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Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries

Georgia Country Report

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DISCLAIMER

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ACRONYMS

ACSM	Advocacy Communication Social Marketing
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Treatment
ARV	Anti Retroviral
BCC	Behavior Change Communication
CBO	Community Based Organization
CCM	Country Coordination Mechanism
CIS	Common Independent States
CSO	Civil Society Organizations
CME	Continuous Medical Education
CN	Concept Note
DOT	Direct Observed Treatment
DFID	Department for International Development
DST	Drug Sensibility Test
EECA	Eastern Europe Central Asia
EQA	External Quality Assessment
ECDC	European Centre for Disease Prevention and Control
EU	European Union
FSW	Female Sex Worker
GASW	Georgian Association of Social Workers
GDP	Gross Domestic Product
GEL	Georgian Lari
GLC	Green Light Committee
GMP	Good Manufacturing Practice
GDF	Global Drug Facility
GARP	Global AIDS Response Progress
GNI	Gross National Income
GHRN	Georgia Harm Reduction Network
GHSPIC	Georgia Health and Social Projects Implementation Center
GPIC	Global Projects Implementation Center
HCV	Hepatitis-C Virus
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
IDACIRC	Infectious Diseases, AIDS and Clinical Immunology Research Center
IDU	Injected Drug Use
KP	Key Populations
LGBT	Lesbian, Gay, Bisexual and Transgender
LEPL	Legal Entities of Public Law
MTEF	Medium Term Expenditure Framework
MDR	Multi Drug Resistance
XDR	Extensively Drug-resistant Tuberculosis
MoLHSA	Ministry of Labor, Health and Social Affairs
MoE	Ministry of Education
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NFM	New Funding Model

NGO	Non Governmental Organization
NELE	Non Entrepreneur Legal Entity
NCDCPH	National Center for Disease Control and Public Health
NCTBLD	National Center for Tuberculosis and Lung Diseases
NRL	National Reference Laboratory
NSP	National Strategic Plan
NTP	National TB Program
OSGF	Open Society Georgia Foundation
OST	Opioid Substitution Therapy
PIU	Program Implementation Unit
PHC	Primary Health Care
PLWHA	People leaving with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
PUDR	Progress update and disbursement request
RCC	Rolling Continuation Channel
RRL	Regional Reference Laboratory
SARMA	State Agency for Regulation of Medical Activities
STI	Sexually Transmittable Infection
SR	Sub Recipient
SSR	Sub Sub Recipient
SW	Sex Worker
TGF	The Global Fund
TB	Tuberculosis
TPAF	Transition Preparedness Assessment Framework
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
URC	University Research Center
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

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EXECUTIVE SUMMARY

Transition Risk Assessment Rationale

The Georgia country case study was undertaken in the frame of a research project entitled “Transition from Global Fund Support and Programmatic Sustainability Research in four CEE/CIS countries”, which was commissioned by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and implemented by Curatio International Foundation (CIF).

Since its foundation in 2002, the Global Fund has invested nearly US\$4 billion a year to support programs addressing these diseases in over 140 countries. Currently the Global Fund measures a country’s eligibility for funding in each disease by assessing its disease burden and income.

Changes in how the Global Fund allocates resources to recipient countries have important consequences for how countries will continue to conduct previously donor-funded activities. This is particularly relevant for the Commonwealth of Independent States (CIS) and the Central and Eastern European (CEE) region, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Unless the transition from GF support is well planned and effectively implemented, the sustainability of HIV and TB programs in these countries is at risk.

Current case study is one among the four studies undertaken in Georgia, Belarus, Bulgaria and Ukraine with a purpose to pilot *Transition Preparedness Assessment Framework (TPAF)* and generate prospective evidence to inform an adequate transition planning process from the Global Fund support.

The TPAF used in the case study was developed by this research project. The framework assesses country readiness for transition from TGF funding and identifies areas that might hinder this process.

For the purposes of this research project, the following definitions of transition and sustainability were used:

Transition is defined as “*the process of moving away from direct donor support by developing mechanisms to manage health programmes, practices or interventions in a sustainable manner through the interaction of internal and external enabling factors*”.

Sustainability is defined as “*the capacity of a country to independently manage their disease-specific programmes in the long-term without interruption or compromising quality by developing a sense of ownership and enabled by an adequate internal and external national environment*”.

The TPAF looks at two general domains. The *external environment* that includes factors that are outside of the health sector but have an impact on the health response, such as: political and economic environment and the *internal environment*, or those factors that are within health sector and is composed of three main sub-domains: governance, inputs to the program and the program itself. All sub-domains are further divided into components. Factors related to *Governance* are subdivided into governance-specific factors and accountability. *Inputs* are subdivided into financial resources, human resources and health information systems. *Program* sub-domain is composed by service delivery, organizational capacity and transition planning components.

The assessment was conducted using mixed methods: a desk review, secondary analysis of data available in global databases (UNAIDS, WHO, WB etc.) and primary data through semi-structured interviews with country stakeholders.

Transition Risk Assessment

Findings presented arise from the Georgia country case study and, separately, some general findings, which resonate and align with the results of other studies¹ and lead to more general conclusions. The general conclusions and disease-specific conclusions are described in the respective sections.

Sustainability Risk Assessment (page Table 2) summarizes the assessment of Georgia's readiness for transition from GF support, and singles out program level bottleneck that may impede transition. While a summary score of transition risk (47%) indicates that Georgia is exposed to moderate transition risk, the scores for each individual domain help identify critical areas that may pose highest risk and therefore should be addressed during the transition process.

