverage. About 9% of the population was covered by private health insurance, and less than 1% of the population had no form of coverage (UHCP or private health insurance)⁶.

The package of benefits under UHCP is broad but extremely complex, involving different co-payment schemes based on priority grouping and stratified by income, age or other criteria⁷. The main priority group by income covers households living below the poverty line. Other priority groups are children aged 0–5 years, children in foster care, students, pensioners, people registered as disabled, veterans, internally displaced people (IDP), teachers and public artists (laureates). The highest-income households (around 1% of the population, defined as households earning over Georgian Lari (GEL) 40,000 or USD 12,300 a year) have been excluded from most UHCP benefits since 2017⁸. The high cost of outpatient medicines is the biggest barrier to accessing care for the lowest-income households.

Healthcare service providers (both state and private) generate revenue from out-of-pocket payments (including fee-for-service and the UHC co-payments), transfers from state healthcare programmes and payments from private medical insurance companies. Medical insurance companies depend on revenues from medical insurance policies purchased by employers for their employees and by individuals for their own use. Out-of-pocket expenditure on healthcare in Georgia still exceeds public financing and private insurance, as there is very limited financing of pharmaceutical products by the state, and most of them are paid out of pocket⁹.

In general, health expenditure is on the rise but still accounts for approximately 8% of GDP. After introducing UHCP in 2013, the Government health expenditures (GHE) have increased several times; however, GHE as the share of GDP was rising at a slower pace from 1.6% to only 2.8% in 2020, which remains below the WHO European Region average (5%). Domestic general government health expenditure per capita (current USD) is one of the lowest in the region (USD 117 in 2020). As the government investment in health is increasing, the coverage has expanded, and out-of-pocket spending on health has fallen considerably from 73.4% in 2012 to 46.8% in 2020¹⁰.

The Ministry of Internally Displaced Persons from the occupied territory (MoIDPLHSA) is formally accountable for the population's health, oversight of the health system and the quality of health services. There are legal entities under state control of the Ministry, including LEPL “Social Service Agency” (SSA) that provides UHCP, and LEPL “National Centre for Disease Control and Public Health” (NCDC), which is the main state institution responsible for public health and various state-funded vertical health programmes for communicable and non-communicable diseases, including HIV/AIDS programme, Safe Blood programme, TB programme, immunisation programme, hepatitis elimination programme, tobacco control, etc. Since 2014, it has served as a Principal Recipient (PR) of the Global Fund funding for both disease programmes in Georgia.

⁶ WHO 2022 Edition. Health systems in action: Georgia. ISBN: 978 92 890 5912 1

⁷ WHO 2022 Edition. Health systems in action: Georgia. ISBN: 978 92 890 5912 1

⁸ Ministry of Health. Universal Healthcare program. <https://www.moh.gov.ge/ka/529>

⁹ Georgia Healthcare Group. 2022. <http://ghg.com.ge/industry-and-market-overview>

¹⁰ WHO 2022 Edition. Health systems in action: Georgia. ISBN: 978 92 890 5912 1

Communicable disease control has broadly become a political priority for Georgia, which was one of the first countries globally to introduce and roll out an innovative hepatitis C elimination programme. Through the generous support from Gilead Sciences, Georgia offers unrestricted, free-of-charge treatment for hepatitis C using direct-acting antivirals (DAA)¹¹. By 2022, over 78,000 individuals (representing more than 50% of the affected population) were treated, and 99% of them achieved sustained virologic response (SVR). A repeated sero-survey conducted in 2021 showed a chronic HCV prevalence of 1.8% among adults, a 67% reduction from 2015¹¹.

Epidemiology of HIV infection: Georgia remains a low HIV prevalence country with concentrated epidemics in key populations, mainly among MSM, transgender (TG) people and, in some areas, among PWID¹². HIV prevalence and AIDS-related deaths have been stable over the last decade and are contained under 500 per 100,000 populations and under 2 deaths per 100,000, respectively. HIV incidence per 1000 adults aged 15–49 years was 0.28 (0.25–0.3), and HIV incidence in all ages per 1000 population was 0.13 in 2020, slightly increasing to 0.17 in 2022¹³. This indicator stays somewhat higher than the target set (less than 0.1 by the end of 2022). Nevertheless, this indicator is still lower than the average for the Eastern part of the WHO European region (32.6 per 100,000 population in 2020)¹⁴.

The annual number of HIV-registered new cases reached its peak in 2015–2016 and since then has remained somewhat stable with a declining trend. The lowest numbers of HIV cases were registered in 2020–2021 (530), which can be directly attributed to COVID-19-related restrictions that resulted in reducing HIV testing uptake and downsizing the scale of HIV prevention services in general. In 2022, 617 new cases of HIV were registered. Despite concerted efforts made to improve access to HIV prevention and testing services, more than half of new HIV diagnoses are made at the late stage, with variation among different districts (in 54% of cases CD4<350, and in 33% of cases CD4<200)¹⁵. Nevertheless, it should be noted that there has been a slow improvement in the proportion of late diagnosis (CD4 cell count <350) among newly reported HIV cases, from 67% in 2010 to around 55% in 2021¹⁶.

Over the last several years, a major route of HIV transmission in Georgia has been heterosexual contacts: in 2022, more than half of all newly registered HIV cases were infected through heterosexual contacts (51.4%); injecting drug use and homosexual contacts account for 33% and 13%, respectively. However, new cases have been identified, particularly among the male population, that may reflect HIV transmission among men who have sex with men (MSM) who, due to a high level of stigma, opt not to disclose their sexual orientation or gender identity. However, this trend may also potentially indicate signs of spreading HIV transmission into the general population¹⁶.

¹¹ Georgia Hepatitis Elimination Program. Progress Report 2020–2021. Ministry of Health of Georgia; CDC; NCDC

¹² GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023–2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. Tbilisi. 16 February 2022

¹³ UNAIDS Data book. 2022

¹⁴ UNAIDS Data Book 2023

¹⁵ GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023–2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. Tbilisi. 16 February 2022

¹⁶ GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023–2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. Tbilisi. 16 February 2022

In 2022, HIV prevalence among the general population was 0.3%, with prevalence being twice as high among the male population (0.4%) than among the female population (0.2%)¹⁵. HIV prevalence among PWIDs and SWs has been contained under 3% during the last decade. HIV prevalence among MSM and transgender people is high, indicating a concentrated HIV epidemic among these vulnerable groups. Table 3 summarises population size estimates for key populations and HIV prevalence among each group. Despite low HIV prevalence in the general population and high HIV prevalence among MSM and transgender (TG) people, rates of recent HIV transmission in the MSM population and young population indicate ongoing transmission and a potential threat to worsening HIV epidemic in key populations and their sexual partners¹⁶. As shown in the table below, most data concerning key affected populations are outdated because surveys that were supposed to be conducted regularly were not carried out for various reasons, including the COVID-19 pandemic.

Table 3. Key populations: size estimates and HIV prevalence *

Key Populations: population size estimates and HIV prevalence					
	2012	2015	2017	2021	2022
People who inject drugs					
PSE (2022 IBBS/PSE) 51,000 (45,400-57,700)/ 49,700 per 18-64 y.o population					
HIV Prevalence	2.2%	2.2%	2.3%		0.9%
MSM					
PSE (2018 IBBS/PSE) – 18,500; (Tbilisi 6900; Batumi 700; Kutaisi 800)					
HIV Prevalence - Tbilisi		25.1%	21.5%		
HIV Prevalence - Batumi		22.3%	15.6%		
HIV Prevalence - Kutaisi			9.6%		
FSW					
PSE (2014 IBBS/PSE) - 6,500					
HIV Prevalence - Tbilisi	0.6%	0.6%	1.5%		
HIV Prevalence - Batumi	0.8%	0.8%	0.0%		
Prisoners					
Total number of prisoners (Actual 2022) - 9,542					
HIV Prevalence	0.3%	1.4%			
Transgender people					
PSE (2023) - trans and non-binary persons represent 0.06% of the country's population (Tbilisi 720; Batumi - 100; Kutaisi - 80)					
HIV Prevalence				23.8%	

* Note: Only the years when IBBS/PSE studies were conducted are shown in the table.

Based on the latest Spectrum estimates, there were 8400 (7900–9000)¹⁷ adults and children living with HIV in Georgia in 2022. The estimated number of PLHIV has been revised since the latest NSP 2019–2022, and it reduced from 10,500 to 8,400, which also caused changes in the values of some indicators that were reported in the previous Transition Monitoring report¹⁸.

¹⁷ UNAIDS. Country Factsheet. Georgia 2022

¹⁸ Tabatadze M. Georgia: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund's support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021.

A wide range of HIV prevention, support and care services have become available and scaled up in Georgia since 2003, when the first Global Fund HIV grant was launched. In total, USD 94,117,444 has been disbursed for the HIV programme by the Global Fund from 2003 until the present; the budget of the latest (currently ongoing) TB/HIV grant exceeds USD 17 million¹⁹. The availability of generous financial support for 2 decades and extensive technical support from the GF enabled the country to strengthen its institutional and human capacity to deliver quality services. This process has also promoted the development of strong civil society organisations and self-organised community groups that have been meaningfully engaged in HIV policymaking, service delivery, advocacy and research.

The latest National HIV strategy for 2023–2025, which is expected to be approved by the MoIDPLHSA in 2023, defines the following key affected populations: PLHIV, MSM, PWID, sex workers, prisoners and transgender people. The latter was added as one of the priority groups only in the HIV strategy 2023–2025.

HIV Services for key populations: HIV prevention services for key populations were initially mainly supported by the Global Fund. Over time, however, as a part of a transition process, the government has increasingly been **co-financing** some portion of HIV services, including prevention interventions, which are mainly provided by NGOs. The Government is committed to fully sustaining and further scaling up HIV services after the Global Fund funding ends.

Table 4. Availability of HIV prevention services by key population groups

Type of HIV Prevention Services	MSM	PWID	FSW	TG	Prisoners
Behaviour change communication and counseling services	✓	✓	✓	✓	
Testing for HIV; Hep B and C: testing at fixed sites	✓	✓	✓	✓	✓
Testing for HIV; Hep B and C through mobile laboratories		✓			
HIV self-testing	✓	✓		✓	
HIV prevention commodities: condoms and lubricants	✓	✓	✓	✓	✓
HIV prevention commodities: safe injection paraphernalia		✓			
STI testing and treatment	✓	✓	✓	✓	✓
Pre-exposure prophylaxis (PreP), including community-based PreP	✓			✓	
PreP on demand	✓			✓	
Post-exposure prophylaxis (PEP)	✓			✓	
OAT		✓			✓
Hepatitis B vaccination	✓	✓			
SIGMA - vending machines - disbursing prevention commodities (including safe injection supplies, self-tests; condoms, lubricants, naloxone, etc.)	✓	✓		✓	
Psycho-social and legal assistance, including through paralegals and/or professional lawyers	✓	✓		✓	
Access to mental health services (though on a limited scale)	✓			✓	
Case management, including social accompaniment for those who test HIV+	✓	✓		✓	
Gender based violence; shelters for victims of GBV/discrimination	✓			✓	

¹⁹ <https://data.theglobalfund.org/grant/GEO-H-NCDC/3/overview>

The scope of HIV prevention services has been limited in prisons: per official data, condoms are accessible in 'low-middle-risk' prisons; the OAT is offered, though long-term maintenance therapy has not been available for inmates; safe injecting paraphernalia as a part of harm reduction services are also not available for prisoners; hepatitis B vaccination has not been offered to inmates. Most HIV prevention interventions still remain dependent on the availability of donor funding. For instance, the interventions listed below have been available through donor financial support: legal assistance (through paralegals and/or professional lawyers), interventions to prevent or react to gender-based violence among KPs, offering shelters to GBV victims, distribution of safe injection materials to PWIDs, operation of SIGMA vending machines, case management, counselling for psychologists /psychiatrists, etc.

HIV service delivery: The National Centre for Disease Control and Public Health (NCDC) is the main state agency responsible for the control of the HIV epidemic and disease surveillance in the country. The Infectious Diseases, HIV/AIDS and Clinical Immunology Research Centre (National AIDS Centre) is the leading medical institution providing HIV/AIDS clinical services; OAT services are provided by a number of medical institutions, including the Centre for Mental Health and Prevention of Dependence and other private clinics. HIV prevention services targeting key affected populations are provided by several CSOs as well as state-funded medical institutions in various cities throughout the country. Low-threshold HIV prevention and harm reduction services are provided by local NGOs.

HIV prevention services among MSM and transgender populations in Georgia are currently being delivered by three organisations: the NGO Tanadgoma and two CBOs – Equality Movement and Identoba Youth. Programmes have been operational in major cities, including Tbilisi, Batumi, Kutaisi and Zugdidi; however, outreach work has also been carried out in other small cities.

Services targeting PWIDs, including low-threshold harm reduction services, are delivered by the Georgia Harm Reduction Network (GHRN), which unites 26 NGO and CBO members, out of which 11 provide HIV-prevention services for PWID in various cities countrywide, including Sokhumi, in a breakaway region of Abkhazia.

SIGMA - vending machines, originally initiated through financial support from the 5% Initiative (implemented by Expertise France)²⁰, are currently supported by the GF and implemented by NGO – Addiction Research Centre Alternative Georgia. In total, 10 SIGMA machines have been operational in Tbilisi since 2019. This innovative service delivery model has become sustainable, and furthermore, services are being expanded to cover more regions: five new SIGMA machines will be installed in various cities in 2023 and four in 2024²¹.

²⁰ <https://www.initiative5pour100.fr/>

²¹ GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023-2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoIDPLHSA) of Georgia. Tbilisi. 16 February 2022

Services for non-injecting drug user youth: Over the last few years, a community-based youth organisation – Mandala has emerged, which provides HIV/drug use awareness, overdose prevention and drug checking services to non-injecting drug user youth who frequently attend music festivals and nightclubs.

Services targeting SW have been exclusively delivered by NGO Tanadgoma in five major cities of the country: Tbilisi, Batumi, Kutaisi, Zugdidi and Telavi.

Other services (COVID-19) – In 2020–2021, **COVID-19** presented a major challenge to the country, seriously affecting HIV services. Large-scale prevention measures were implemented for key populations in the civic sector as well as in the penitentiary system: face masks and other PPE materials were widely available for KPs and NGOs working with vulnerable groups; intensive COVID-19 testing was in place, with PCR testing for staff and inmates every two weeks; these population groups were prioritised for COVID-19 vaccination. An online primary healthcare service (Tele-clinic) was launched in 2020 to help PLHIV and KPs country-wide get online consultations on COVID-19 prevention, testing and home-based case management; in addition to family doctors, psychologists were involved in providing free online consultations. These services were available only through 2022, and stakeholders believe they were effective during health emergencies when the mobility of patients was restricted and access to services was limited. However, the service seemed no longer relevant and was ceased in 2023.

Key challenges in service delivery for key populations within the context of transition:

The key challenges related to service delivery for key populations, as identified during the interviews with stakeholders, are as follows:

Criminalisation of drug use: A major challenge for service delivery for key populations, particularly for PWID, remains the punitive drug legislation. Despite all the efforts of civil society organisations for almost 2 decades, no tangible progress has been achieved in this direction. Thus, even though harm reduction services are available in Georgia, they operate without legal basis. In the long run, this may jeopardise the sustainability of harm reduction services, specifically low-threshold services.

Stigma and discrimination towards PLHIV and vulnerable populations: MSM, transgender and non-binary people, PWUD and sex workers continue to face barriers to access services due to stigmatised attitudes towards these populations. Stigma also persists in healthcare settings. The stigma attached to HIV-affected populations may pose a substantial risk to the transition process.

Other challenges include a highly centralised system for HIV diagnostics and treatment, geographic barriers to prevention and treatment services, the lack of psycho-social support and mental health services, the absence of long-term rehabilitation services for PWIDs, etc.

HIV funding landscape: A wide range of HIV prevention, support and care services have become available and scaled up in Georgia since 2003 when the first Global Fund HIV grant was launched. In total, USD 94,117,444 have been disbursed for the HIV programme by the Global Fund from 2003 till the present; the budget of the latest (currently ongoing) TB/HIV grant exceeds USD 17 million²². Currently, HIV services in Georgia are funded from two major sources: the state and the Global Fund, with relatively small contributions from other donors and international development partners.

Per the Global Fund's Eligibility Policy, Georgia, classified as an upper-lower-middle-income country, is still considered eligible to receive funding given the fast-growing HIV epidemic among MSM and transgender population (with a prevalence above 20%). Nevertheless, the GF funding started declining, and currently, Georgia is in the phase of transitioning from donor to domestic financing of HIV services. The Government of Georgia has declared its commitment to sustain and further expand the scope and scale of HIV interventions previously financed by the Global Fund.