EXTERNAL ENVIRONMENT

Economic development. Georgia is a lower-middle income country whose GPD per capita has gradually increased in the last decade, albeit its growth rate has significantly fluctuated. In general, the current economic situation cannot be considered as hindering factor for the sustainability of TGF program but it will be important to look at fiscal space for a more comprehensive picture of the country's financial possibilities.

Political Commitment. The Government has showed a clear political commitment to the health sector and it has increased the share of public spending on health and total health expenditures over the last few years. In 2013 the government started the Universal Health Coverage program and it declared health care one of its priorities. The response to HIV/AIDS and TB is prioritized in the state health concept and is guided by well-developed National Strategic Plans. Although the overall legal environment in the country protects the rights of HIV and TB patients, there are still medium level risks for the programs as the laws are not effectively enforced to safeguard KP from discrimination. A restrictive drug policy and no legal basis for the needle exchange activities create barriers to the HIV program. Sex work is not legally regulated, thus hindering prevention activities.

INTERNAL ENVIRONMENT

Financing. Both HIV and TB National Programs are vertical programs with significant, and increasing, state financial contributions. In 2014 the public expenditure on HIV and TB was respectively 46% and 56.7% of the entire programs spending. There are dedicated MTEF budget lines for both diseases, which are aligned with NSP and NTP. However, the total share of state expenditures on prevention remains low and this component largely depends on donor funding, which is primarily TGF for both diseases. The latter fact creates high risk for program sustainability.

- **Human Resources.** The HIV program can count on sufficient and qualified human resources, while the staff employed in the TB control is not adequate, and the average professional is over 40. Low motivation and meager wages of TB doctors/staff are the leading problems in the sector. Lack of general knowledge about the diseases among general practitioners builds barriers, creates stigmatization, and discrimination towards the patients and it can often lead to the refusal to provide the needed service. Continuous medical education is not mandatory in Georgia and it completely depends on the good will of the doctors and managers/owners of the medical facilities. The USAID-funded program is coming to an end in 2015 and the future of training and updates for TB staff on treatment schemes and medications remains unclear. TGF-funded salaries are aligned with the national pay scale.

¹ Gotsadze T., Fuenzalida H., et al. Thematic Review on Transition and Sustainability of Global Fund Supported Programs. Curatio International Foundation, 2015

- **Information Systems.** The HIV and TB M&E systems are integrated into the national reporting systems, however challenges remain in the standardization of the data collection standardization and data disaggregation. The routine surveillance system provides the necessary data for the program management and M&E but it lacks adequate analysis. Second-generation surveillance studies in the HIV field are conducted regularly and follows rigorous methodology, but they completely depend on donor funding and there is a high risk that this component will be discontinued.

Governance. The Government is committed to take over the financing of HIV and TB programs, especially the diagnostic and treatment components. The future of the prevention activities, especially among KP, is unclear. The CCM is well-coordinated and managed with equal representation of all sectors and groups, although the structure of the national disease programs is not defined, which means that roles and responsibilities of all involved stakeholders are not clearly specified. The fragmented program structure creates significant risk to program's continuity and sustainability in the future, since its success depends more on particular leaders rather than on the system's efficiency.

Program. Despite the Government's strong political commitment to sustain the national responses to HIV and TB, additional efforts are needed in order to manage a smooth transition. In particular, early diagnostics and timely link to treatment remains challenging for both diseases. Adherence support and prevention to KP completely depend on TGF funding, which increases the risks for the transition process. Although the OST services are state-financed, they lack a psychosocial component which might put at risk effectiveness and efficiency of the contributions.

Organizational Capacity. The agency under the Ministry of Health, NCD/CPH, is currently the PR for the GF HIV and TB grants. The organization for the service delivery, the M&E, and the procurement and supply chain management are adequate, which creates an enabling environment for the transition. The risks in the process are high though, due to the blurred structure and management of the national disease programs.

Transition preparedness. Although the transition has not started yet, the Government's commitment to take over the financial responsibilities and gradually increase the programs' domestic funding shows some readiness. Several steps have already been taken like the financing of the 1st line medicines in HIV and TB starting from Autumn 2015, the co-financing system for the TB adherence payments from 2014, and the state-funded OST program. However, an assessment of the transition readiness indicates a medium risk.

GENERAL RECOMMENDATIONS

Based on the findings of the transition and sustainability assessment discussed in previous chapters, this section provides bold recommendations that can guide the Government and key stakeholders towards an easy transition after external funding ends.

Transition plan. While country is discussing and actively working on the elements of the transition, there is no overall plan governing this process. Adequate conceptualization of and careful planning for the transition would most likely be of benefit. Other country experiences prove that planned transitions reduce/minimize transition challenges, while rushed transitions cause more problems and undermine sustainability. Therefore, developing time-bound and actionable plans, which have sufficient legal power and adequate indicators to monitor the plan implementation, seem to be necessary first steps for the country to consider. Finally, effective implementation of the plan would also require sufficient resources (human and financial) to achieve transition objectives.

Gradually reducing financial dependence on the Global Fund. Experiences prove that the transition process become smoother and odds for sustainability increases, when the Global Fund's contribution to the national response is not significant, e.g less than 25%. Consequently, the country has to strive to gradually reduce its dependence. The first and most important area for

transition to consider is commodity procurement, so that national procurement mechanisms function adequately and allow for such a transition. The most challenging area seems to be transition of preventive interventions, especially those delivered by the NGOs/CSOs, which could be left for the latter phases, provided that sufficient preparatory work is done during the lead-up time to transition date (see CSO contracting for more details).