²² <https://data.theglobalfund.org/grant/GEO-H-NCDC/3/overview>

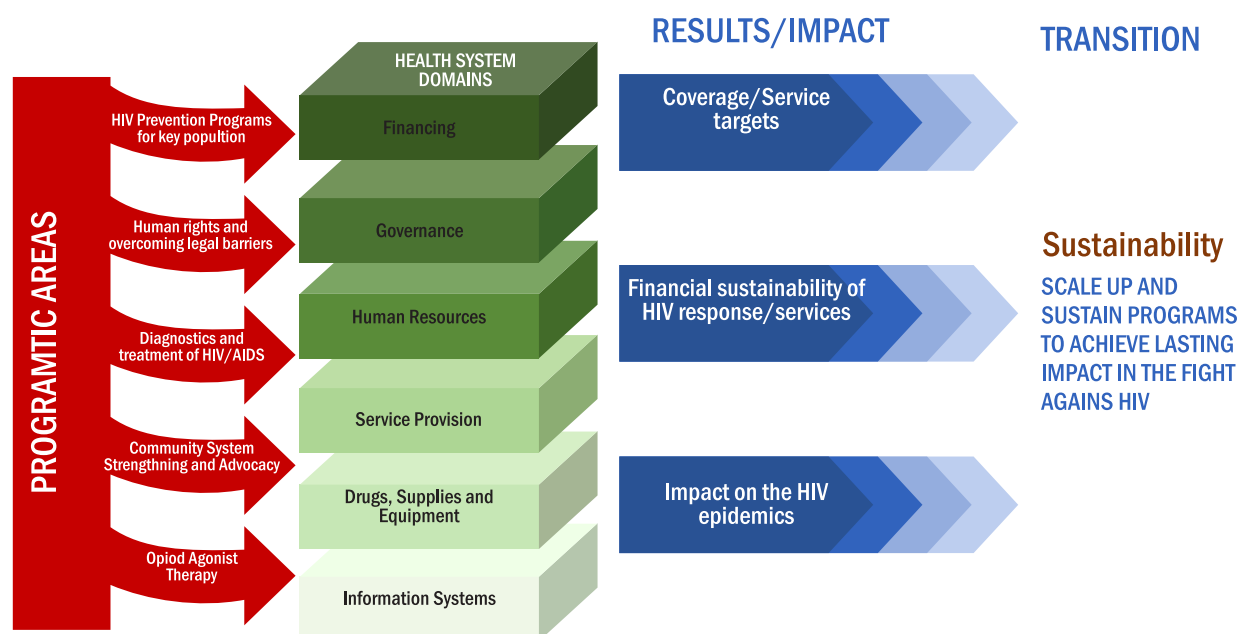
6. PURPOSE AND METHODOLOGY

Assessment methodology and model: The assessment of public commitments to ensure the sustainability of HIV response for key populations in the context of the transition to national funding was conducted in Georgia twice – in 2021 and 2023. The assessment aims to assist key affected communities and policy and decision makers in obtaining evidence-based information about the progress made in the transition from donor funding to national funding of HIV national response. The assessment will enable community members to get engaged in the monitoring and advocate for a smooth transition process.

The assessment was based on the Methodological Guide and Transition Monitoring Tool (TMT) developed in 2020 by the Eurasian Harm Reduction Association (EHRA)²³ that was tested in 2021 in nine CEECA countries: Belarus, Georgia, Kazakhstan, Kirgizstan, Moldova, North Macedonia, Serbia, Tajikistan and Montenegro. Based on the results of the pilot project, the TMT was revised and finalised in 2022²⁴.

The TMT has been designed to collect and evaluate the extent to which the Government has fulfilled its commitments as stated in public documents: national strategic plan, state budgets, programme budgets, allocation letters, study reports, etc. Analysis involves tracking the progress of the health system domains and programmatic areas (see Figure 3).

Figure 3. Analytical scheme



²³ Serebryakova L. Benchmarking Sustainability of the HIV Response in the Context of Transition from Donor Funding. A Methodological Guide. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2020.

²⁴ L. Serebryakova. Assessing Public Commitments to Ensure Sustainability of the HIV Response Among Key Populations in the Transition to National Funding. Methodological guide. – Vilnius: Eurasian Harm Reduction Association, 2022 <https://eecaplatfrom.org/tmt-ru/>

The assessment implementation process involved five main steps:

Step 1: Identification of data sources, national legislative and other regulatory, policy and programme reports to collect relevant data. Formation of the National Reference Group (NRG) involving state and non-state actors and representatives of key populations.

Step 2: Identifying commitments and grouping them by programmatic areas and health system domains.

Step 3: Working closely with the NRG to prioritise those commitments that stakeholders believe are most critical for achieving smooth sustainability of the programme targeting key populations.

Step 4: Data collection and analysis of the results. Completing the TMT Excel tool by entering data on the fulfilment of commitments.

Step 5: Summarising the obtained results, validating the results and findings with the NRG members, developing an assessment report, and communicating study results with a wider circle of HIV stakeholders.

National Reference Group: In accordance with the EHRA Methodological Guidance, the in-country review was carried out and led by a National Reviewer, and it was supported by a National Reference Group (NRG) created for the purpose of this assignment. The National Reviewer worked closely with the NRG to ensure the transparency of the assessment process by agreeing on the choice of commitment and the approach used to assess the fulfilment of the commitments and to validate the results and assessment report.

The NRG was composed of 15 members representing the state (NCDC; AIDS Centre – 2 persons) and non-state actors – civil society organisations involved in HIV service delivery to key population groups, representatives of key constituencies (12 persons) and academia (1 person). Per the TMT guidance, key population communities or organisations representing those made up the majority of the NRG. It should be noted that in the previous TMT assessment, representatives from the Ministry of Health and the Ministry of Finance were involved in the NRG. However, in the 2023 assessment, no representatives from the ministries were enrolled in the NRG. The Ministry of Finance was not contacted as no contributions were expected to the process. The Ministry of Health was formally invited by the National Reviewer²⁵. The Ministry of Health opted not to designate its representative in the NRG; however, the formal response received from the MoIDPLHSA²⁶ conveyed a clear message that the Ministry was supporting the transition monitoring process and expressed its readiness to provide any data that would be necessary for the assessment.

Data analysis and presentation: The current assessment covers the period of 2020–2022. Per the standard methodological guidance, commitments and corresponding indicators with targets were entered into the data spreadsheet. Then, the actual results for each commitment were compared to the targets set for the given year. For each indicator, achievement progress

²⁵ NRG Membership invitation letter sent to the MoIDPLHSA; Registration N886855 22.08.2023

²⁶ Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. Letter# MOH 3 23 00990316; signed by Ms. Irina Javakhadze. 20 September 2023.

was measured as a percentage (Commitment compliance score); while analysing health system domains, arithmetical means of all commitments under the given health system domain were calculated and entered as a final score. The fulfilment of the government's commitment per programmatic area for each key population was assessed. In addition, representatives of CSOs and key population groups were interviewed to reflect their perception in terms of transition sustainability. Per the guidance, the NRG was allowed to change the final score if there were well-grounded arguments and changes were justifiable.

Prioritisation of commitments: Per the TMT guidance, commitments that were not specific to KPs (such as blood safety or elimination of mother-to-child transmission of HIV, etc.) were excluded from the initial list of commitments, given no foreseeable risk to sustainability. The list of KP-specific commitments was shared with the NRG members, and they were asked to consider local context and assign the priority score to each commitment per the pre-defined scoring system: “1 – not important; 2 – somewhat important; 3 – quite important; 4 – very important (must monitor); or 0 – cannot tell.” Based on the summary results and consensus reached within the NRG meeting, some commitments specific to key population groups were still considered less critical or important for monitoring the transition process.

For instance, the Government has declared its commitment to expand OAT services for PWID and gradually increase the number of those on OAT. Under this commitment, three different indicators with corresponding targets were defined in the NSP:

1. Number of individuals receiving OAT (NSP M&E. Cov 19);
2. Percentage of people who inject drugs (PWID) receiving OAT (NSP M&E. Cov 20);
3. Percentage of individuals receiving OAT who received treatment for at least 6 months (NSP M&E. Cov 21).

However, the NRG members righteously declared that since 2017, the Government has already assumed full responsibility for financing OAT for PWID, and the programme coverage has been expanded considerably. Thus, stakeholders do not anticipate any risk to sustainability, and they decided to monitor only one indicator.

Several commitments in the domain of Service Provision – an increased number of MSM, PWIDs, and SWs who were tested and know the results – were also removed as the RG believed that coverage of KPs with HIV prevention package would be sufficient to monitor the transition process. Besides, HIV testing coverage, by its operational definition, should be based on the IBBS data that have not been available for MSM, sex workers and prisoners since 2017. Even though the IBBS among PWID was conducted in 2022, the survey instrument did not ask standard questions that would enable measuring this indicator.

Several indicators specific to HIV prevention coverage among KPs were removed as they lacked baseline data and targets. These indicators are:

NSP M&E. Cov 17 – Percentage of PWIDs reporting having received a combined set of HIV prevention interventions (past three months);

NSP M&E. Cov 22 – Number of prisoners who received detox/OAT in the penitentiary system;

NSP M&E. Cov 24 – Percentage of MSM reporting having received a combined set of HIV prevention interventions (past three months);

NSP M&E. Cov 28 – Percentage of SWs reporting having received a combined set of HIV prevention interventions (past three months).

As described below in the report, there were several commitments about conducting studies and generating research-based data for informed decision making. Out of eleven commitments defined in the NSP, only five that were very specific to KPs, including PLHIV, were prioritised and monitored. The commitments that were considered less critical to transition monitoring and were not prioritised include the following:

NSP M&E HIS.64 – IBBS among prisoners;

NSP M&E HIS.65 – HIV vulnerability and size estimation study among children living and working in streets;

NSP M&E HIS.66 – HIV vulnerability among the migrant population;

NSP M&E HIS.67 – IBBS among youth;

NSP Res.70 – Conduct research to assess engagement in HIV care;

NSP Res.71 – Conduct a survey on health service accessibility.

Most of these studies were planned to take place in 2020–2021, during the COVID-19 pandemic, which might explain the delay in realising these objectives.

As a result of the prioritisation process, out of 43 initially identified commitments, 34 were prioritised and analysed. The disaggregation of prioritised commitments by health domains is shown below:

- Impact commitments – 6 (and 90-90-90 indicators - 4)
- Financing commitments – 6
- Governance commitments – 6
- Service provision – 13
- Drug, supplies and equipment commitment - 1
- Data and information systems commitment - 6
- Human resources commitment - 1

For better visualisation, a standard **Progress Scale** showing the results in a colour-coded manner was applied per the methodological guide.

Table 5. The Progress Scale for visualisation of the results

<i>Definition of Sustainability</i>	<i>Description</i>	<i>Completion Percentage</i>	<i>Colour code</i>
Significant progress	Significant progress in meeting commitments compared to planned indicators and/or target values	>85–100%	Green
Substantial progress	Substantial progress toward meeting commitments compared to planned indicators and/or target-values	70–84%	Light green
Average progress	Average progress toward meeting commitments compared to planned indicators and/or target values	50–69%	Yellow
Moderate progress	Moderate progress toward meeting commitments compared to planned indicators and/or target values	36–49%	Orange
Fairly low progress	Insignificant progress toward meeting commitments compared to planned indicators and/or target values	26–35%	Dark orange
Low progress	Low progress toward meeting commitments compared to planned indicators and/or target values	<25%	Red

Limitations: The assessment may have certain limitations. Prioritisation of government commitments has been done by the National Reviewer in collaboration with NRG. Thus, to some degree, the selection can be considered arbitrary and biased. Most commitments were taken from the National HIV Strategic Plan 2019–2022, which, though approved by the CCM, was not formally endorsed by the Government (NSPs for 2016–2018 as well as 2022–2023 have been approved by the Prime Minister)²⁷. This may raise the question of whether the government perceived these documents as legally binding and whether these documents should guide the national decision-making process. The comparison between the waves of assessments was made for the domains as a whole to give a general overview of progress. It should be noted that the commitments under the health systems' domains and programmatic areas for the first and the second assessments were not identical, and notably, they were prioritised differently.

Data quality is not equally high for all indicators. Most data under the health system domain 'Financing' were based on the AIDS Spending Matrix that has been submitted to the UNAIDS Global AIDS Monitoring tool by the Ministry of Health on an annual basis. During the data analysis, some discrepancies and unreliable data were spotted in the funding matrix, which raises concerns about the quality, completeness and accuracy of some findings under the Financing domain. In general, wherever data quality concerns arise, they are specified in the relevant part of the report. Due to the limited scope and timeframe of the transition monitoring assessment exercise, exploring genuine reasons for discrepancies was not possible.

27 <http://www.georgia-ccm.ge/wp-content/uploads/HIV-strategy-2016-2018-GEO1.pdf>

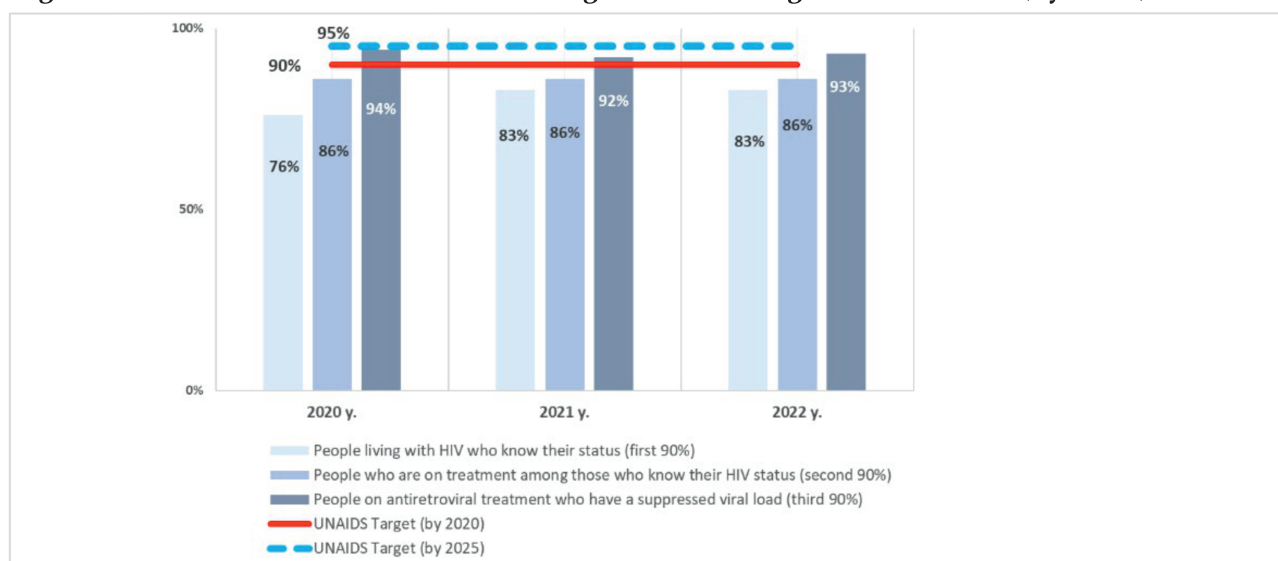
7. Findings

Impact Commitments

Impact commitments found in the NSP included indicators about HIV prevalence among the general population as well as in each key population group, AIDS-related mortality and HIV incidence rate. The UNAIDS 95-95-95 indicators were also considered as impact indicators. Due to the absence of updated IBBS data among MSM and FSWs, the results of the latest surveys and HIV programme data for these two KPs were used. The 2022 IBBS among PWIDs showed that HIV prevalence has been contained (0.9%) among problem drug users in the country. Routine surveillance data from the AIDS Centre shows that the country successfully managed to contain HIV prevalence among the general population and reduce AIDS-related mortality. HIV incidence has remained low; however, it was slightly higher than the target set for 2022.

The Georgian ART programme has been recognised as one of the best in the region due to its high coverage, good retention and high viral suppression rate²⁸. Georgia was one of the first countries to initiate the WHO Treat All strategy in 2015 and, since then, has been offering uninterrupted ARV treatment to all individuals regardless of their CD4 count. While the country has traditionally had substantial achievement in the 2nd and 3rd indicators of the HIV care continuum, it lagged behind the target of diagnosing 90% of all people living with HIV (1st indicator). This result has noticeably improved over the last three years, from 76% in 2019 to 83% in 2021 and 2022²⁹; however, this improvement may not be a genuine sign of enhanced HIV case detection, but it can rather be attributed to reducing the denominator (the estimated number of PLHIV in Georgia generated by SPECTRUM was adjusted several times; it decreased from 11,000 in 2017 to 9,100 in 2019 and 8,400 in 2022)²⁹.

Figure 4. HIV care continuum: Achieving UNAIDS targets of 90-90-90 (by 2022)²⁹



²⁸ Georgia Brief 2020. The Global Fund Programs in Georgia. MoIDPLHSA. NCD/CPH. The Global Fund

²⁹ Infectious Diseases, HIV/AIDS and Clinical Immunology Research Centre. Program data. Provided by Dr. Nikoloz Chkhartishvili; Dr. Akaki Abutidze. Email communication. April 2023

As for the treatment coverage and treatment success indicators, Georgia has one of the best results in the region: 86% of all diagnosed PLHIV are on ARV, and of those, more than 90% (94% in 2020, 92% in 2021 and 93% in 2022)²⁹ have achieved viral suppression. The results of the 3rd indicator are close to the targets set by UNAIDS for 2025 – 95% of people on ARV have a suppressed viral load.