Many countries give lower priority to prevention compared to treatment. In many instances, the lack of national budget allocation (even with small amounts) has challenged transition and undermined sustainability prospects. While prevention could be last element to be transitioned, it seems important to start developing prevention budget lines/allocations during the transition process, which may eventually drive increased budget allocations when the country stops receiving Global Fund support. In other countries, legally empowered national programs that already reflect a gradual reduction in donor dependence in their budget have often served as an effective instrument in other countries.

CSO contracts. The overall legal environment is not conducive for NGO/CSO contracting and the country lacks detailed contracting procedures for CSO contracting in the health sector. Georgia would benefit significantly if these rules/procedures were developed during transition and institutionalized.

A similar situation was observed in the countries that graduated from the Global Fund without having such rules in place and facing transition challenges. Based on other country experiences, such detailed contracting rules/procedures are at least expected to address at least the following: service definition, service pricing and/or methodology to estimate quoted prices, which on one hand helps evaluate the value for money for the submitted bids during tendering/national procurement process and on the other, and most importantly, helps the government to estimate overall program costs for a given disease and adequately budget during the budgeting process; tendering procedures that are aligned with the national procurement laws and regulations; bid evaluation procedures for both quality and value of the bid; procedures for monitoring quality and/or volume of services delivered by CSOs, etc.

Effective national coordination, with or without the CCM as a coordinating body, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. One of the greatest benefits that the Global Fund has delivered worldwide is creating the space for governments and civil society to jointly engage in the national/global response planning and coordination^{2,3,4}. In most states CCMs, or similar structures, that formally provide a seat and voice for NGOs/CSOs in the national coordination, have been critical in achieving the gains observed globally. Consequently, retaining and/or enhancing effective coordination structures proved to be important in many countries after the Global Fund support. Therefore, it seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous NGO/CSO engagement. For such coordination to be effective the production, availability, transparency and easy access to information should be ensured for the development of an evidence-based (or informed) responses.

Enhancing public accountability during and after transition will be critical to assure quality partner engagement e.g NGOs, SCOs, journalists and development partners. This would require the routine production of information describing results of the national response e.g. disease program specific epidemiological and financial expenditure data; the results of program performance, including outcomes and challenges. During transition, the country (perhaps with the Global Fund

² Spicer N., Aleshkina J., et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? *Globalization and Health* 2010, 6:3.

³ Kapilashramia A., O'Brien O. 2012. The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? *Global Public Health: An International Journal for Research, Policy and Practice* Volume 7, Issue 5, 2012.

⁴ Duvvury N., Cornman H., Long C. 2005. Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. www.icrw.org.

support) should strive to assure (maybe contractually and/or through legislative action) that this information is not only routinely produced but is also freely accessible for all stakeholders involved, government and civil society alike.

Addressing human resource challenges should be viewed in two parts: a) assuring adequate quantity and re-distribution of the needed human resources and b) continuous education of the professionals involved in the national response – service provision. The latter has been extensively supported by the Global Fund grants, and not only in this country⁵. However, the sustainability of these trainings raise concerns due to the lack of institutionalization achieved during the grant implementation. Consequently, the transition period has to be explicit about what could be achieved, in terms of preparing the necessary human resources and how this function can be institutionalized and eventually funded and delivered by the government. The question of human resources goes well beyond the disease response and results from health sector policies, education policies and the overall socio-economic environment in the country. It also affects the whole health care system of the country. Instead of addressing these challenges as a transition issue, therefore, it is necessary to look at these challenges more holistically and outside of the transition process.

Country-Specific Recommendations

RECOMMENDATION # 1: To Enhance the Stewardship and Governance of National Programs

Coordination (HIV and TB Programs)

- Resolve structural, coordination and stewardship challenges related to disease programs.
- Ensure that National Strategic Frameworks has legal power.
- Ensure there is an assigned body to coordinate, manage and control its implementation.

Program Management (HIV and TB Programs)

- Create a clear structure with evident and defined roles and responsibilities across all levels.
- Ensure that disease programs are led by effectively functioning and legally empowered organizations that could also play a bridging role between CSO and government.
- Ensure that program data reports, M&E reports, other periodic updates and financial data are available.
- Enhance the MoLHSA's capacity to manage tenders by making sure that officials are able to develop technically-sound specifications for any tender related to TB/HIV programs.

Partnership (HIV and TB Programs)

- Strengthen the partnership between state and non-state actors for coordinated service provision, transition planning and implementation of the transition plan.
- Create an enabling environment for strengthening the capacity of local CBOs, who are currently involved in implementing of TGF program.

Legislation and regulation

HIV and TB Programs

- Ensure the current legislative acts to decrease stigma and discrimination towards HIV/AIDS and TB are implemented.
- Ensure that the existing legal documents and policies are enforced and followed up.

⁵Bowser.D.,Sparkes.SP., et al. 2013. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. Health Policy and Planning 2013; 1–12.

- Ensure that rule and procedures for contracting CSOs for health service delivery are developed and introduced.

HIV

- Review and amend the legislation related to KP in order to ensure avoiding stigma and discrimination.
- Develop legal documents creating the base for the needle exchange program in the country and its regulation, as after phasing out TGF, this particular activity can become illegal.
- Liberalize the restrictive drug policy in the country by clearly emphasizing that drug use is a medical and public health problem and it should not be considered as a crime (with MoLHSA leading the process) and at the same time ensure that Ministry of Internal affairs fully understands all public health related risks of such a restrictive drug policy.

TB

- Ensure that the TB law is approved, introduced and enforced during the planned period.

Guidelines

HIV

- Continue the optimization of the ARV treatment schemes and switching to the public health approach.

TB

- Ensure that the revision of treatment guidelines are ongoing and necessary financial sources are available for continuous training of the medical staff.