Table 6. Impact Commitments

IMPACT COMMITMENT	Commitment Compliance Indicator	Final Score of Commitment Compliance	Final Score of Impact Commitments
<i>Impact 1: Contain HIV prevalence among the general population under 500 per 100,000 population by 2022</i>	100%	100%	97%
<i>Impact 2: Contain AIDS-related mortality below 2 deaths per 100,000</i>	100%	100%	
<i>Impact 3: Contain HIV prevalence among MSM under 25% by 2022</i>	100%	100%	
<i>Impact 4: Contain HIV prevalence among SWs under 2% by 2022</i>	100%	100%	
<i>Impact 5: Contain HIV prevalence among PWIDs under 3% by 2022</i>	100%	100%	
<i>Impact 6: Improve prevention of HIV transmission (HIV Incidence rate per 1,000 population)</i>	84%	84%	
<i>Impact 7: People living with HIV who know their status (first 90%)</i>	92.2%	92.2%	
<i>Impact 8: People who are on treatment among those who know their HIV status (second 90%)</i>	95.6%	95.6%	
<i>Impact 9: People on ARV who have a suppressed viral load (third 90%)</i>	103.3%	103.3%	

Conclusion: The final average score for fulfilling impact commitments shows that significant progress was achieved in terms of realising impact commitments. Georgia has successfully managed to contain the spread of the HIV epidemic not only among the general population but also among key populations. However, recent data about the high level of HIV among transgender people requires special attention. In addition, traditionally, Georgia has been very successful in providing ARV treatment to all PLHIV regardless of CD4 count, and the vast majority of people on ARV achieve viral suppression. This contributes to containing AIDS-related mortality under 2 deaths per 100,000 populations per year.

Health Domain: Financing

Average commitment compliance score: 82% — substantial progress has been achieved in terms of the financial sustainability of HIV interventions.

Under the health system domain – Financing, in total, six commitments were prioritised and monitored. Data about HIV/AIDS expenditure was based on the GAM funding matrix tool prepared by the MoIDPLHSA in partnership with a wide range of HIV stakeholders: state agencies, medical institutions, civil society organisations, UN agencies, donor organisations and others on an annual basis. In addition, data about the state vertical programmes on HIV and TB, as well as state budgets, Medium Term Expenditure Framework (MTEF), etc., were obtained from the Ministry of Finance and Ministry of Health websites to analyse public spending for HIV response.

Table 7. Health system domain: Financing – Commitment compliance summary

Financing Commitments	INDICATOR	End line target 2022	Actual 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance	Final Score of Impact Commitments
Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response						82%
Ensure full budgetary commitment and allocative efficiency for national HIV response	The share of public spending out of the total spending for HIV national response	96%	80%	83%	91%	
Ensure full budgetary commitment and allocative efficiency for national HIV response	% of public spending on HIV targeting KAPs	>10%	>10	100%	100%	
Ensure state funding to support HIV related researches, including second-generation studies (Population Size Estimation studies, IBBSs among KAPs)	The share of public spending out of the total spending on IBBSs & PSE among KAPs (%)	75%	0%	0%	0%	
Conduct HIV program allocative and technical efficiency study to inform HIV strategic planning during the transition period. Conduct HIV/AIDS Spending data analysis on an annual basis	Analyzing data on AIDS spending by each KAP to assess the allocative efficiency	Yes	Yes	100%	100%	
At least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations and/or highest impact interventions within a defined epidemiological context	At least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations and/or highest impact interventions within a defined epidemiological context.	50%		Yes	100%	
At least 75% of additional co-financing contributions must be invested in disease program interventions.	At least 75% of additional co-financing contributions must be invested in disease program interventions.	75%		Yes	100%	

The government of Georgia has declared its commitment to sustain and further scale up HIV/TB strategic interventions that have been originally fully or partially supported by the Global Fund. There is ample evidence that shows the Government's commitment has been substantiated with increased investments in disease programmes. Since 2015, the GoG has been covering 100% of costs for FLDs. The share of state spending on second-line drugs is rising (from 43% in 2020 to 70% in 2022). AIDS Spending under the category 1.2 Antiretroviral treatment shows that 77% of all spending was paid by the state (USD 1.7 million), and the share of the Global Fund was less than 23%³⁰.

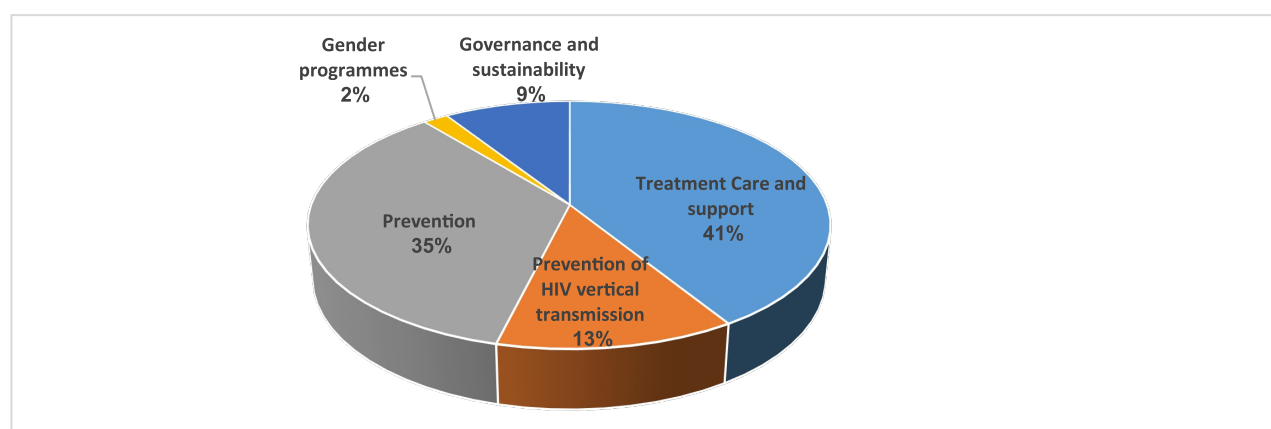
The State is the sole source for financing specific HIV-related laboratory monitoring (CD4 count, viral load, etc.) as well as for opportunistic infections (OI) prophylaxis and treatment for PLHIV and palliative care. The GoG is fully responsible for clinical and laboratory monitoring for the PrEP Programme. Since 2017, the Government has already sustained and substantially scaled up OAT for PWIDs, enrolling more than 50% of all opioid-dependent drug users in Georgia. Over the last 3 years, the Government's share of total AIDS spending has ranged from 78% (in 2020) to 85% (in 2021)³⁰.

³⁰ AIDS Spending Matrix. UNAIDS/Global AIDS Monitoring Report. Prepared by MoIDPHLSA. 2022

Table 8. AIDS Spending data 2020–2022³⁰

AIDS Spending by two major financial sources: Public funding & the Global Fund			
Total AIDS Spending	Total Public (USD)	The Global Fund (USD)	Total all financial sources (USD)
2022	\$14,052,301	\$3,373,626	\$17,511,483
	80%	19%	
2021	\$13,974,325	\$2,462,747	\$16,437,072
	85%	15%	
2020	\$12,449,435	\$2,812,934	\$15,892,206
	78%	18%	

In 2022, the largest share of government funding was dedicated to treatment, care and support services for people living with HIV (41%). The state started investing more in HIV prevention, and in 2022, more than one third of the total Government spending on HIV was allocated to cover the costs of HIV prevention interventions, including those implemented by CSOs for key population groups. The Government started investing in HIV testing services targeting key populations.

Figure 5. Government spending on HIV/AIDS in 2022 by strategic directions³⁰

In 2019, the government approved HIV prevention service standards for key populations and started funding key population services under the State HIV Programme budget based on the Results-Based Funding (RBF) model. The HIV NSP 2023–2025 states that to meet the GF co-financing requirements, HIV counselling and testing (HCT) for PWIDs and FSWs were transitioned to state funding in 2021, and since 2022, HCT for MSM and transgender people has been funded through the state HIV Programme. However, most representatives from civil society organisations interviewed do not believe that state funding is a good 'replacement' of the GF funding given that under the state HIV programme, only costs related to HIV testing are covered; however, the state does not provide funds to cover other critical costs of HIV services, such as psycho-social support services, awareness raising interventions, legal assistance, etc. Additionally, the state does not provide any funds to civil society organisations to cover programme management and administration costs, organisational strengthening, professional development costs, etc.

One of the commitments of the government is increasing the share (%) of public spending on HIV targeting KPs³¹. However, the target (>10% by the end of 2022) seems to be extremely low and does not encourage the government to invest more. In 2022, around 35% of all public spending on HIV is categorised under the section HIV prevention among KPs. This includes OAT, which accounts for a substantial portion (63%) of all public spending on HIV prevention (over USD 3 million in 2022); besides, public spending for prevention includes USD 1.1 million, which is categorised under 'Synergies with health sector'. However, civil society representatives do not clearly understand what types of services are reported in this spending category. Evidently, spending in only these two subcategories is significantly higher than the end-line target value. Thus, this indicator may not be a good measurement of financial commitments and requires revision.

Most findings for four commitments selected under this domain rely on AIDS spending data submitted to UNAIDS by the MoIDPLHSA. Traditionally, spending reports have been prepared by the Ministry through engaging all relevant actors. However, there are some concerns that data collected may not be categorised by programmatic areas in a precise and accurate way. For instance, the previous TMT report³² states that some public spending in the GAM funding matrix was not clear to civil society (such as spending USD 106,383 for HIV prevention work among transgender persons or procurement of condoms by public funds (USD 110,926) in 2019). Similar to the previous observation, some uncertainties in spending data were also found during the current study. The 2022 AIDS spending data indicate that the State spent some amount on certain activities about which the NRG members were not informed. For instance, the report says that:

- More than USD 360,000 was spent by the state on condoms (spending matrix, 3.2), while civil society organisations distributing free condoms to KPs have never received condoms procured through the state budget.
- The state paid USD 97,426 for prevention, promotion of testing and linkage to care programmes for transgender persons (spending matrix 3.8), though the transgender community is not aware of public spending for this population in 2022.
- The state paid USD 92,160 for PrEP for young women and adolescent girls (spending matrix 3.3.6) – this intervention is only recommended for high HIV prevalent countries with generalised epidemics, and evidently, this intervention has never been implemented in Georgia.
- The State paid USD 3,471 for PrEP for prisoners (spending matrix 3.3.5), while PrEP service has never been available in prisons.

Unfortunately, due to the limited scope and timeframe, a more in-depth analysis of AIDS spending data was not possible within this TMT mission. Given that the **health system domain** – Financing has been an important, if not most critical, domain in terms of financial sustainability of HIV services targeting KPs, special efforts should be undertaken to make the spending data publicly accessible, review the data and publish the report on the UNAIDS website only after the data is validated by stakeholders.

³¹ National HIV/AIDS Strategic Plan. 2019-2022. M&E. Indicator Fin.56

³² Tabatadze M. Georgia: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund's support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021.

Out of six commitments monitored under the domain 'Financing', two were selected from the GF 2020–2022 Allocation Letter³³. These two commitments are as follows: i) At least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations and/or highest-impact interventions within a defined epidemiological context; ii) At least 75% of additional co-financing contributions must be invested in disease programme interventions. A formal note about meeting these requirements was not published in any national documents. However, the NSP 2023–2025 says that the Georgian government was “on track to meet the co-financing and programmatic commitments it made under the agreement with the Global Fund”. This data was also confirmed during the NRG meeting, and commitment compliance scores for these two commitments were set at 100%.

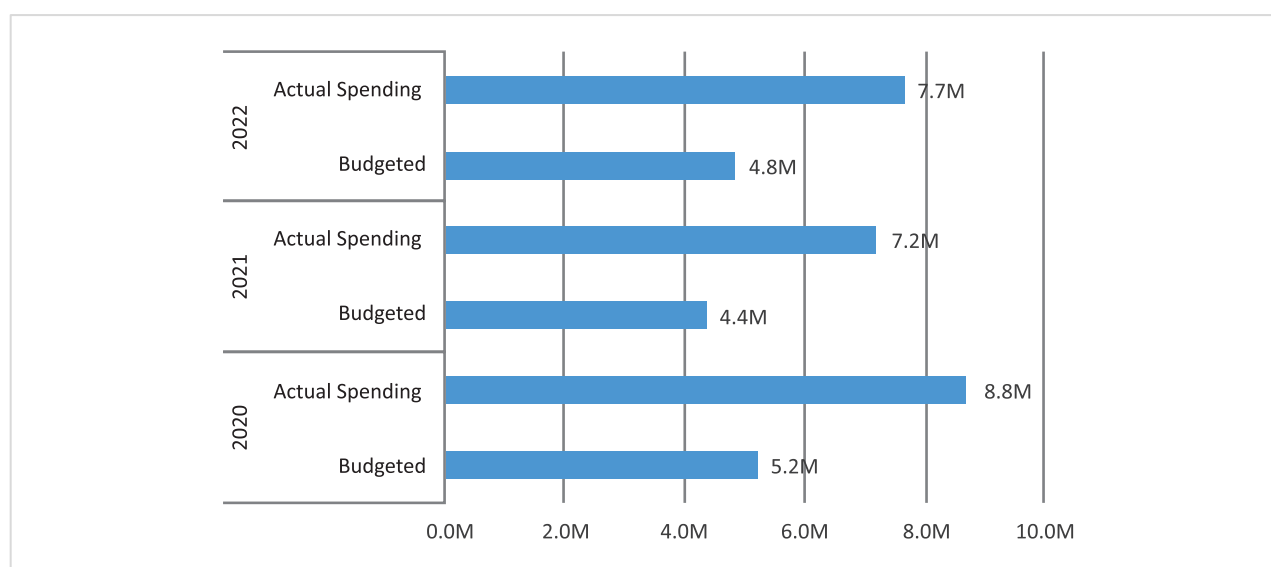
The Government of Georgia has demonstrated its commitment to the HIV/TB national response. The State budget dedicated to HIV/AIDS has been steadily increasing and will continue this trend in upcoming years. The Ministry of Health officially submitted a letter to the NRG about the budgets for HIV and TB national programmes approved in the medium-term expenditure framework (MTEF) for 2023–2027.

Table 9. MTEF: HIV and TB Programme budgets for 2023–2027³⁴

Program code	Program name	Medium term budget (US\$)				
		2023	2024	2025	2026	2027
27 03 02 06	TB management national program	6,515,152	6,628,788	7,325,758	7,916,667	7,916,667
27 03 02 07	HIV/AIDS control national program	6,060,606	6,477,273	6,893,939	7,575,758	7,575,758

Furthermore, experience shows that every year, the actual public expenditure for the HIV State Programme significantly exceeds the budgeted amounts (by 60–70%).

Figure 6. HIV/AIDS State Programme: annual budgets and actual expenditures³⁵



³³ 2020–2022 Allocation Letter to the Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs in Georgia. No:01/6413; dated 12.12.2019. Signed by the Acting Minister.

³⁴ Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. Letter# MOH 3 23 00990316; signed by Ms. Irina Javakhadze. 20 September 2023.

³⁵ Ministry of Finance of Georgia. State Budget Performance Reports. <https://www.mof.ge/en/4565>

As defined by the Global Fund allocation letter, the minimum requirement for the additional co-financing investments for the allocation period 2017–2019 (implementation period 2020–2022) was USD 3,9 million. Despite the negative influence caused by the COVID-19 pandemic, local currency depreciation and fiscal space limitations, the actual increase in the domestic funding between the three-year allocation periods (2017–2019 and 2020–2022) reached USD 9,4 million³⁶.

The country's increasing domestic investments in the diseases programme in the period 2020–2022 were focused on sustaining the following interventions:

- Universal access and high coverage with quality anti-retroviral treatment (ART) of PLHIV;
- Procurement of ARV medicines (100% of FLDs and 70% of SLDs);
- OAT services for PWID;
- The full clinical and laboratory monitoring for ARV treatment and PrEP Programme;
- Testing for HIV, hepatitis B and C and syphilis for KPs (PWID, MSM and FSWs);
- STI diagnostics and treatment for all Kps;
- ART adherence-support mobile ambulatory units;
- Procurement of infant formula for newborns of HIV-positive mothers.

Per the latest national HIV Strategic Plan (2023–2025), the Government of Georgia declares its commitment towards achieving the following targets by the end of 2025:

- HIV screening targets: the state budget will cover 100% of testing needs in 2023–2025, including that for key populations;
- ART targets: The state will fully cover ART clinical and lab monitoring and 100% of FLD and up to 90% of SLD;
- HIV prevention targets:
- The state will cover 100% of the cost related to STI diagnostics and treatment for Kps;
- 100% of the cost of clinical and lab monitoring of PrEP beneficiaries;
- 100% of costs related to OAT services;
- 100% cost of infant formula procurement for new-born babies of HIV-positive mothers;
- 100% cost of Mobile ART monitoring units.

The State will start investing in providing a defined package of HIV prevention services to cover 11% and 23% of the estimated number of PWID with services in 2024 and 2025, respectively, and 22% and 38% of the estimated number of FSWs during the same years³⁷.

Conclusion: Substantial progress (with an overall commitment compliance score of 82%) has been achieved to fulfil the government's commitment to increase HIV investment and dedicate more share of public spending on HIV prevention interventions targeting key populations. Out of six commitments, five were achieved, and only one commitment was not met: HIV surveillance studies – integrated bio-behavioural surveys and population size estimation studies among each key population have still been funded by the Global Fund without the state investment. Despite this progress, there has been a significant volume of HIV prevention interventions, particularly low-threshold harm reduction and prevention services run by civil society or community-based organisations for KPs that remain heavily dependent on the availability of donor funding.

³⁶ GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023-2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia. Tbilisi. 16 February 2022

³⁷ GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023-2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoIDPLHSA) of Georgia. Tbilisi. 16 February 2022

Health Domain: Drugs, Supplies and Equipment

Commitment compliance score – 100% – significant progress.

Only one commitment was formulated under this domain in the NSP 2019–2022. The Government declared its commitment to ensuring an uninterrupted supply of quality ARV drugs. The commitment is measured as a percentage of healthcare facilities reporting no stockouts of ARV medicines. Georgia uses the Global Fund pooled-procurement mechanism (wambo.org) for ARVs that also guarantees the quality of drugs. By 2022, the State covered 80% of all ARV-related costs, with 20% covered through the GF³⁰. The score of this commitment is 100%, as no stock outs of ARV were reported by any health facilities in 2020–2022.

Table 10. Health system domain: Drugs and Supplies – Commitment compliance

Drugs and supplies	INDICATOR	End line target 2022	Actual 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance	Final Score
<i>Commitment: uninterrupted supply of ARV</i>						100%
<i>Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)</i>	<i>Percentage of healthcare facilities reporting no stock-outs of ARV medicines</i>	100%	100%	100%	100%	

The government is closely watching the level of stocks not only for ARV drugs but also for some other HIV prevention commodities. The latest NSP states that there were a few episodes of stockouts of harm reduction commodities (e.g., needles and syringes) in 2020 that were undoubtedly caused by external factors, namely the COVID-19 pandemic and restrictions in transportation and international shipping³⁸. However, the government showed responsiveness, and as a short-term solution to this unpredictable challenge, the NCDC procured safety stocks locally through a regular and state-consolidated tendering system. In general, civic society representatives see no threat to ensuring an uninterrupted supply of lifesaving ARV drugs or methadone; however, concerns do exist about other HIV prevention commodities (non-medical supplies, such as condoms, lubricants, syringes, needles, etc.) for KPs considering that the government seems to be reluctant to invest in harm reduction supply materials.

Conclusion: The government demonstrates significant progress in meeting its commitment to ensure universal access to ART and safeguard the uninterrupted supply of high-quality lifesaving drugs. Similarly, the Government ensures continuous supplies of substitution drugs, HIV laboratory consumables and other reagents needed for treatment monitoring. No stockouts in these supplies have been observed. Nevertheless, some concerns still persist among civil society that the provision of HIV prevention materials and other supplies is heavily reliant on donor funding with no clear plan for transitioning.

³⁸ GEORGIA HIV NATIONAL STRATEGIC PLAN. 2023-2025. Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoIDPLHSA) of Georgia. Tbilisi. 16 February 2022

Health Domain: Service Delivery

Commitment compliance score – 90% – significant progress.

Improved service coverage is one of the most critical areas for sustainability. Service delivery commitments that were prioritised by the NRG can be grouped into five thematic sub-domains:

- HIV treatment cascade (with corresponding five indicators);
- HIV prevention among PWIDs (measured by four indicators);
- HIV prevention among MSM (two indicators);
- HIV prevention among FSWs (one indicator);
- HIV prevention among prisoners (one indicator).

However, per the EHRA TMT guide, HIV case detection and treatment-cascade-related commitments were analysed under the section **Impact**. Thus, in total, eight indicators were monitored under the Service Delivery domain.

HIV national response in Georgia has been successful in providing HIV prevention, treatment and care services to PLHIV and KPs. The commitment compliance scores for most sub-domains show that significant progress has been evidenced during 2020–2022. Treatment and care services were further strengthened with increased coverage and improved outcome and impact indicators. Impressive results were found in terms of expanding OAT for PWIDs and community-based PrEP among the MSM population.

Table 11 below presents commitment compliance calculated for each commitment, as well as summary results for each sub-domain and the final score of all commitments for the Service Delivery domain.

Table 11. Health system domain: Service Delivery – Commitment compliance summary

Commitments - Health system domain: Service delivery	INDICATOR	End line target 2022	Actual 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance	Overall Score of Commitment
Total Score - Service Coverage						87.2%
HIV Prevention among PWIDs						93.3%
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among PWID: Increase coverage of preventive services	Number of needles and syringes distributed per PWID per year	140	87	61%	80.0%	
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among PWID: Increase coverage of preventive services	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	>90%	93%	103.2%	103.2%	
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among PWID: Increase coverage of preventive services	Percentage of PWIDs reporting having received a combined set of HIV prevention interventions (last year)	75%	69%	90.0%	90.0%	
Increase coverage of prevention services: Expansion of OST services	Number of individuals receiving OST	11000	17646	138.6%	100.0%	
HIV Prevention among MSM						93.3%
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among MSM: Increase coverage of preventive services	Percentage of MSM reporting having received a combined set of HIV prevention interventions (last year) (Tbilisi)	60%	65%	87.1%	87.1%	
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among MSM: Increase coverage of preventive services	People receiving pre-exposure prophylaxis	1000	958	99.6%	99.6%	
HIV Prevention among FSWs						82%
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among FSW: increase coverage of preventive services	Percentage of SWs reporting having received a combined set of HIV prevention interventions (last year) Tbilisi	60%	56%	82%	82%	
HIV Prevention among prisoners						56%
Increase coverage of prevention services among prisoners	Percentage of prisoners that have received an HIV test during the reporting period and knew their HIV test results	75%	74%	56%	56%	

HIV Prevention among PWIDs: Commitment compliance score – 93.3%. The Government declared its commitment to improve HIV prevention, case detection and timely progression to care and treatment services for PWIDs. This commitment was monitored by several indicators, including the PWID's coverage with prevention package, HIV testing coverage, the number of syringes and needles distributed, OAT coverage and safe injection practices. The 2022 IBBS survey data and harm reduction programme data were used to assess the progress.

The score of one indicator – “number of needles and syringes distributed per PWID per year” – was adjusted by the NRG, and the arithmetic mean (61%) was upgraded (to 80%) after discussing the context. The UNAIDS guidance on Global AIDS Monitoring 2022³⁹ states that if the number of syringes distributed per person per year is below 100, the coverage is low, and the coverage is considered high if this number exceeds 200 per PWID per year. At the same time, the same source highlights that “Countries that have legalised sales of needles and syringes without a prescription may appear to have artificially low coverage with this indicator.” This argument applies to Georgia as syringes and needles are accessible through pharmacies without a prescription at a very low price; thus, it is highly likely that some PWIDs choose to buy syringes from pharmacies rather than visit HIV programmes. Over the last few years, Georgia has made efforts to diversify channels for distributing needles and syringes (through fixed sites, outreach and vending machines), and only in 2022, almost 4 million (3,970,248) syringes and needles were distributed by the GHRN organisations, and nearly half a million (468,616) needles and syringes were disbursed to PWIDs through vending machines. Therefore, the number of syringes distributed per PWID per year has increased from 70 in 2020 to 87 in 2022 (a 25% increase). Consequently, the NRG believed that the country had made substantial progress and set the score at 80%. Nevertheless, the NRG members agreed that stakeholders should not fall into complacency and should continue improving the coverage in the upcoming years.

The summary score of all commitments related to HIV services targeting PWIDs was set at 93.3%, and it reflects the significant progress that has been achieved in this programmatic area: coverage with a combined set of HIV prevention packages was increased, more syringes and needles were distributed in 2022 compared to any other year in past, and OAT service has been expanded covering more and more opioid-dependent people every year. Though delayed, the IBBS survey and PSE among PWIDs were successfully completed, generating reliable, evidence-based data about this group.

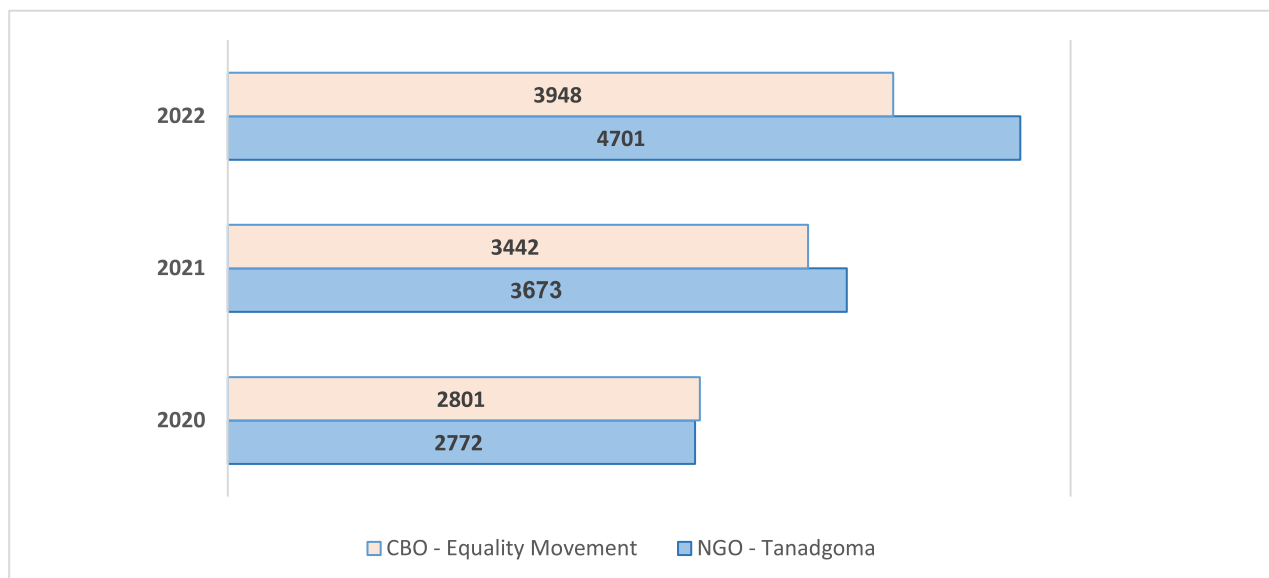
HIV prevention among MSM: Commitment compliance score – 93.3%. MSM have been most affected by the HIV population in Georgia with the fast-growing HIV epidemic. The Government recognises the need to prioritise this group; however, public spending targeting MSM remains suboptimal, and most services are still delivered with financial support from donor organisations. Nevertheless, it should be acknowledged that lately, innovative services to scale up HIV testing (HIV self-testing and home delivery of prevention packages) and community-based PrEP have received political support (though they have been financed through the GF funds). Due to the absence of IBBS data among MSM, the HIV testing coverage indicator was not monitored. However, programme data from two CSOs working with the MSM population suggest that HIV testing coverage has been on the rise and HIV case detection has improved over the last two years. Coverage with the HIV prevention

³⁹ Global AIDS Monitoring 2022. UNAIDS 2021. Guidance.

<https://www.aidsdatahub.org/sites/default/files/resource/unaids-global-aids-monitoring-2022.pdf?fbclid=IwAR1RRenMlMvL0Z17H8SwRaOvzIhrDunj6-2P67hLexr0hGjWkCgAg3BnyYE>

package also improved in 2022 (coverage indicator was overachieved in 2022; actual 65% vs target 60%); however, the coverage was low in 2020–2021 due to COVID-19, which influenced the final summary score for the three-year period. The number of MSM receiving PrEP has considerably increased from 258 in 2019 to 958 in 2022.

Figure 7. HIV testing among MSM by service provider organisations 2020–2022



Nevertheless, there has been significant progress in expanding the scope and scale of HIV prevention interventions among MSM during 2020–2022; however, the evidence is not enough to attribute this progress to the Government's determinations.

Relatively low results were found in two sub-domains: **prevention among FSWs** and **prevention among prisoners**. It should be noted during 2020–2021, due to the COVID-19 pandemic and the government-imposed restrictions, HIV prevention and testing services were downsized, and subsequently, the coverage indicators for 2020–2021 years were noticeably lower than the targets set for the given years for all KPs including that for FSWs. Due to the pandemic, conducting planned IBBS among this group was not possible, and only programme data from Tanadgoma was used for analysis. HIV testing among FSWs in 2020 and 2021 did not exceed 1535 and 1918, respectively. In 2022, testing increased by 50% (2810), reaching 43% of the estimated number of FSWs (N=6526).

HIV prevention among prisoners: Similar to other KPs, HIV testing in the penitentiary system was the lowest in 2020–2021 and tripled in 2022. Testing was scaled up, covering two thirds of all prison populations in 2022. However, the final score shows that only average progress has been achieved.

Table 12. HIV testing coverage among prisoners

	2022		2021		2020	
Total number of prisoners ⁴⁰	9,542		9,203		9,143	
Tested for HIV (number & coverage)	7,047	74%	2,212	24%	2,375	26%
Tested positive on HIV screening	12		5		9	

In general, the availability and accessibility of HIV prevention services remain relatively limited in correctional settings. Available prevention services include counselling and testing for HIV, viral hepatitis, TB screening and short-to-medium-term OAT with methadone. However, there are no condoms and lubricants available to prisoners, no access to harm reduction commodities (needles and syringes), no long-term maintenance therapy and/or no pre-exposure prophylaxis.

Conclusion: Significant progress in fulfilling the Government's commitment to increase access to HIV prevention, treatment and care services for vulnerable populations has been documented, with an overall compliance score of 87.2%. A high degree of progress was also evidenced in terms of providing HIV prevention services to PWIDs and MSM population through introducing and further expanding not only conventional services, including OAT, but also innovative prevention services (SIGMA vending machines, community PrEP, self-tests, home delivery of HIV tests, etc.). Relatively low progress was found in expanding services for FSWs and prisoners.

⁴⁰ National Statistics Office of Georgia. <https://www.geostat.ge/ka/modules/categories/132/siskhlis-samartlis-statistika>

Health Domain: Governance

Commitment compliance score – 68% average progress has been documented.

In total, six commitments have been prioritised by the NRG. Creating a detailed operational manual to support CSOs' participation in state tendering was no longer seen as critically important as all service provider organisations have already received state grants through public procurement.

Table 13. Health system domain: Governance – Commitment compliance summary

Governance Commitments	INDICATOR	Actual 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance	Final Score of Impact Commitments
<i>Ensure sustainability of response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society.</i>					68%
Create the conducive legal environment to ensure smooth implementation of HIV national response and achieve greater engagement of civil society	Georgian Criminal Code and Administrative Offences Code, Georgia Framework Law on Drugs, Psychotropic Substances, Precursors and Narcological Aids - revised; amendments adopted to remove barriers to HIV& harm reduction services	No	0%	0%	
Support development and enforcement of the Four-pillar Drug Policy, Anti-Drug Strategy, and Action Plan	The 4-pillar Drug Policy, Anti-drug strategy and 3-year Action Plan developed and approved by the Government	Yes	100%	100%	
Create the conducive legal environment to ensure smooth implementation of HIV national response and achieve greater engagement of civil society	Review HIV/AIDS State Law; development and adoption of corresponding bylaws	In Progress	80%	80%	
Create enabling environment for CSO engagement in HIV national response	Barriers and opportunities for CSOs/CBOs to satisfy the state procurement requirements identified	Yes	80%	80%	
Publish HIV programmatic and financial reports to make them accessible on public domains	Publishing HIV programmatic and financial reports to make them accessible on public domains	Partially	50%	50%	
Monitor the progress towards implementation of NSP by external monitoring committee/community monitors	Monitoring the progress towards implementation of NSP by external monitoring committee/community monitors	Yes	100%	100%	

Revision of drug legislation towards decriminalisation: One commitment refers to revising existing, punishment-based drug legislation, which criminalises drug use and limits the ability of HIV prevention services to operate in a safe and legitimate environment in both the civil sector and penitentiary system. No changes have been documented in 2020–2022 in terms of amending drug legislation.

Anti-drug Strategy and Action Plan: The second commitment was about the development of an Anti-drug strategy and 3-year Action Plan. This commitment was completely fulfilled: strategic documents were developed under the leadership of the Ministry of Justice and are accessible on public domains⁴¹. Two rounds of Action Plan for Anti-drug Strategy for 2021–2022 and 2023–2024 were prepared and approved by the Government⁴². However, to what extent these plans have been implemented and how they have supported HIV interventions among KPs is unknown. It should be noted that a local NGO – the Social Justice Centre – is currently reviewing the implementation of the strategic plan, and the report will be available on its website in the near future⁴³.

Adoption of bylaws for HIV/AIDS state law: According to the NRG members, a group of experts in 2021–2022 revised the HIV/AIDS State Law and developed corresponding bylaws that were submitted to the Ministry of Health. Apparently, the review process has been taking considerably more time than expected. Thus, the deadline for adopting the bylaws was not met, but given that all regulatory documents had already been prepared, the NRG decided to set the final score at 80%.

⁴¹ Anti-drug Strategy. Ministry of Justice. <https://justice.gov.ge/files/tJuJnhoQsvwS.pdf>

⁴² Action Plan for Anti-Drug Strategy for 2023-2024. Ministry of Justice <https://justice.gov.ge/files/MB5RkSywVIVq.pdf>

⁴³ Social Justice Center <https://socialjustice.org.ge/en>

Facilitated state procurement: Another commitment under the domain Governance refers to making the state procurement process more friendly and convenient to CSOs/CBOs. Examining to what extent this commitment was fulfilled was arbitrary: the NRG members agreed that there are still some challenges associated with participation in state procurement (such as somewhat complicated electronic tendering, bank guarantees, etc.); however, evidently, civil society organisations have already gained good knowledge and skills on tendering procedures as there have been tens of service contracts signed by the NCDC with civil society organisations that have successfully participated and won state tenders over the last several years. Thus, members agreed to set the commitment compliance score at 80%.