Accountability (HIV and TB Programs)

- Make sure that M&E data and health expenditure information, in particular for HIV/AIDS and TB programs are available.

RECOMMENDATION # 2: To ensure efficiency of current allocations, identification of additional funding sources to fill up the gaps already demonstrated in the NFM concept notes

Finances (HIV and TB Programs)

- Ensure that adequate funding from public sources is available for prevention programs (especially to cover low threshold programs for KAP's)
- Ensure that the share of public spending is adequate to cover the needs of HIV/AIDS and TB programs after TGF.
 - Ensure that allocations are made based on existing epidemiological data.
- Look for alternative sources of funding to cover the gap.
- Increase public spending on HIV prevention for epidemiologically priority groups.

RECOMMENDATION # 3: To Improve service delivery based on recent evaluation of HIV and TB control systems by WHO

Service Delivery

- Strengthen coordination between HIV and TB programs and other integrated services, especially in rural areas.

HIV

- Prioritize and address low detection rate related problem.

- Re-design OST program by missing psycho-social element added, in order to make sure, it is a ready-to-replicate model for the state to take over without any doubts in its effectiveness.

TB

- Address challenges related to low case detection, late diagnostics and weak adherence support.
- Strengthen engagement of local NGOs in service delivery.

RECOMMENDATION # 4: To Ensure adequate supply, motivation and training of human resources

(HIV and TB Programs)

- Ensure that TGF-supported trainings for health personnel are institutionalized in the national education system.
- Initiate the integration of the HIV and TB training modules into the undergraduate and postgraduate education schemes.
- Develop the policy for production/training of CSO personnel.

RECOMMENDATION # 5: To Streamline forecasting, procurement and supply management systems

HIV

- Develop the capacity of the social services agency (under the MoLHSA) in planning the purchase process and in providing detailed specifications for the medicines and supplies in the purchase orders.

TB

- Specify the status, scope of work, roles and responsibilities of the central pharmacy unit at NCTBLD
- Strengthen the human resources capacity at the central and regional levels in the area of inventory management through training and monitoring.
- Identify administrative regulations to allow redistribution of medicines between facilities, which will allow to use efficiently the existing medicines and avoid waste.

RECOMMENDATION # 6: To enhance surveillances system by improving data collection flow and developing analytical capacities

HIV and TB Programs

- Increase analytical capacity of the disease programs and ensure data use for the program and budget planning, for the evidence-based decision-making and advocacy purposes.

HIV

- Develop analytical capacity of the NCDCPH in analyzing HIV data by making it ready to use by decision-makers as a strong evidence.
- Ensure that IBBS studies are implemented on a regular basis and funding is allocated from public sources or alternative funding is secured.

TB

- Produce annual analytical surveillance report and disseminate it for better use of data for decision-making and advocacy purposes.

CHAPTER 1: PURPOSE AND METHODOLOGY

1.1 PURPOSE

The Georgia country case study was undertaken in the frame of a research project, “Transition from the Global Fund Support and Programmatic Sustainability Research in four CEE/CIS countries” which was commissioned by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and implemented by the Curatio International Foundation (CIF).

Since its foundation in 2002, the Global Fund has invested nearly US\$4 billion a year to support program addressing these diseases in over 140 countries. Currently the Global Fund measures a country’s eligibility for funding in each disease by assessing their disease burden and income.

Changes in how the Global Fund allocates resources to recipient countries, have important consequences in how countries will continue to conduct previously donor-funded activities. This is particularly relevant for the Commonwealth of Independent States (CIS), and the Central and Eastern European (CEE) region, which are still burdened by fast-growing HIV/AIDS and TB epidemics. Unless the transition from the Global Fund support is well planned and effectively implemented the sustainability of HIV and TB program in these countries is at a risk.

Current research seeks to generate prospective evidence to inform adequate transition planning process from the Global Fund support. The research intends to understand the factors affecting sustainability and to identify strategic and operational issues to assure the sustainability of HIV and TB programs.

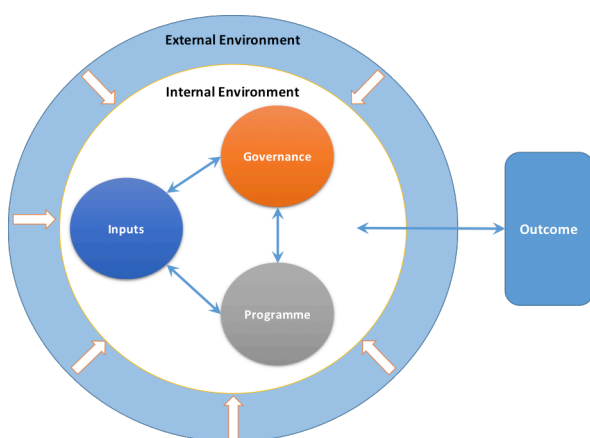
1.2 METHODOLOGY

For the purposes of this research project, the following definitions of transition and sustainability apply.

Transition is defined as “the process of moving away from direct donor support by developing mechanisms to manage health programs, practices or interventions in a sustainable manner through the interaction of internal and external enabling factors”.

Sustainability is defined as “the capacity of a country to independently manage their disease-specific programs in the long-term without interruption or compromising quality by developing a sense of ownership and enabled by an adequate internal and external national environment”.

Figure 1: Transition Assessment Framework



Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. Gotsadze T. et al (2015). *The road to sustainability: Transition Preparedness Assessment Framework*. Tbilisi, Georgia: Curatio International Foundation

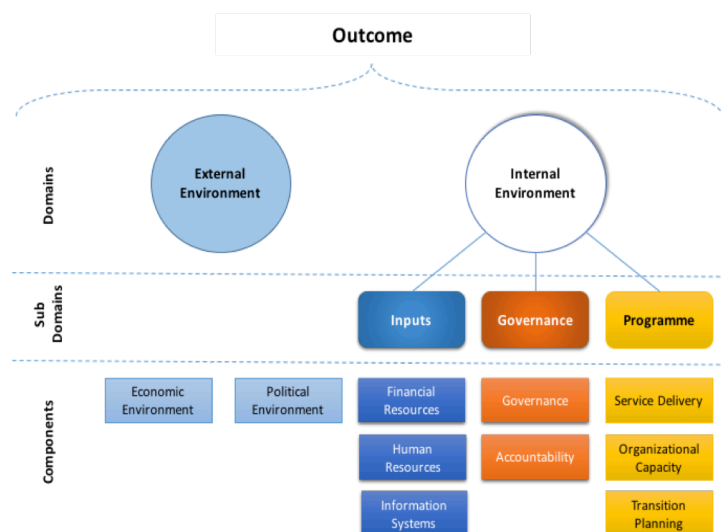
The conceptual framework distinguishes two overarching domains (

Figure 1). The external environment is the first domain, which includes political, social and economic environment sub-domains. The external environment includes factors that are outside of the health sector but have an impact on the health response, such as: a country’s political and governance structure, economic and social environment, human rights, stigma and discrimination, and an enabling environment for a civil society.

The second domain is the internal environment, which represents those factors that are specific to the health sector, and has three main sub-

domains: governance, inputs to the program and program itself.

Figure 2: Transition and sustainability assessment components



Source: Amaya, A.B., Gotsadze, G. and Chikovani, I. Gotsadze T. et al (2015). The road to sustainability: Transition Preparedness Assessment Framework. Tbilisi, Georgia: Curatio International Foundation

All sub-domains are further divided into components that affect transition and sustainability of the public health programs, after graduating from a donor support (Figure 2). Collectively these components, sub-domains and domains included in the conceptual framework, help to unpack the transition and sustainability-related issues/areas and present the findings in a well-organized and logical manner.

Finally, by analysing these external and internal environments, the framework allows us to examine a country’s readiness and/or identify the steps required to reach the intended outcome, which is defined

as successful transition from Global Fund support to program sustainability.

Table 1: Illustration of the Transition and Sustainability risk assessment framework

Risk Assessment	Low risk X criteria are met	Medium risk X criteria are met	High risk X criteria are met	Risk assessment for a given area
External Environment				
Indicators				
Internal Environment				
Indicators				
Overall Country Risk Assessment				

Each framework component was operationalized into indicators for each domain and its components.

Table 1 illustrates how this tool assesses country readiness for transition.

Quantitative and qualitative indicators were developed to respond to each component of the framework. These indicators have been used to assess possible risk to transition by assigning a range of low risk,

moderate risk and high risk and a final score for assessing country risk for the transition.

The assessment utilized a mixed method of data collection entailing desk review, analysis of secondary quantitative data and in-depth interviews. The interviewees were key stakeholders from the government or directly working with Global Fund grants, and were identified based on their relationship with these grants as well as through the snow-ball technique in which, where interviewees nominate other potential interviewees. The interviewees included government officials, donor representatives, staff from international organizations, and civil society members, among others.

The quantitative and qualitative data arising from case study were triangulated using documentation, conceptualization, coding, and categorizing in line with the conceptual framework domains, sub-domains and components, which allowed us to examine relationships between them and have led to major findings that eventually informed the recommendations.

The research was conducted in four countries CEE/CIS countries Belarus, Bulgaria, Georgia and Ukraine. Country case study findings are collated in a synthesis report that will serve as input to the development of a Global Fund Strategy on Transition and Sustainability and will feed in to the new Global Fund Strategy.

CHAPTER 2: EXTERNAL ENVIRONMENT

2.1. Country Background and Political System

Georgia is a country in the Caucasus region located at the crossroads of Western Asia and Eastern Europe. It borders the Black Sea to the east, Russia to the north, Turkey and Armenia to the south, and Azerbaijan to the south-east. Georgia covers a territory of 69,700 square kilometers and its population is 3.7 million.⁶ The capital and largest city is Tbilisi.

Georgia is a unitary, semi-presidential, democratic republic. The government is elected through a representative democracy and implements executive, domestic and foreign policies. The Government consists of the Prime Minister and ministers, including a state minister and is accountable to the President and the Parliament of Georgia. The government's executive power is regulated by the constitution, which administers its structure, powers and order of activity and other legislative and normative acts approved by the president or the government's legislative branch. The government is guided by its program, which is endorsed by the president. The relevant state law regulates the governmental structure, the authorities and the order of the activity in Georgia⁷.

Worldwide Governance Indicators have improved significantly over the last decade, i.e. ranking of the country in 2005-2014 has increased from 46.6 to 54.5 in voice and accountability, from 18.2 to 30.8 in political stability/no violence, while the indicator in government effectiveness change is between 39.5-69.8, in regulatory quality-33.3-73.6, in control of corruption 47.3-66.5, and in rule of law 30.1-53.5.⁸

Between 2006 and 2010 the overall score for the Democracy Index was stable at 3.34, it then decreased to 3.04 in 2013, and climbed to 3.69 by 2014. Globally Georgia's democracy ranks as 81 out of 167 countries.⁸