Accountability and access to public information: The state only partially completed its commitment to make HIV prevention programmatic and financial reports accessible to the public. Georgia has been collecting and analysing data, and reports are prepared on an annual basis; however, programme reports are not published on public domains for easy access to interested parties. These reports are available upon the written request. Moreover, obtaining public data from state agencies, including NCDC and MoIDPLHSA, has become more formalised than ever. The National Reviewer has had many years of experience collecting HIV-related programmatic and financial data over the last two decades and used to get the data through phone or email communication without any hassle. However, in 2023, while working on this project, she was systematically asked to submit formal requests for any data or documents (that used to be readily available on the websites of the Ministry, NCDC or CCM in the recent past). While there is no indication to conclude that the government is withholding public information, civil society should be aware that the process has become formal and prompt response may not always be guaranteed.

Monitoring the progress of NSP implementation: The NRG decided that the Transition Monitoring research studies that were supported by EHRA in 2021 and 2023 have assessed to what extent the government was fulfilling its commitments towards a smooth transition from donor funding to domestic funding. These research studies involve substantial work to measure the progress towards the implementation of national strategic plans and examine actual results against the targets set for a critical mass of national indicators. In addition, these studies are independent assessments carried out by external consultants through active engagement of community groups. Thus, these studies have addressed the need for community-led monitoring of national strategies, and it can be concluded that monitoring has been completed. However, no evidence exists that the state will sustain such community-led monitoring beyond the GF funding. Nevertheless, it should be highlighted that the government has supported the Transition Monitoring research and participated in data collection and data validation processes.

Conclusion: Based on the commitments identified and monitored, only average progress was found (68%) in terms of improving the components under the Governance domain. The most critical need that remains unmet has been existing punishment-based drug legislation that will continue posing sustainability risk, given that HIV prevention services targeting PWIDs operate in an environment where the legality and legitimacy of harm reduction services can be confronted.

Health Domain: Data and Information Systems

Commitment compliance score – average progress has been achieved, with the final score set at 58%.

Generating evidence for informed decision making has been one of the critical commitments, and to measure the fulfilment of this commitment, eight indicators were proposed in the HIV NSP 2019–2022. Of them, four refer to conducting integrated bio-behavioural surveillance and population size estimations studies among target populations: PWIDs, MSM, FSWs and IBBS study among prisoners. Based on the NRG decision, one commitment was added – Population Size Estimation study for transgender and non-binary people. The latter is important given that transgender population, for the first time ever in Georgia, was formally recognised as a key population in the 2023–2025 HIV NSP. Having reliable estimates about the population has been a critical factor in defining the scope and scale of HIV prevention among this population.

IBBS surveys and PSE studies among KPs were supposed to be carried out in 2020–2021; however, due to the COVID-19 pandemic, conducting studies was not possible. IBBS and PSE studies among two KPs – PWID and transgender and non-binary people – were successfully completed in 2022. A survey and PSE study among the MSM population has already been initiated and will be completed in 2023. Even though the IBBS survey among MSM was not completed in the three-year period under observation, the NRG decided to consider this commitment partially met, and the compliance score was set at 50%.

Table 14. Health system domain: Data and Information Systems – Commitment compliance summary

Data and information system commitments	INDICATOR	End line target 2022	Actual 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance (2020-2022)	Final Score of Commitments for the Domain
Generate evidence for informed decision making						58%
Conduct Integrated bio-behavioral surveillance studies (IBBS) among KAPs incorporating population size estimates	IBBS and PSE among PWIDs	Done	Done	100%	100%	
Conduct Integrated bio-behavioral surveillance studies (IBBS) among KAPs incorporating population size estimates	IBBS and PSE for FSWs	Done	No	0%	0%	
Conduct Integrated bio-behavioral surveillance studies (IBBS) among KAPs incorporating population size estimates	IBBS and PSE among MSM	Done	In progress	50%	50%	
Conduct population size estimation study among transgender and non-binary persons in Georgia	PSE among TG and non-binary persons	Done	Done	100%	100%	
Conduct Pre-treatment HIV drug resistance survey	HIV Drug resistance survey	Done	No	0%	0%	
Monitoring recent HIV infections using recent infection testing algorithm (RITA)	Monitoring recent HIV infections using recent infection testing algorithm (RITA)	Done (annually)	Done	100%	100%	

Under this domain, four studies were also planned: (1) a pre-treatment HIV drug resistance survey, (2) monitoring recent HIV infections using a recent infection testing algorithm (RITA), (3) an assessment of engagement in HIV care and (4) survey on health service accessibility. The NRG members have prioritised the first two studies. Unfortunately, a pre-treatment HIV drug resistance survey was not conducted, mostly due to the unavailability of financing. The RITA monitoring studies were performed as planned every year through successful fundraising from WHO and other external donors. In general, none of these studies were financed by the State.

Conclusion: Average progress has been evidenced in terms of fulfilling the commitments regarding HIV research, including IBBS surveys and population size estimation studies among KPs. Some studies were completed, though with delay. Some studies were not carried out. Most importantly, none of these studies were financed through public funds. Heavy reliance on donor funds to conduct research studies poses a threat to sustainability. More advocacy efforts will be needed to convince the government to allocate more resources to research. Moreover, CSO and community representatives are concerned that the budgets allocated for IBBS surveys and PSE studies have been noticeably reduced over the last several years after the NCDC started purchasing this service through state tenders. They believe the extremely low cost of studies does not allow competition as businesses opt out of participating in tenders. Eventually, this may jeopardise the quality of research studies in the long run.

Health Domain: Human Resources

Commitment compliance score – 25%, insignificant progress has been achieved.

No commitment in this domain was found in any formal documents issued recently. The only commitment selected was identified from the Transition and Sustainability Plan⁴⁴ for 2017–2021. This commitment aimed at integrating the TGF-supported training modules into the formal education system, as well as the development of an e-learning platform that would facilitate access to capacity-building opportunities for medical and non-medical staff employed in the HIV field, including staff from civil society organisations. The NRG members declared that very little effort was made to fulfil this commitment. The e-learning platform has been developed by UNFPA at the Tbilisi State Medical University, and e-training on sexual and reproductive health is accessible on the platform. Besides, training on HIV voluntary counselling and testing has been accessible on the AIDS Centre website. Eventually, the NRG decided to give a score of 25 % – insignificant progress.

Table 15. Health system domain: Human Resources

Human Resources	INDICATOR	Commitment Compliance Indicator	Final Score of Commitments
<i>Human resources commitment</i>			25%
Integrate HIV training modules in the undergraduate and postgraduate education system to improve access to training opportunities (including for) CSOs	Number of training modules integrated into formal education system	25%	

Conclusion: Low progress (with an overall score of 25%) was documented in fulfilling government commitments to strengthen human resources. It seems that addressing the challenges related to human resources in the health sector has not been perceived as a priority issue by the healthcare system in Georgia. At some point in time, the Government was making public announcements about the development of a policy for Human Resources in Health (HRH), the establishment of a continuous medical education system, the institutionalisation of training programmes, the creation of a functional e-learning platform, etc. However, none of these objectives have yet been realised in general in the health sector, including in the field of HIV.

⁴⁴ Georgia Transition Plan 2017-2021. Tbilisi; Curatio International Foundation, 2017.

Transition Progress in the Programmatic Area Pertinent to Key Affected Populations

In the context of the transition, meeting the commitments within the programmatic areas is considered the most critical, and it will ensure the sustainability of essential services for key populations. Considering the HIV and the country context, the following programmatic areas were analysed:

- HIV prevention among PWID;
- HIV prevention among MSM;
- HIV prevention among FSWs;
- HIV prevention among prisoners;
- HIV treatment and care.

Numbers of monitored commitments are relevant to HIV prevention for all key populations – PWIDs, MSM and FSWs. These common commitments fall under three health domains: Financing, Governance and Human Resources. For instance, within the 'Financing' domain, a total of six commitments highlight the extent to which the government has increased state investment in the HIV response, mainly focusing on the amplified share of state funding allocated for HIV prevention targeting key populations. These commitments, although not disaggregated by specific KAPs, are common for all groups. Likewise, four commitments under the domain 'Governance' and one commitment under the domain 'Human Resources' are relevant to all KPs, and disaggregation of scores by key populations is not possible. The summary scores of 'common' commitments are shown in the table below. These scores are applied while analysing commitment fulfilment progress in programmatic areas specific to each key affected population.

Table 16. Analysed commitment in the programmatic area of HIV prevention common to all KPs (PWID, MSM and SWS)

Health system domain	Commitment	Score	Summary score (average)
Financing	Ensure full budgetary commitment and allocative efficiency for national HIV response	90.9%	81.8%
	Increased share of public spending on HIV targeting KAPs	100%	
	Ensure state funding to support HIV-related research, including second-generation studies (Population Size Estimation & IBBSs among KAPs)	0%	
	Conduct HIV programme allocative and technical efficiency study to inform HIV strategic planning during the transition period. Conduct HIV/AIDS Spending data analysis on an annual basis	100%	
	At least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations and/or highest-impact interventions within a defined epidemiological context	100%	
	At least 75% of additional co-financing contributions must be invested in disease programme interventions	100%	

Governance	Create a conducive legal environment to ensure the smooth implementation of HIV national response and achieve greater engagement of civil society (revision of HIV/AIDS legislation)	80%	77.5%
	Create an enabling environment for CSO engagement in HIV national response (CSO contracting)	80%	
	Publish HIV programmatic and financial reports to make them accessible on public domains	50%	
	Monitor the progress towards implementation of NSP by external monitoring committee/community monitors	100%	
Human Resources	Integrate HIV training modules in the undergraduate and postgraduate education system to improve access to training opportunities (including for CSOs)	25%	25%

Programmatic area: HIV prevention among PWIDs

It is important to note that, apart from the four 'common' commitments under Governance, there is an additional set of two commitments specific to PWIDs. These commitments hold particular significance for this population as they involve changing punishment-based drug legislation, which creates barriers to accessing services. Consequently, a decision was made to reduce the 'weight' of the 'common' commitments. Instead of including individual scores for all four common commitments, a combined summary score of 77.5% was considered in the calculation. This resulted in an average score of 59% for the fulfilment of commitments under the Governance domain within the programmatic area of HIV prevention among PWIDs (representing average progress).

The table below illustrates the analysis of three commitments under 'Service Provision' and one specific commitment under the 'Data and Information System' domain, along with the calculated scores for each domain within the programmatic area.

Table 17. Analysed commitments in HIV prevention specific to PWIDs

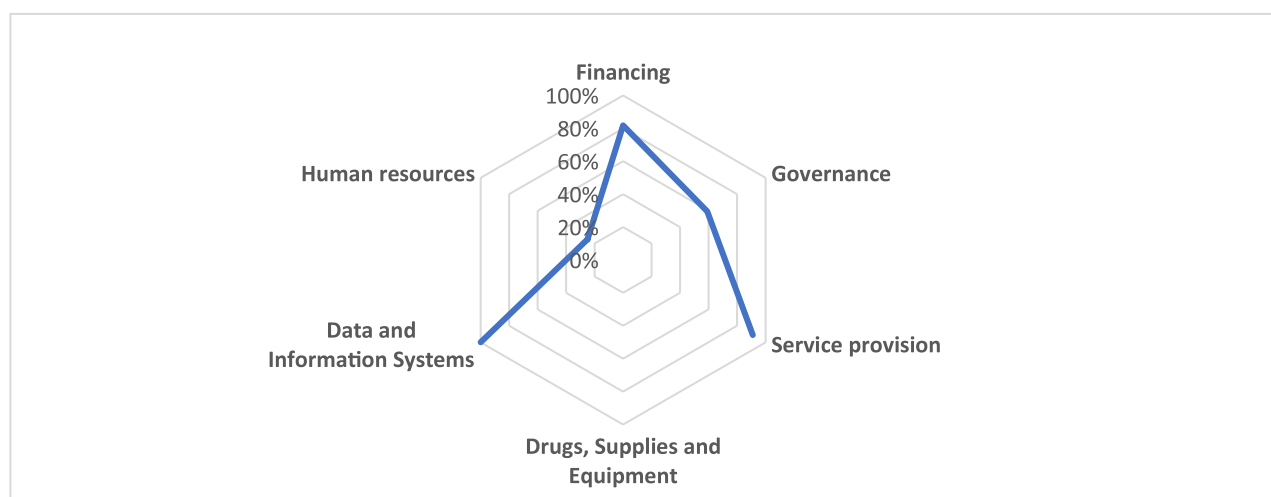
Health system domain	Commitment	Score	Summary score (average)
Governance	Create the conducive legal environment to ensure smooth implementation of HIV national response and achieve greater engagement of civil society	0%	59%
	Support development and enforcement of the Four-pillar Drug Policy, Anti-Drug Strategy, and Action Plan	100%	
	Summary average score of four 'common' commitments	78%	
Service Provision	Improve HIV prevention among PWIDs (Number of needles and syringes distributed per PWID per year)	80%	91%
	Improve HIV prevention among PWIDs (Percentage of PWID reporting the use of sterile injecting equipment the last time they injected)	103.2%	
	Improve HIV prevention among PWIDs (Percentage of PWIDs reporting having received a combined set of HIV prevention interventions (last year)	90%	
Data and information	Conduct Integrated bio-behavioral surveillance studies (IBBSS) among PWIDs incorporating population size estimates	100%	100%

Overall, progress in fulfilling transition-related commitments within the programmatic area of HIV prevention among PWIDs has been substantial, reaching a score of 71%. The lowest progress was observed in the domain Governance (59%), primarily due to the persistently harsh drug legislation that criminalises drug use and imposes disproportionately high sentences for drug-related crimes. However, in terms of service provision, there has been significant fulfilment of commitments, evident in the increased coverage of PWIDs with a comprehensive set of prevention packages and improved behavioural data, as indicated by the latest IBBSS conducted among PWIDs in 2022.

Table 18. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among PWIDs

Health System Domain	Financing	Drug and Supplies	Service Provision	Governance	Data and Information	Human Resources
Number of commitments	6	0	3	8	1	1
Progress score by domain	81.8%	NA	91%	59%	100%	25%
Final progress score for fulfillment of commitments for the programmatic area Prevention among PWIDs						71%

Figure 8. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among PWIDs



Programmatic area: HIV prevention among MSM

Alongside the common commitments, two specific commitments under the 'Service Provision' domain and one under the 'Data and Information Systems' domain were evaluated. The progress in sustaining and expanding HIV prevention services has been significant, achieving a score of 93%. This achievement is attributed to the implementation of several innovative models for delivering HIV prevention services to the MSM population. These include diversified HIV testing modalities, such as the introduction of HIV self-testing that can be delivered to homes via courier services or obtained through vending machines. Additionally, outreach efforts have expanded beyond street outreach to include extensive use of online platforms. Furthermore, PrEP service has been expanded, including that provided by the community-based organisation.

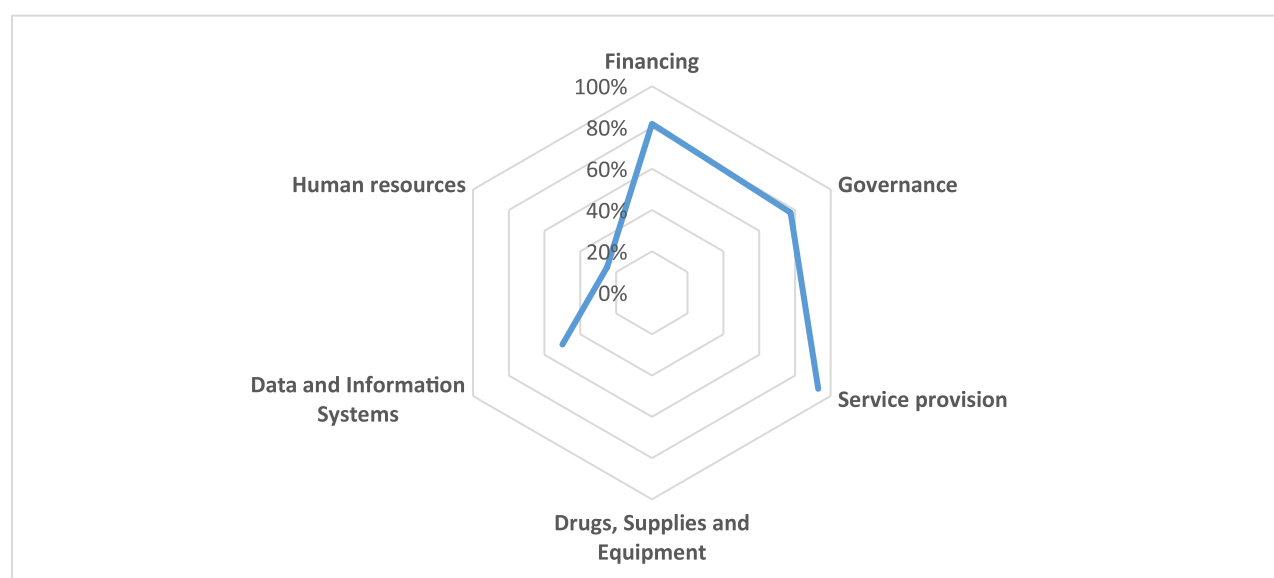
Table 9. Analysed commitments specific to MSM

Health system domain	Commitment	Score	Summary score (average)
Service Provision	Improve prevention of HIV among MSM: Increase coverage of preventive services	87%	93%
	Improve prevention of HIV among MSM: Increase coverage of MSM with PrEP	99.6%	
Data and information	Conduct Integrated bio-behavioural surveillance studies (IBBSS) among MSM incorporating population size estimates	100%	50%

As outlined earlier, the transition progress under the domains of Financing, Governance and Human Resources, with the summary scores of 82%, 77.5% and 25%, respectively, significantly impacted the overall score for fulfilling transition-related commitments within the programmatic area of HIV prevention among MSM. This resulted in an overall score set of 65%, indicating that substantial progress was achieved.