2.2 Economic Development

According to the World Bank (WB), Georgia is a lower-middle-income country, with intermediate human development ranked 79th out of 187 countries in 2013. The country underwent turbulent times during the political transition from Soviet Union to independent statehood and the economic transition from a centrally-planned to market approach. In the first five years after independence, Georgia experienced hyperinflation, which prevented economic development and increased social hardships. The dived by 78%.⁹ Since 1995, the situation has gradually improved. Despite impressive economic reforms and performance over the last decade, Georgia ranks 13 among the 17 countries of EECA region in terms of real GDP per capita. In 2013 GDP per capita at current prices grew to US\$3,599,¹⁰ from US\$2,623 USD in 2010. In terms of the production structure, the country has moved from an agriculture-driven to a more diversified and service-driven economy. Between 1996 and 2013 the contribution of agriculture to the GDP decreased from 34% to 13%, despite remaining among the largest sector along side trade (12-15%) and manufacturing (8-14%),

⁶ Ministry of economy and sustainable development of Georgia, 2015.

http://www.economy.ge/uploads/meniu_publicaciebi/ouer/OUTLOOK_16.05.15_eng.pdf, accessed in July 2015

⁷ Law of Georgia on the structure, powers and order of activity of the Government of Georgia.

⁸Source: Economies Intelligence Unit, <http://www.eiu.com/home.aspx>.

⁹World Bank- World Development indicators (WDI).

¹⁰GeoStat data 2014.

with relatively stable shares in GDP. The fastest growing sector is finance, which increased from 1% to 13% in 1996-2013. The economic dependency indicator has been quite volatile over the last two decades, but the trend has been declining.¹¹

In 2013 the GINI index was 41.4 according to the WB, showing a declining trend in recent years and indicating improvements in the income redistribution although inequality challenges remain.¹²

Despite the moderate economic dependency, unemployment is the leading problem in the country. The rate has steadily decreased, from 16.9% in 2009 to 12.4% in 2014¹³. According to a WB study, unemployment rates are high in the urban settlements, mainly among young age groups and educated people – for men and women it was 16.1% and 13.8% respectively (2013).¹¹ Poverty rates have remained stable over the last ten years. The number of the poorest households who see themselves as vulnerable has increased from 62% to 72% in 2009-2011. Poverty has regional variations in the country, and old age pensioners are the most vulnerable among the poorest population.^{Error! Bookmark not defined.}

2.3 Social and Human Development

Data on the total population vary depending on the sources, but figures from the national Statistics Office, GeoStat, set it at 3.7 million.¹³ Despite a long series of civil registration data, censuses and high quality surveys, there are considerable doubts about demographic trends because of gaps in the civil registration process, uncertainties about the migration flows, and different options of handling data from the two breakaway regions of Abkhazia and South Ossetia.¹¹

According to WHO, in 2013 life expectancy at birth was 71 and 78 for males and females respectively¹⁴. At present, 19,1 % of the Georgian population is over 60. UNDP maintains this figure could reach 32% by 2050, potentially becoming one of the highest in the region, albeit lower than extremely old population in the world.¹¹

The mortality rate(per thousand population)has increased from 9.6 in in 2006 to 13.2 in 2014.¹⁵

The Human Development Index is categorized as “high” and has steadily grown from 0.71 to 0.744 between 2005- 2013. In 2013 Georgia ranked 79th among 187 countries.

2.4 Other External Factors

From early nineties, Abkhazia and South Ossetia are partially-recognized breakaway territories from Georgia that are recognized by three countries apart from Russian Federation. After the start of a war with Russia in August 2008, the Georgian parliament issued a declaration officially announcing these territories as Russian-occupied. Since 1991, due to different ethnic conflicts and wars, Georgia has a significant number of internally displaced people (IDPs) who are housed in collective centers and settlements across the country. By September 2014, 259,247 persons were officially registered in the database of the Ministry of Internally Displaced Persons.¹⁶ There are no data available about how these events have affected the HIV/AIDS situation, but collective centers could be definitely considered bottlenecks for spreading the TB infection - living condition are quite poor, access to clean water is often limited, and access to medical services is minimal due to the remote location of the IDP settlements from the surrounding cities/villages.

¹¹ Population Situation Analysis (PSA) Georgia, 2014, Final report, UNFPA.

¹² World Bank - <http://data.worldbank.org/indicator/SI.POV.GINI>.

¹³ GeoStat data 2014.

¹⁴ World Health Organization - <http://www.who.int/countries/geo/en/> assessed on July 4, 2014

¹⁵ GeoStat - http://www.geostat.ge/?action=page&p_id=151&lang=geo.

¹⁶ Ministry of Internally displaced persons from the occupied territories, accommodation and refugees of Georgia, <http://www.mra.gov.ge/eng/static/55>; assessed on July 4, 2015

From 2008, the TGF program is operating in Abkhazia. The implementing partner is the Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC), also known as the National AIDS Center¹⁷, which is carrying out the treatment and diagnostics components in cooperation with the Sukhumi AIDS Center and is supported by the de-facto government. There is also a harm reduction component, which consists in the distribution of needles/syringes and other relevant supplies. (the Abkhazia constituent is detailed in section 3.3 Service Delivery).

Since 1996 MSF supports the TB program in Abkhazia. The organization provides treatment for MDR-TB patients, laboratory support, and supply of equipment and drugs. It also covers training and writing medical care protocols. In 2014 the program was taken over by a local NGO established by former MSF staff. MSF continues to facilitate the transport of sputum samples from Abkhazia to the culture laboratory in Tbilisi.¹⁸

There is no international health program functioning in South Ossetia at the moment. According to one of the Internet sources, South Ossetians are allowed to cross the administrative boundary line (ABL) in case of a healthcare emergency. In recent years, the number of people opting for treatment in Georgia has increasing and reached 400 in 2014.¹⁹ There is no statistics available about how many people residing in the breakaway territories seek treatment in Tbilisi for HIV and/or TB.

2.5 Brief Health System Overview

In the early nineties, the Georgian health system moved away from centralized Semashko model inherited from the Soviet Union. Over the last 20 years, health system has undergone intensive reforms, mostly progressive, but partly inconsistent (see more below).

Challenges remain in the primary healthcare (PHC), despite the number of large-scale programs supported by different donors (WB, DFID, EU) and implemented in Georgia from 2003. Currently there are almost 2,000 Family Doctors around the country who are serving the population living in villages. They all are independent entities of private law and are not organized in any formal structure, which creates obstacles in service provision, collection of medical statistics etc. Moreover, competence and knowledge of PHC professionals raises questions. PHC services are provided at the level of bigger municipalities (rayons) by polyclinics, the majority of which are owned by private entities or by insurance companies.

According to the new health reform, in 2006, the provision of health service was almost fully privatized. This was followed by simplified regulations and radical changes in the state health financing schemes and allocation. Therefore, Georgia moved to a deregulated market health system involving private insurance companies to provide state-funded coverage to only most socially vulnerable population.²⁰ Almost 95% of hospitals in Georgia are privately owned. As a result of the privatization process, this AIDS Center is currently located on the premises of a private investor (the pharmaceutical company Aversi). Since the land plot and the building was privatized, there have been promises to build the new

center in order to ensure the continuation of the facility and the services. So far, that hasn't happened and the AIDS Center actually depends on the good will of the private owner²¹. The privatization of TB facilities at both district and region level has created the barriers for the TB service provision and the

¹⁷ In this report IDACIRC and National Aids Center will be used inter-changingly

¹⁸ International Activity Reports 2013 and 2014, MSF.

¹⁹ "Healthcare Draws South Ossetians Back to Georgia", <http://www.eurasianet.org/node/72386> accessed on July 15th, 2015

²⁰ DFID Georgia Primary Health Care Reform Support Programme 2003-2008, Oxford Policy Management, Volume 1

²¹ HIV programme review, WHO, March, 2015.

routine data collection system. In some districts, TB services are provided by primary healthcare facilities located in private hospitals, which do not report to the Ministry of Labor, Health and Social Affairs (MoLHSA) and have no clear agreement and instruction on how to manage a TB facility, how to organize space and drugs' storage, or how to handle patients' rights.

The new government elected in 2012 introduced further reforms moving to the principle of universal health care (UHC) coverage and has increased the health budget. Compared to the previous year in 2013 the health care allocation was raised by 17%, in 2014 by 25%, and in 2015 by 3.4%. The recent UHC reform was indeed political success for the leading coalition. However, most health service providers are private companies and there is no proper regulation in place

“Most of the NGOs that are well established in the field of the activity [HIV] are not willing to grow and are not oriented on further development. They are not strong financially and mostly depend on donor grants.”

Key Informant from PR

allowing MoLHSA to control in those premises. This creates barriers to the overall system management and quality/efficiency control of the services provided. Increasing the budget of the universal coverage program is also raising concern among many experts who maintain, that the state budget will not be able to cover the growing burden created by UHC. Currently, the national health system is financed through the general budget's revenues. The pharmaceutical market is quite well developed, although there are some regulatory gaps and the

Government has pledged to harmonize the national legislation with European standards in nearest period.²² Human resources are not distributed proportionally across the country (see more details in section 3.4 Human Resources).

Summary: The fact that almost 95% of the medical facilities are private creates limitations for the MoLHSA and its LEPLs to monitor quality of the services, information flow and patient's rights at private clinics.

2.6 The Role of Civil Society Involvement in Public Service Delivery

The NGO sector in Georgia was established in 1993 and it represents a wide variety of areas. There are no legislative barriers for local and International NGOs to get involved in oversight or service delivery-related activities. In general, the legislative framework regulating the NGO activities creates an enabling environment and there is no restrictive policy to forbid any type of activity. NGOs' activities are regulated by the Georgian constitution, organic laws and the civil code.²³

It is hard to estimate or find written information about how many NGOs are operating in the country. However, there are a number of well-established organizations working in all sectors, including the health care and social sector and implementing projects at all levels, from grassroots community to state policy levels with the competence to carry out high-level research and studies. The NGO sector in the HIV field is well established and features a higher number of organizations than those working on tuberculosis, which is relatively a new sub-sector in CSO. In recent years, issue-based organizations more often establish networks and coalitions in Georgia as this practice promotes advocacy efforts and policy changes. There are also networks working on HIV and TB, the Prevention Task Force (PTF) uniting up to 35 member organizations working in HIV/AIDS and recently created TB Georgian Coalition (TBG) with 11 members. Both networks include CBOs and patients.

²² The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, pg.8, Government of Georgia Ordinance No 724, December 26, 2014.

²³ <http://csogeorgia.org/legislationArchive/geo>.

The NGO sector provides prevention services in TGF program and mobile clinics run by local NGOs are allowed to perform the rapid HIV test. NGOs and CBOs are providing VCT, outreach, harm reduction and care and support related services. The self-evaluations of the NGOs' capacity and the evaluations by state institutions differ significantly. In most cases, NGOs working at the grassroots level and representing KP are not able to gain credibility in order to promote some ideas/suggestions related to governmental decisions and changes in the policy. Different points between NGOs and state officials over the same questions were clear during the interviews. NGOs

“Now we have to participate in state tender that is very restrictive: we have to pay bank interests as we took a loan for providing the guarantee. At the same time, we are paid after completing activities and not in advance, as it were before. All these create barriers to our work... with former PR [with NGO status] the process was easier.”