Table 20. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among MSM

Health System Domain	Financing	Drug and Supplies	Service Provision	Governance	Data and Information	Human Resources
Number of commitments	6	0	2	4	1	1
Progress score by domain	81.8%	NA	93%	77.5%	50%	25%
Final progress score for the fulfilment of commitments for the programmatic area Prevention among MSM						65%

Figure 9. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among MSM

Programmatic area: HIV prevention among FSWs

The coverage of FSWs with a combined set of prevention packages has not reached the desired target, scoring 82% for the fulfilment of this commitment. Importantly, there have not been any IBBSS and PSE studies among FSWs since 2017. Due to the outdated research data available for this group, only programme data was utilised. Overall, the absence of recent IBBSS data has constrained the analysis.

Table 21. Analysed commitments specific to FSWs

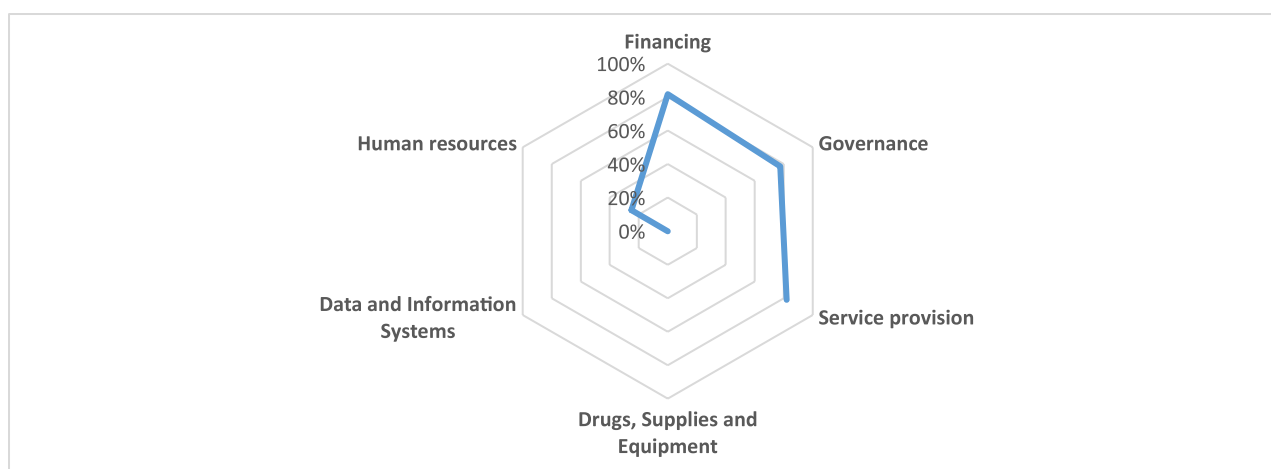
Health system domain	Commitment	Score	Summary score (average)
Service Provision	Improve prevention of HIV among FSWs: Increase coverage of preventive services	82%	82%
Data and information	Conduct integrated bio-behavioural surveillance studies (IBBSS) among FSWs incorporating population size estimates	0%	0%

Combining the transition-related commitments across all domains resulted in an overall progress score of 53%, indicating only average progress in fulfilling commitments within the programmatic area – HIV prevention among female sex workers. As outlined earlier in the report, the government has initiated investments in HIV testing among FSWs. However, the level of funding replacement was considered inadequate by the implementing organisation. Additionally, efforts to scale up services or innovate prevention strategies have been slow, apparently due to low HIV prevalence among this group.

Table 22. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among FSWs

Health System Domain	Financing	Drug and Supplies	Service Provision	Governance	Data and Information System	Human Resources
Number of commitments	6	0	1	4	1	1
Progress score by domain	81.8%	NA	82%	77.5%	0%	25%
Final progress score for the fulfilment of commitments for the programmatic area Prevention among FSWs						53%

Figure 10. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among FSWs



Programmatic area: HIV prevention among prisoners

HIV prevention among prisoners is implemented by the penitentiary system with very limited involvement of civil society organisations. The scope of prevention services is also very limited, as prisoners do not have access to prevention commodities such as condoms, needles or syringes, as well as long-term opioid agonist maintenance therapy. Essentially, HIV prevention in prisons encompasses only HIV testing and counselling with suboptimal coverage. The only commitment to increasing coverage of prisoners with HIV counselling and testing was assessed with a progress score of 56%. As for the other commitment specific to prisoners, it should be noted that the IBBS survey has not been conducted in prison settings since 2015.

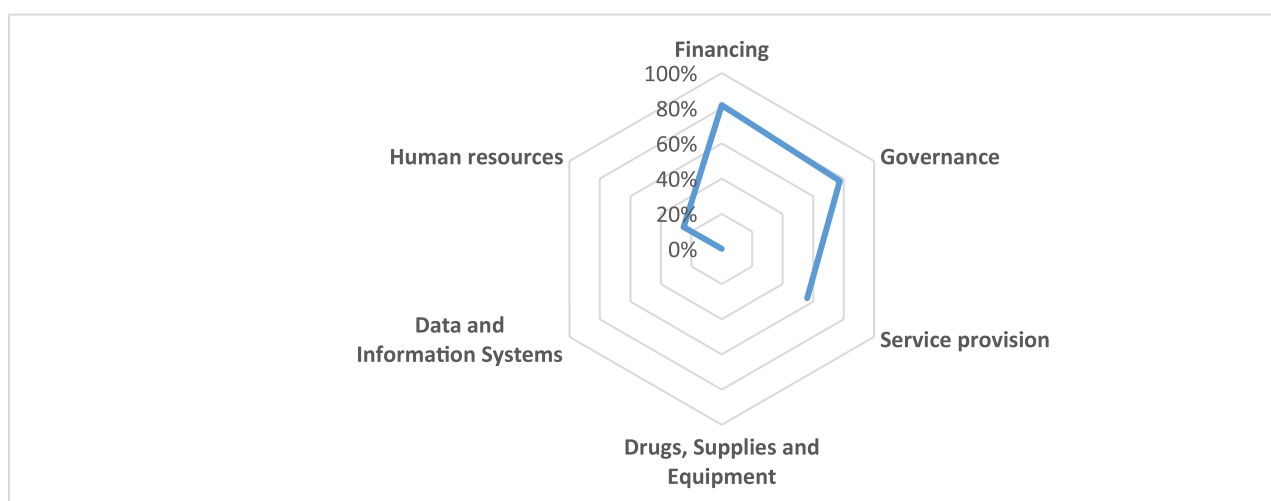
Table 23. Analysed commitments specific to the programmatic area – HIV prevention among prisoners

Health system domain	Commitment	Score	Summary score (average)
Service Provision	Increase coverage of prevention services among prisoners	56%	56%
Data and information	Conduct integrated bio-behavioural surveillance studies (IBBSS) among prisoners	0%	0%

Analysis of all transition-related commitments revealed moderate progress in fulfilling commitments within the programmatic area of HIV prevention among prisoners. It is important to note that the costs associated with HIV prevention among prisoners are covered by the state. However, the sustainability of transition extends beyond secured state funding; it also considers the scope and scale of available services that prisoners are entitled to receive within the penitentiary system. The strict drug legislation in Georgia further exacerbates the need for increasing the availability of harm reduction services, including long-term OAT for prisoners.

Table 24. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among prisoners

Health System Domain	Financing	Drug and Supplies	Service Provision	Governance	Data and Information	Human Resources
Number of commitments	6	0	1	4	0	1
Progress score by domain	81.8%	NA	56%	77.5%	0%	25%
Final progress score for the fulfilment of commitments for the programmatic area Prevention among prisoners						48%

Figure 11. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV prevention among prisoners

Transition Progress in the Programmatic Area of HIV Treatment and Care

Several specific commitments within the programmatic area of HIV treatment and care were evaluated. The fulfilment of the four commitments under the 'Service Provision' domain, as shown in the table below, indicates significant progress. There were no reported stockouts of ARV drugs in any healthcare facilities, achieving a progress score of 100%. While the government has assumed a substantial portion of the costs associated with treatment and care services in Georgia, it falls short in investing in HIV-related research. Among the two commitments under the 'Data and Information Systems' domain, only one was fulfilled: the RITA study was conducted, albeit through donor funding. The second commitment to carrying out a pre-treatment HIV drug resistance survey was not fulfilled, resulting in a score of 50% for this domain.

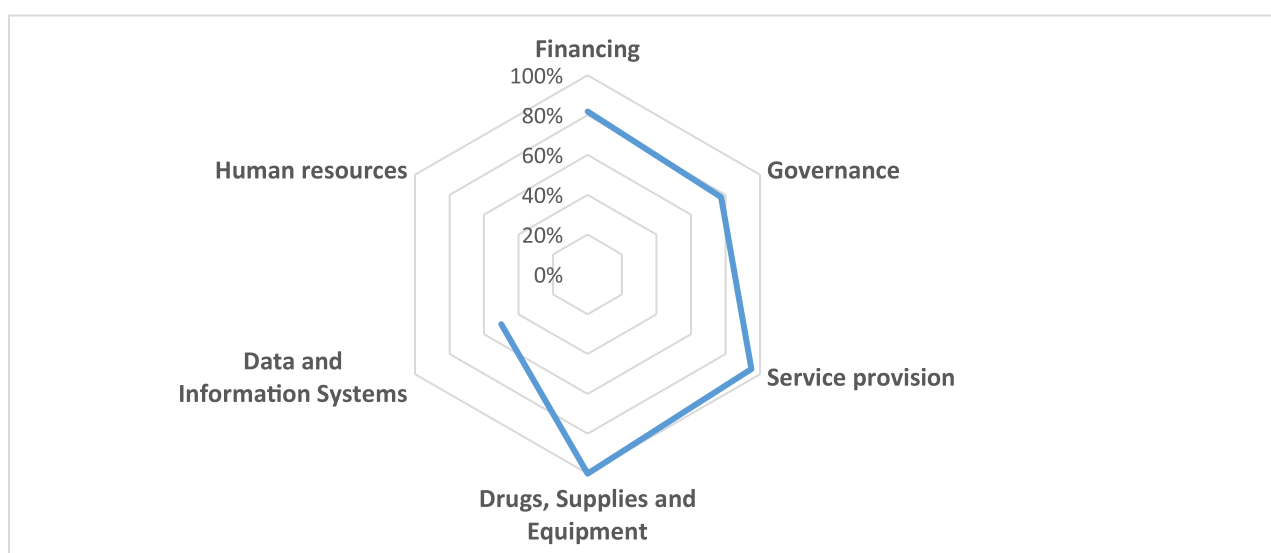
Table 25. Analysed commitments specific to HIV treatment and care

Health system domain	Commitment	Score	Summary score (average)
Service Provision	Provide HIV/AIDS clinical care services: % of adults and children diagnosed with HIV receiving antiretroviral therapy at the end of the reporting period	96%	95%
	Increase ART coverage: Percentage of people living with HIV currently receiving ART among the estimated number of adults and children living with HIV	85%	
	Treatment retention: Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	97%	
	Treatment success: Percentage of people on ART who are virologically suppressed (VL) with VL level ≤ 1000 copies/ml	103%	
Drugs, Supplies and Equipment	Percentage of healthcare facilities reporting no stockouts of ARV medicines	100%	100%
Data and Information	Conduct pre-treatment HIV drug resistance survey	0%	50%
	Monitoring recent HIV infections using a recent infection testing algorithm (RITA)	100%	

The overall progress score in the programmatic area 'HIV treatment and care', based on the selected transition-related commitments, is 81%, indicating substantial progress. It is important to note that one commitment under the 'Human Resources' domain, although relevant to all KAPs, appeared less pertinent to the programmatic area of HIV treatment. This was due to extensive on-the-job training provided to medical staff in the field of HIV/AIDS facilitated by the excellent collaboration between the National AIDS Centre and other leading universities in Europe and the United States. Therefore, this commitment was considered irrelevant under this programmatic area and was excluded from the calculation.

Table 26. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV treatment and care

Health System Domain	Financing	Drug and Supplies	Service Provision	Governance	Data and Information	Human Resources
Number of commitments	6	1	1	4	1	0
Progress score by domain	81.8%	100%	95%	77.5%	50%	NA
Final progress score for fulfilment of commitments for the programmatic area HIV Treatment and Care						81%

Figure 12. Progress in fulfilling transition-related commitments by health system domains within the programmatic area – HIV treatment and care

The overall transition progress across programmatic areas: The overall transition progress across programmatic areas in Georgia shows varying degrees of fulfilment for prioritised transition-related commitments. Ranging from moderate progress, as seen in the programmatic area of HIV prevention among prisoners (48%), to substantial progress observed in two areas: HIV treatment and care, scoring 81%; and HIV prevention among PWIDs, scoring 73%. The differences in progress scores across programmatic areas targeting KAPs primarily stem from varying levels of achievements in expanding the scope and scale of HIV services tailored to key affected populations. Additionally, the final scores were influenced by disparities in conducting IBBS and PSE studies among KAPs, ranging from 0% for FSWs and prisoners to 50% among MSM and 100% among PWIDs.

Table 27. Overall progress in the fulfilment of the selected transition-related commitments by programmatic areas

Programmatic area		Overall progress
HIV prevention among KAPs	HIV prevention among PWIDs	73%
	HIV prevention among MSM	65%
	HIV prevention among FSWs	53%
	HIV prevention among prisoners	48%
HIV treatment and care		81%

Given the importance of transition assessment for the HIV response, especially in HIV prevention, additional data was analysed to discuss transition challenges in programmatic areas related to HIV prevention among KAPs.

In the recent past, most prevention services largely relied on the Global Fund, although, over the last five years, the share of state funding for HIV prevention has been on the rise. In June 2020, the government, for the first time, contracted a civil society organisation under the public fund – Georgian Harm Reduction Network – to cover HIV testing services targeting PWID. In 2021, state funding was expanded to another CSO – Centre Tanadgoma – to support HCT among SWs, and in 2022, the government contracted a CBO Equality Movement to finance HIV testing for the MSM population.

Table 28. State funding for KP through contracting local CSOs – 2020–2022 (in Georgian Lari and USD)⁴⁵

KP	Local CSO contracted by the State	2020 Year (July-Dec)	2021	2022
PWID	Georgian Harm Reduction Network	323,166 ₾	654,532 ₾	830,809 ₾
		\$124,775	\$203,271	\$284,524
MSM	Centre Tanadgoma		38,436 ₾	80,234 ₾
SWs			\$11,937	\$27,477
MSM	Equality Movement			39,894 ₾
				\$13,662
All KPs	TOTAL	\$124,775	\$215,207	\$325,663

As shown in Table 28, the volume of state funding for HIV prevention services targeting key populations has considerably increased from 2020 to 2022 (by 160%), which is clearly a positive message from the government. However, stakeholders are concerned that state funding covers only the costs related to HIV counselling and testing, but a substantial volume of prevention services still remains dependent on donor funding. Respondents interviewed feel that some components of prevention strategies are not prioritised by the Government as the government has never procured HIV prevention commodities (syringes and other injecting paraphernalia, condoms and lubricants) to be distributed to KPs. Some NRG members remain concerned that certain services – such as psycho-social and legal support services or mental health services – are still entirely dependent on the Global Fund funding.

⁴⁵ MoIDPLHSA Letter MOH 4 23 01170226; dated 02.11.2023

In general, even though state funding is increasing, the level of replacement funding seems suboptimal to civil society organisations. Most of them state that actual cumulative funding CSOs receive for delivering HIV prevention services for key populations has been declining. One CSO representative complained that the organisation has already faced challenges in maintaining its human resources, and some highly qualified employees have already left the organisation.

Even though the volume of the Global Fund funding for Georgia has been stable during the last years and it is not declining sharply as it was expected by stakeholders some years ago, the GF assistance to HIV prevention services and key affected communities has been reducing. In fact, a substantial portion of the GF funds has been directed towards building resilient and sustainable systems for health rather than towards strengthening community systems or service delivery. A few respondents expressed concerns that after the Global Fund funding ends, civil society organisations may not have funds for organisational development or staff professional development, as such interventions have been traditionally only supported by the Global Fund or other donors. Another critical problem named by stakeholders is having extremely limited resources for advocacy and monitoring purposes with no indications that the government will be willing to invest in this direction.

Community members and CSO representatives shared diverse concerns based on the specific needs of KPs. However, HIV-associated stigma has been a cross-cutting issue for all respondents interviewed. They believe that very little, if any, attention has been paid to stigma and discrimination (S&D) associated with HIV and/or vulnerable social groups over the last few years. Government commitments to tackling the problem of S&D have not been evident in the latest HIV National Strategic Plan¹².

Stakeholders involved in MSM-specific programmes worry that the attitudes towards minority groups among the general population remain discriminatory, and there is a sizeable number of politicians and decision makers in Georgia who hold negative opinions about vulnerable populations. This may create a threat to the sustainability of MSM & TG - oriented services.

PWID community members and service providers acknowledge that the government increasingly funds HIV prevention for PWIDs. The most successful example has been the OAT programme, which was not only sustained but also expanded significantly under state funding. However, some respondents stated that the government has been ignoring the community request to revise the OAT service delivery modus and provide take-home dosages for five days to stable patients. The requested change is a critically important aspect of the programme delivery. The OAT, inter alia, has been designed to support the social reintegration of programme beneficiaries, which is difficult to achieve if a person needs to go to the OAT centre on a daily basis to get their dose. It should be emphasised that the consolidated package of regulatory changes in OAT programme operation was developed by the Centre for Mental Health and Prevention of Addiction through financial support from the GF. Development of the package was a participatory process involving medical doctors, lawyers, and relevant civil society and community-based

organisations. The package was submitted to the MoIDPLHSA for approval on February 28, 2022⁴⁶, but no progress has been made since then. The topic has been repeatedly brought to the Ministry's attention during high-level meetings, including at the CCM meetings;⁴⁷ however, the government has been slow to respond to the community demand.

Last but not least, PWID stakeholders share their frustration because of the failure to influence legislators to amend existing punitive drug legislation. This critical challenge was highlighted in the previous report, saying that despite permanent advocacy for 2 decades, which, among other things, included the preparation of amendment packages to drug legislation, no progress has been achieved in this direction. PWID service providers point out that harm reduction services in Georgia operate without any legal basis, which may jeopardise the sustainability of such services, specifically low-threshold services, in the long run. One NRG member, who did not seem optimistic about changing the legislation, suggested that until drug legislation is liberalised in Georgia, mentioning harm reduction as an effective HIV prevention strategy in other legislation (i.e., State Law on Public Health) might be an intermediary result increasing the legitimacy of HR services in Georgia.

⁴⁶ Georgia CCM. 99th Meeting Minutes

⁴⁷ Georgia CCM. 101st Meeting Minutes

8. Conclusions and Recommendations

Conclusions

This Transition Monitoring analysis has been focused on the commitments taken by the government aimed to ensure the sustainability of HIV response among key affected populations in Georgia in 2020–2022. The majority of commitments refer to the general healthcare system response to HIV, and some of them were specific to certain KP groups. Whenever possible, transition monitoring assessment results were calculated based on health system domains, programmatic areas and key populations.

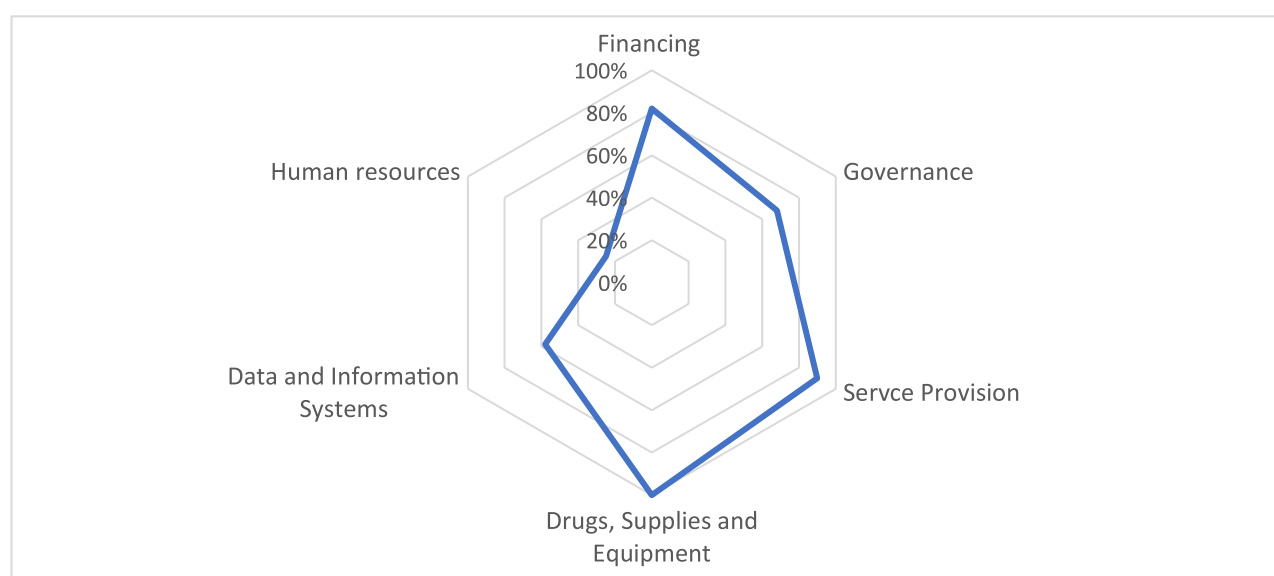
Summary results and brief conclusions by each health system domain are presented below.

Table 29. Commitment compliance scores by health system domains

Total scores by health system domains		
Financing	82%	Significant progress
Governance	68%	Average progress
Service Provision	87%	Significant progress
Drugs, Supplies and Equipment	100%	Significant progress
Data and Information Systems	58%	Average progress
Human Resources	25%	Insignificant progress

Table 29 presents summary data about the extent to which the government has fulfilled its declared commitments in all six health system domains being identified and prioritised for the assessment within this study. Scores are presented in a pre-defined colour-coded system for better visualisation. As shown, significant progress has been achieved in most domains, average progress was found in two domains, and only in one domain was progress deemed insignificant.

Figure 13. Commitment compliance by health system domains



Impact commitments: The final average score for measuring the fulfilment of impact commitments was set as high as 97%, meaning that significant progress was achieved in terms of fulfilling the government commitment to strengthen its HIV national response, including all chains of continuum of care – prevention, treatment and care. The HIV prevalence was contained among the general population as well as among key populations; AIDS-related mortality has reduced; case detection, treatment coverage, retention and viral suppression rates improved. Altogether, impact indicators show that the HIV response in Georgia has been successful in achieving its overarching goals.

Health system domain – Financing: Substantial progress (with an overall **commitment compliance score of 82%**) has been achieved to fulfil the government's commitment to increase HIV investment and dedicate a larger share of public spending to HIV prevention interventions targeting key population groups. Despite this progress, there has been a significant volume of HIV prevention interventions, particularly low-threshold harm reduction and prevention services run by civil society or community-based organisations for KPs that remain heavily dependent on the availability of donor funding.

Health system domain – Drugs, Supplies and Equipment: The government demonstrates significant progress (**commitment compliance score of 100%**) in meeting its commitment to ensure universal access to ART and safeguard the uninterrupted supply of high-quality lifesaving drugs. Similarly, the Government ensures continuous supplies of substitution drugs, HIV laboratory consumables and other reagents needed for treatment monitoring. No stockouts in these supplies have been observed. Nevertheless, some concern still persists among civil society that the provision of HIV prevention materials and other supplies is heavily reliant on donor funding with no clear plan for transitioning.

Health system domain – Service Provision: Significant progress in fulfilling the Government's commitment to increase access to HIV prevention, treatment and care services for vulnerable populations has been documented, with an overall **compliance score of 87.2%**. The Georgian ART programme has been recognised as one of the best in the region, and the country is on track to meet the UNAIDS targets of 95-95-95 by 2025. A high degree of progress was also evidenced in terms of providing HIV prevention services to KPs through sustaining traditional prevention interventions and introducing and further expanding diversified and innovative prevention services to PWIDs and MSM (SIGMA, community PrEP, self-tests, home delivery of HIV tests, etc.). However, the financial sustainability of some interventions targeting KPs has not been ensured, as they continue to be financed through the GF. Overall, despite the declared political commitment, the state seems to be slow in absorbing the costs of certain services targeting Kps.

Health system domain – Governance: Based on the commitments identified and monitored, only average progress was achieved (**commitment compliance score of 68%**) in terms of improving the components under the Governance domain. The most critical need that remains unmet has been existing punishment-based drug legislation that will continue posing sustainability risk, given that HIV prevention targeting PWIDs operates in an environment where the legality and legitimacy of harm reduction services can be questioned. That explains the fact that civil society and community groups feel insecure in terms of the sustainability of harm reduction services in Georgia. They underline that the country needs to pursue a new policy landscape that will allow policy makers to create a drug policy that respects the human rights and health rights of those who choose to use drugs.

Health system domain – Data and Information Systems: Average progress (**commitment compliance score of 58%**) has been evidenced in terms of fulfilling the commitments regarding HIV research, including IBBS surveys and population size estimation studies among KPs. Some studies were completed, though with delay. Some studies were not carried out. Most importantly, none of these studies were financed through public funds. Heavy reliance on donor funds to conduct research studies poses a threat to sustainability.

Health system domain – Human Resources: Only insignificant progress (**commitment compliance score of 25%**) has been achieved to strengthen human resources in the field of HIV. It seems that addressing the challenges related to human resources in the health sector has not been perceived as a priority issue by the healthcare system in Georgia. The Government has placed little (if any) emphasis on the development of a policy for Human Resources in Health (HRH), the establishment of a continuous medical education system, the institutionalisation of training programmes, the creation of a functional e-learning platform, etc. None of these objectives have yet been realised in the health sector, including in the field of HIV.

It was interesting to see how the transition process in Georgia has evolved since the first transition monitoring study was conducted in 2021⁴⁸. Comparing summary results from the two research studies has demonstrated that the progress in achieving the government's commitments for smooth transitioning has been more substantial and visible in 2023. While, in 2019, no progress (0%) was found in two domains, a similar score has not been assigned to any domain in 2023. The progress is evident if comparing arithmetic means of composite scores under health system domains for both years: 46.2% in 2019 vs 69.1% in 2023, which shows a 50% increase in scoring. However, conclusions must be drawn with caution, given that some changes in methodology have occurred since the previous assessment. During the first assessment, per the methodological guideline, those commitments already fulfilled by the government should have no longer been considered relevant to transition and should not have been analysed. Eventually, during prioritisation and analysing commitments, emphases were placed on those commitments, the realisation of which was delayed or was at risk⁴⁸. Thus, it should be admitted that the findings from the 2021 assessment were inclined towards negativity bias about the transition process. For instance, if the instructions for prioritisation of commitments in 2021 were identical to that in 2023, the final achievement score for the Governance domain would have been 47% rather than 27%, as shown in Table 30.

Table 30. Trend in achieving progress in commitments compliance: 2023 vs 2021 study results

Health system domains	Summary results	
	2023 Year	2021 Year
Financing	82%	67%
	Significant progress	Average progress
Governance	68%	27%
	Average progress	Fairly low progress
Service Provision	87%	98%
	Significant progress	Significant progress
Drugs, Supplies and Equipment	100%	85%
	Significant progress	Significant progress
Data and Information Systems	58%	0%
	Average progress	Low (no) Progress
Human Resources	25%	0%
	Insignificant progress	Low (no) Progress

⁴⁸ Tabatadze M. Georgia: Benchmarking sustainability of the HIV response among Key Populations in the context of transition from Global Fund's support to domestic funding. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2021.

Nevertheless, comparing the data from the two assessments shows visible progress towards a smooth transition. Evidently, the government has started investing in interventions that were not financed under public funding before 2022, i.e., HIV testing for the MSM population through contracting a local NGO and community-based organisation. This fact can be interpreted as a positive sign that the government is planning to gradually absorb more costs for HIV prevention services targeting KPs. However, there are well-grounded concerns among civil society organisations and key constituency groups regarding the sustainability of some critical components of comprehensive HIV response in Georgia.

Recommendations

Recommendations for the MoIDPLHSA, Ministry of Finance, CSOs and civil activists

Integrate HIV/AIDS Programme into universal healthcare: It is well acknowledged that the best way to achieve smooth transitioning and full sustainability of HIV interventions under domestic funding is to integrate the HIV/AIDS state vertical programme into universal healthcare. HIV prevention, treatment, care and support services that are sensitive to the needs of different, oftentimes marginalised, criminalised and discriminated communities should be part of the universal health benefit package. UNAIDS suggests that HIV should be included from the very beginning of the establishment of universal health coverage, even where HIV is externally funded⁴⁹.

Recommendations for the MoIDPLHSA and CSOs

HIV prevention services should be scaled up through adequate public funding. The government started investing in HIV prevention targeting KPs and started absorbing the cost related to HIV testing. However, civil society organisations believe that the funding is not adequate. The increasing trend in funding is accompanied by progressive targets for service coverage, and the funds received from the government do not leave any space to cover costs of other relevant interventions and/or administrative costs, organisational strengthening, or staff professional development costs. It is recommended that the government and civil society organisations start an open dialogue about the programme budgets to understand each other's perspectives and expectations. Some service provider organisations state that without having complementary funding from the Global Fund, they may not express an interest in providing HIV services under public funding. This can be viewed as a threat to sustainability, and the government needs to be prepared for such complex challenges.

Practical use of the TMT findings to prioritise commitments: This Transition Monitoring report should guide the government to start revising its policy, programming and funding in the areas of underachievement. CSOs are encouraged to advocate with the government to convince the Ministry of Health to:

- Initiate long-awaited changes in drug legislation to create a conducive environment for HIV services among PWIDs;
- Start investing in harm reduction services (beyond OAT) and demonstrate that the government is actually committed to low-threshold programmes through investing in syringes and needles to be distributed to PWIDs;
- Ensure availability of long-term OAT services for prisoners;
- Ensure access to harm reduction and HIV prevention commodities in correctional settings;
- Despite the availability of the GF funds, start absorbing costs of HIV-related research, such as IBBS surveys, PSE studies among KPs, RITA, etc.;

⁴⁹ HIV/AIDS and Universal health coverage. UNAIDS

https://www.unaids.org/sites/default/files/media_asset/hiv-uhc-guide-civil-society_en.pdf

- Invest in strengthening human resources in the health sector and the HIV field.

Align NSP indicators and IBBS survey tool to make sure the latter is able to generate UNAIDS GAM standard indicators or indicators outlined in the national strategic plan.

For instance, the HIV testing coverage indicator (measured as a percentage of people from key populations who report having tested negative for HIV in the past 12 months or who know that they are living with HIV) could not be generated from the data collected by IBBS among PWID in 2022. Having standard indicators for KPs is necessary for UNAIDS GAM reporting and, most importantly, for exploring trends in behaviours and surveillance data.

Advocacy recommendations for civil society organisations:

Commitments and indicators outlined in the HIV NSP 2023–2025 may not provide sufficient data for the next round of transition monitoring: During the 2023 TMT research and through the review of the latest approved HIV NSP for 2023–2025, it was found that some specific commitments and corresponding indicators related to transition funding are removed (i.e., share of state funding for prevention out of all public spending, % share of state funding out of all prevention spending targeting KPs, % share of public funds out of total spending for IBBS/PSEs, etc.). Therefore, for the next round of Transition Monitoring assessment, community monitors/the National Reference Group may not be able to analyse financial data that are critical for transition. This may undermine the ability of civil society to monitor and demand investing in the areas that are most challenging in terms of sustainability and transition. A thorough analysis of the NSP is desired (the sooner, the better) to predict future gaps in data and advocate for taking corrective measures.

Institutionalise data validation process for the UNAIDS GAM reporting: Georgia has been committed to submitting the Global AIDS Monitoring (GAM) report to UNAIDS every year. This is a very useful resource for all interested stakeholders to monitor standard indicators. However, the quality of reporting can be further improved. Apparently, data validation of all indicators reported has not been done routinely. Not all data validation questions from UNAIDS have been answered – answering all questions would enhance the accuracy and reliability of the data. If civil society improves the monitoring of GAM reporting, the availability of HIV programme data will be enhanced.

Validation of HIV spending data and budget monitoring: More emphasis should be placed by civil society organisations on budget monitoring as well as validation and/or critical review of AIDS spending data submitted by the MoIDPLHSA to UNAIDS annually. As described in the report, some inaccuracies in spending and/or categorisation of spending have persisted over the last few years without any efforts from civil society organisations/budget monitors to seek clarification. The AIDS spending data can be a very useful tool for transition monitoring as it provides disaggregated data about spending by financial sources (public vs external), programmatic areas, interventions and KP groups. However, the tool can be misleading if spending data's accuracy, completeness and reliability are not ensured.

Obtaining data and key documents from state agencies has become more formalised than ever: As described in the report, most HIV programmatic data and financial reports are not uploaded to domains that are accessible to the public. While there is no indication that the government is withholding public information, civil society should be aware that the process of collecting data from state agencies has become formal and advance planning will be needed, as a prompt response from state agencies cannot always be guaranteed.

Civil society and community activists are encouraged to use the transition monitoring assessment report as a guide that helps them be informed and engaged in community monitoring of the transition process. Data and findings of the assessment can be used as an advocacy instrument for addressing remaining gaps in commitment fulfilment.

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1. Annexes

IMPACT COMMITMENT	PROGRAMMATIC AREA	INDICATOR	Baseline	Baseline Year	Target Value 2020	Target Value 2021	Target Value 2022	Actual Value 2020	Actual Value 2021	Actual Value 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance	Final Score of Impact Commitments
Impact													
<i>Impact 1: Contain HIV prevalence among the general population under 500 per 100,000 population by 2022</i>	Prevention	HIV prevalence rate per 100,000 population (less than)	400/100,000	2017	500	500	500	500	500	500	100%	100%	97%
<i>Impact 2: Contain AIDS-related mortality below 2 deaths per 100,000</i>	Treatment	AIDS-related mortality per 100,000 population (less than)	2	2017	2	2	2	2	2	2	100%	100%	
<i>Impact 3: Contain HIV prevalence among MSM under 25% by 2022</i>	Prevention	Percentage of men having sex with men (MSM) who are living with HIV (less than)	21%	2015	25%	25%	25%	25%	25%	25%	100%	100%	
<i>Impact 4: Contain HIV prevalence among SWs under 2% by 2022</i>	Prevention	Percentage of sex workers (SW) who are living with HIV (less than)	2%	2017	2%	2%	2%	2%	2%	2%	100%	100%	
<i>Impact 5: Contain HIV prevalence among PWIDs under 3% by 2022</i>	Prevention	Percentage of people who inject drugs (PWID) who are living with HIV (less than)	2%	2017	3%	3%	3%	3%	3%	3%	100%	100%	
<i>Impact 6: Improve prevention of HIV transmission</i>	Prevention	HIV Incidence rate (per 1,000 population) (less than)	0.22	2017	0.16	0.13	0.10	0.16	0.14	0.17	84%	84%	

PROGRAMMATIC AREA / COMMITMENT	HEALTH SYSTEM DOMAIN	INDICATOR	Baseline	Baseline Year	Target Value 2020	Target Value 2021	Target Value 2022	Actual Value 2020	Actual Value 2021	Actual Value 2022	Commitment Compliance Indicator	Final Score of Commitment Compliance	Final Score of the Programmatic Area
HIV Prevention: Scale-up of preventive services to ensure timely detection and progression to care													90%
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment	Service Provision	Percentage of people living with HIV who know their status	48%	2017	90%	90%	90%	76%	83%	84%	90%	90%	
HIV Prevention among PWID													91.1%
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among PWID: Increase coverage of preventive services	Service Provision	Number of needles and syringes distributed per PWID per year	73 per person/per year	2017	120	130	140	70	83	87	61%	80.0%	
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among PWID: Increase coverage of preventive services	Service Provision	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected	81%	2017	>90%					93%	103.2%	103.2%	
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among PWID: Increase coverage of preventive services	Service Provision	Percentage of PWIDs reporting having received a combined set of HIV prevention interventions (last year)	52%	2017	70%	75%	75%	62%	67%	69%	90%	90.0%	

Increase coverage of prevention services: Expansion of OAT services	Service Provision	Number of individuals receiving OAT	8038	2017	11000	11000	11000	11806	16291	17646	139%	100.0%	
HIV Prevention among MSM													
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among MSM: Increase coverage of preventive services	Service Provision	Percentage of MSM reporting having received a combined set of HIV prevention interventions (last year) (Tbilisi)	22%	2017	50%	55%	60%	38%	43%	65%	87.1%	87.1%	93.3%
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among MSM: Increase coverage of preventive services	Service Provision	People receiving pre-exposure prophylaxis	50	2017	500	750	1000	487	792	958	99.6%	99.6%	
HIV Prevention among FSW													
Improve prevention of HIV transmission, detection of HIV, timely progression to care and treatment among FSW: Increase coverage of preventive services	Service Provision	Percentage of SWs reporting having received a combined set of HIV prevention interventions (last year) (Tbilisi)	52%	2017	60%	60%	60%	41.9%	48.9%	56.1%	82%	82%	82%
HIV Prevention among prisoners													
Increase coverage of prevention services among prisoners	Service Provision	Percentage of prisoners that have received an HIV test during the reporting period and knew their HIV test results	60%	2017	70%	75%	75%	26%	24%	74%	56%	56%	56%

HIV Treatment and Care: Improve HIV health outcomes through ensuring universal access to quality treatment, care and support													
Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)	Service Provision	Percentage of adults and children diagnosed with HIV receiving antiretroviral therapy at the end of the reporting period	81%	2017	90%	90%	90%	86%	86%	86%	95.6%	95.6%	95.3%
Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)	Service Provision	ART coverage: Percentage of people living with HIV currently receiving ART among the estimated number of adults and children living with HIV	39%	2017	81%	81%	81%	65%	71%	71%	85.2%	85.2%	
Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)	Service Provision	Percentage of adults and children with HIV known to be in treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	87%	2017	90%	90%	90%	87%	88%	87%	97.0%	97.0%	
Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)	Service Provision	Percentage of people on ART who are virologically suppressed (VL) with VL level ≤ 1000 copies/ml	89%	2017	90%	90%	90%	94%	92%	93%	103.3%	103.3%	
Provide HIV/AIDS clinical care services for all people living with HIV (PLHIV)	Drugs, Supplies, and Equipment	Percentage of healthcare facilities reporting no stockouts of ARV medicines	100%	2017	100%	100%	100%	100%	100%	100%	100%	100.0%	

<i>Governance and Policy development: Ensure sustainability of response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society</i>													
<i>Create a conducive legal environment to ensure the smooth implementation of the HIV national response and achieve greater engagement of civil society</i>	<i>Governance</i>	<i>Georgian Criminal Code and Administrative Offences Code, Georgia Framework Law on Drugs, Psychotropic Substances, Precursors and Narcological Aids - revised; amendments adopted to remove barriers to HIV& harm reduction services</i>	<i>NA</i>	<i>NA</i>				<i>No</i>	<i>No</i>	<i>No</i>	<i>0.0%</i>	<i>0.0%</i>	68.3%
<i>Support the development and enforcement of the Four-Pillar Drug Policy, Anti-Drug Strategy and Action Plan</i>	<i>Governance</i>	<i>The 4-Pillar Drug Policy, Anti-drug strategy and 3-year Action Plan developed and approved by the Government</i>	<i>NA</i>	<i>NA</i>				<i>Done</i>	<i>Done</i>	<i>Done</i>	<i>100%</i>	<i>100%</i>	
<i>Create a conducive legal environment to ensure the smooth implementation of HIV national response and achieve greater engagement of civil society</i>	<i>Governance</i>	<i>Review HIV/AIDS State Law; development and adoption of corresponding bylaws</i>	<i>NA</i>	<i>NA</i>	<i>Yes</i>				<i>In progress</i>	<i>In progress</i>	<i>80.0%</i>	<i>80.0%</i>	

Create an enabling environment for CSO engagement in the HIV national response	Governance	Barriers and opportunities for CSOs/CBOs to satisfy the state procurement requirements identified	NA	NA						Arbitrary	80%	80.0%	
Improve accountability: Publish HIV programmatic and financial reports to make them accessible on public domains	Governance	Publishing HIV programmatic and financial reports to make them accessible on public domains	NA	NA	Yes	Yes	Yes	Partially	Partially	Partially	50%	50.0%	
Improve accountability: Monitor the progress towards implementation of NSP by external monitoring committee/community monitors	Governance	Monitoring the progress towards implementation of NSP by external monitoring committee/community monitors	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes	100%	100%	
Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response													81.8%
Ensure full budgetary commitment and allocative efficiency for national HIV response	Financing	The share of public spending out of the total spending for HIV national response	76%	2018	85%	87%	96%	78%	85%	80%	90.9%	90.9%	
Ensure full budgetary commitment and allocative efficiency for national HIV response	Financing	% of public spending on HIV targeting KAPs	NA	NA		10%			>10%		100%	100%	

Ensure state funding to support HIV-related research, including second-generation studies (Population Size Estimation studies and IBBs among KAPs)	Financing	The share of public spending out of the total spending on IBBs & PSE among KAPs (%)	NA	NA	50%		70%			0%	0%	0%	
Conduct HIV programme allocative and technical efficiency study to inform HIV strategic planning during the transition period. Conduct HIV/AIDS Spending data analysis on an annual basis	Financing	Analysing data on AIDS spending by each KAP to assess the allocative efficiency	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes	100%	100%	
At least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations and/or highest-impact interventions within a defined epidemiological context	Financing	At least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations and/or highest-impact interventions within a defined epidemiological context	NA	NA			50%			50%	100%	100%	
At least 75% of additional co-financing contributions must be invested in disease programme interventions	Financing	At least 75% of additional co-financing contributions must be invested in disease programme interventions	NA	NA			75%			75%	100%	100%	

<i>Generate evidence for informed decision making</i>													
<i>Conduct Integrated bio-behavioural surveillance studies (IBBSS) among KAPs incorporating population size estimates</i>	<i>Data and Information Systems</i>	<i>IBBSS and PSE among PWIDs</i>	NA	NA	Yes					Yes	100.0%	100.0%	58.3%
<i>Conduct Integrated bio-behavioural surveillance studies (IBBSS) among KAPs incorporating population size estimates</i>	<i>Data and Information Systems</i>	<i>IBBSS and PSE for FSWs</i>	NA	NA	Yes			No			0.0%	0.0%	
<i>Conduct Integrated bio-behavioural surveillance studies (IBBSS) among KAPs incorporating population size estimates</i>	<i>Data and Information Systems</i>	<i>IBBSS and PSE among MSM</i>	NA	NA		Yes			No		50.0%	50.0%	
<i>Conduct Integrated bio-behavioural surveillance studies (IBBSS) among KAPs incorporating population size estimates</i>	<i>Data and Information Systems</i>	<i>Conduct population size estimation study among transgender and non-binary persons in Georgia</i>	NA	NA	Yes			No		Yes	100%	100%	
<i>Conduct pre-treatment HIV drug resistance survey</i>	<i>Data and Information Systems</i>	<i>Pre-treatment HIV drug resistance survey</i>	NA	NA		Yes			No		0%	0.0%	
<i>Monitoring recent HIV infections using a recent infection testing algorithm (RITA)</i>	<i>Data and Information Systems</i>	<i>Monitoring recent HIV infections using a recent infection testing algorithm (RITA)</i>	NA	NA	Yes	Yes	Yes	Yes	Yes	Yes	100%	100.0%	

Additional Data

Table 31. Georgia data – Health expenditure

Country Statistics	2012	2013	2014	2015	2016	2017	2018	2019	2020
Current health expenditure (% of GDP)	8.0	7.9	7.9	7.4	8.0	7.1	7.1	6.7	7.6
Domestic general government health expenditure (% of GDP)	1.6	1.9	2.2	2.6	2.9	2.6	2.8	2.7	2.8
Domestic general government health expenditure (% of general government expenditure)	5.5	6.9	7.8	9.6	10.3	9.5	10.3	9.4	8.1
Current health expenditure per capita, PPP (current international \$)	775	821	902	886	1016	948	1026	1026	1108
Domestic general government health expenditure per capita (current USD)	68	84	102	105	118	113	131	126	117
Domestic general government health expenditure (% of current health expenditure)	19.4	23.6	27.6	35.6	36.6	37.2	39.5	40.8	36.5
Out-of-pocket expenditure (% of current health expenditure)	73.4	69.1	66.0	57.3	55.5	54.8	47.7	46.8	46.8
External health expenditure (% of current health expenditure)	3.4	3.0	2.5	2.5	2.3	2.4	0.5	0.5	5.6

Figure 14. HIV registered cases in Georgia by years (1989–2023, May)

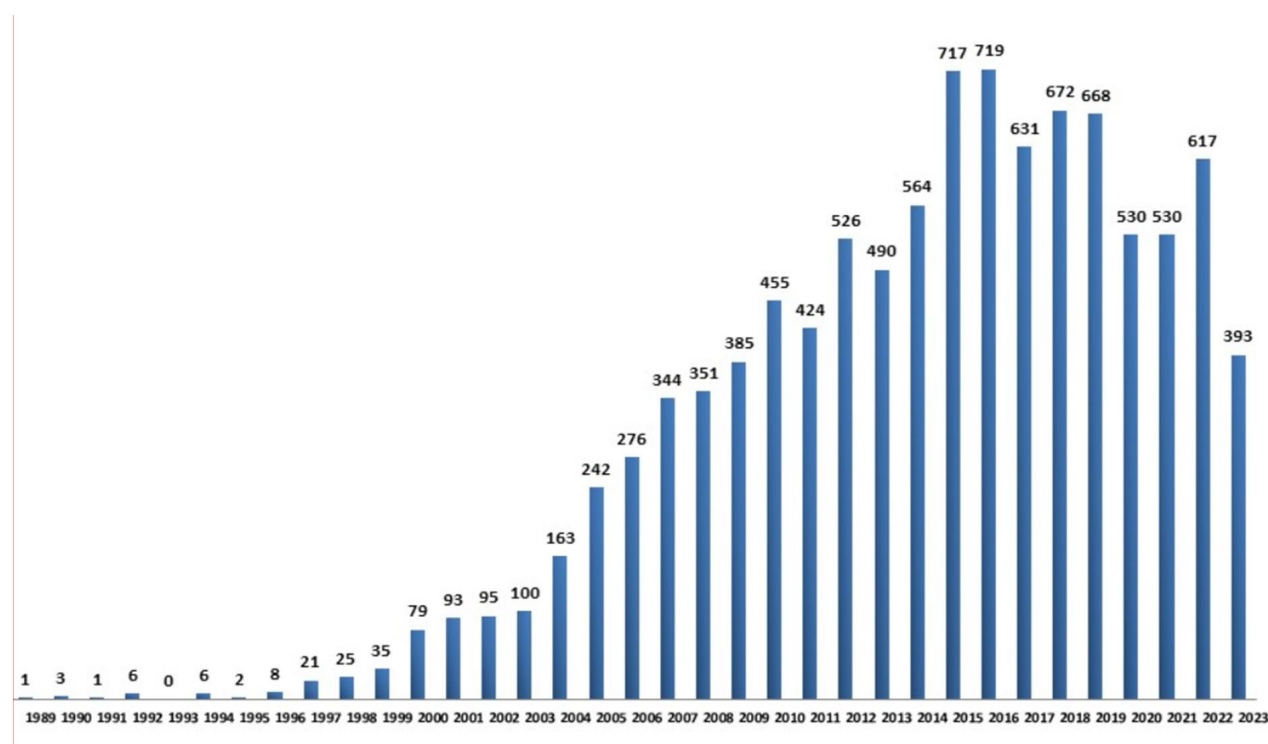
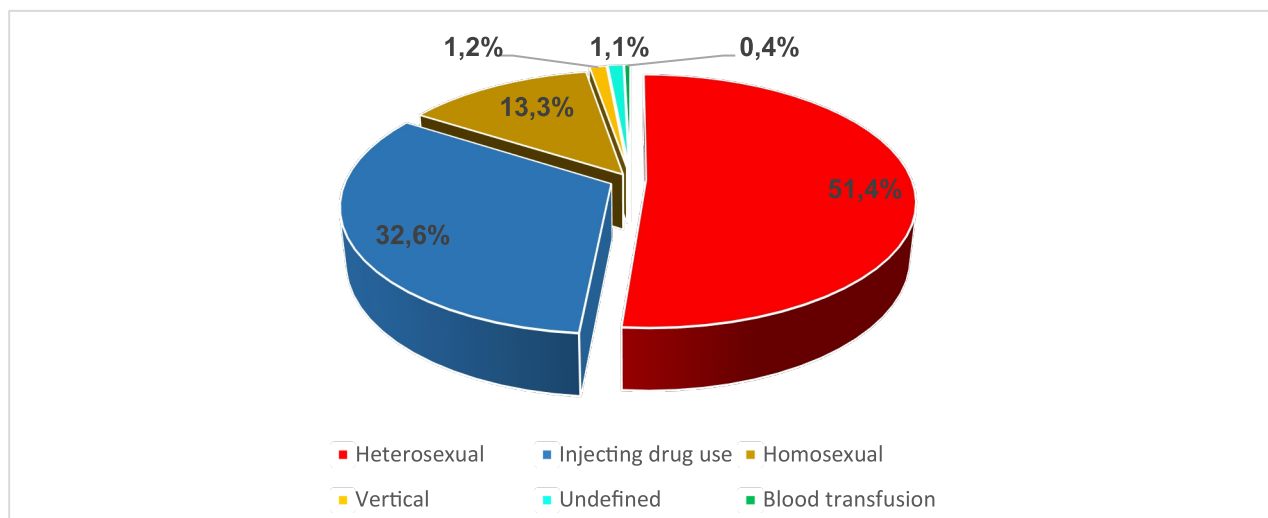


Figure 15. Registered HIV cases by transmission ways – year 2022

National Reference Group

N	Name, Surname	Position/Place of work	Represented sector
1	Ketevan Stvilia	NCDC; HIV Programme Director	General
2	Akaki Abutidze	AIDS Center; Deputy Director	Treatment, care and support
3	Tamar Zurasvhili	PAAC; P&A specialist	Advisory Council
4	Medea Khmelidze	Real People Real Vision	PLHIV
5	Lasha Tvaliashvili	Real People Real Vision	PLHIV
6	Beka Gabadadze	CBO - Temida	LGBTQ+
7	Bart Nikolo	Equality Movement	LGBTQ+
8	Nino Tsereteli	Tanadgoma; Executive Director	NGO - MSM/SWs
9	Ketevan Bidzinashvili	Step to the Future, Gori; Director	PWID
10	Lasha Abesadze	New Vektor	PWID
11	Maka Gogia	GHRN; HIV Programme Coordinator	Harm reduction
12	Zaza Karchkhadze	New Way, Kutaisi	PWID
13	Maia Uchaneishvili	Curatio International Foundation/ Head of Research Unit	General
14	Nika Mirzashvili	Patients Union	TB Patients
15	Irma Kirtadze	Professor/Researcher; Ilia State University	Academia