Key Informant from NGO sector

blame the state of not being committed to lead specific needed changes, i.e. legislative and policy changes, financial contributions for prevention services, etc.,. On the other hand, state institution representatives point at the low quality of narrative and financial reports produced by NGOs, their inability to raise more funds or become self-sustainable, also expressing concern with regards to effectiveness and efficiency of some initiatives performed by NGOs. However, the country has good precedents of state-NGO partnerships, such as Country Coordinating Mechanism (CCM), which is named as the best example of inter-sectoral cooperation in the state health concept document.²⁴

According to the Global AIDS Response Progress Report (GARP,2014), several local NGOs operate in the country and they made significant contributions in the prevention of HIV/AIDS by providing services to KP, promoting policy

changes, and granting care and support to PLWHA. However, the capacity of most local NGOs is quite weak in terms of internal administration and program and financial management. In general, the NGOs sector is solely dependent on donor-funded programs, which is limiting their perspectives to have consistent programming and to retain qualified staff.²⁵

As mentioned above, the NGO sector in the field of tuberculosis is less developed than HIV issue-based ones in Georgia. The USAID-funded TB prevention project (implemented by University Research Co. URC) created an enabling environment for NGOs working in health sector through small grants. The aim of these grants is to support the involvement of the civil society, allowing them to improve the quality of TB treatment facilities, i.e. by introducing infectious disease standards in private medical hospitals and providing relevant training to healthcare personnel. They are also responsible for advocating for increased availability of TB services as well as patient awareness regarding their entitlement to TB treatment. At present, a range of services is being provided through local NGOs including trainings, awareness raising activities, production of information materials, TB control quality improvement tools, and operational assessment. In 2015 the NGO “TB Georgian Coalition” (TBG) was established to facilitate the involvement of community-based organizations and patients in the TB control process. The TBG aims to become the main facilitator of mobilization and collaboration amongst CSOs by developing cooperation with government and TB control program. At the moment, 11 local NGOs are members of the coalition and are currently working on proposals aiming at attracting funds to implement their action plan. Due to the URC program's phasing out in October 2015 and the envisioned reduction of TGF

²⁴The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, pg.8, Government of Georgia Ordinance No 724, December 26, 2014 .

²⁵ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

financing, the future of advocacy, communication and social mobilization (ACSM) activities in Georgia remains uncertain.²⁶

In line with expected phase out of TGF, it is important to describe, how enabling is an environment to contract NGO by state institution, i.e. MoLHSA, National Center for Disease Control and Public Health (NCDCPH), other ministries and LEPLs under the MoLHSA. In general, there is no legislative barrier in the country for contracting NGO.

Currently, the TGF PR is the state agency (NCDCPH) which took over the program management responsibility from NGOs in 2014²⁷. Consequently, they have already purchased services from NGOs and our study enquired about the process and obstacles to both sides: PR and other state representatives on the one hand and SRs/SSRs on the other hand.

NGOs mentioned two main problems related to tender process. First, they found it difficult to present the bank guarantee document as required in the tender application. As most NGOs working in the field of HIV/AIDS do not have any other permanent source of income than TGF grants, it was difficult to show the bank guarantee. To overcome the obstacle, some NGOs took a loan from the bank to show the required deposit on their account. Bank interests are shared between program staff members and are cut from their wages and some NGO representatives presented their own personal savings as a bank guarantee. Secondly, NGOs mentioned the bargaining element of the tender, when they had either to reduce the financial proposal or to lose the tender. They said that the final decision was taken based on price criteria, which is not always fair and does not support the quality of the program. One NGO/SR agreed to implement the activities for a lower price than the one in the initial bid, but during the implementation it faced problems to provide quality services without being covered for items such as transportation and accommodation for training participants. One representative acknowledged they lacked realism in the negotiation process and misjudged the need to precisely estimate the optimal minimal cost for implementing listed activities.

Both the state and the PR are aware of the minor constraints some SRs/SSRs went through, but maintain that the law itself cannot become a barrier to the implementation of the TGF program, in future or in the transition process. State and PR representatives claim that problem is not the tender itself and that the law does not require a price-based decision. Real problem is the capacity to develop technically-sound tendering conditions, which will allow to make a selection based on more than one criterion (in current situation, the easiest criterion to apply- is price). MoLHSA representatives realize that they need to develop such capacity and training sessions are ongoing to enhance the competence in technical specifications development. State representatives also added that the capacity of NGOs and especially those working on grassroots level as CBOs can be problematic. Most NGOs in the country do not have established internal administrative and financial procedures, do not include administrative overheads into the budget, do not diversify the funding sources and therefore they are not able to meet all the tender requirements. State/PR and NGO/SR/SSR expressed quite different concerns for the future. NGOs representatives said that the state may not be willing to contract those particular organizations which have been implementing grassroots level activities for many years, and work with the community, have close contacts with community and KP and hard-to-reach populations, such as PLWHA, MSM, PWID, FSW. State representatives instead said that NGOs should pay attention to their organizational development.

The National Center for Disease Control and Public Health does have a budget line for prevention programs, but it is usually limited to education/information activities and it could be used in the future for other specific prevention programs. The Head of the Health Department at MoLHSA

²⁶Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014

²⁷ Former PR. The projects implementation center initially was a state agency and in 2008 the organization decided to change its legal status in order to avoid a number of complications related to state procurement procedures, also to cope with unconformity of GDF and state procedures.

stressed that they do understand how important prevention is, and is also aware that without the NGOs it will be very difficult to reach KP.

Summary. The NGO sector is well developed and does not face legal or any other barrier to operate or perform its oversight role or policy work. HIV issue-based organizations are better developed with longer history of operations than TB issue-based organizations, which are newly established and less experienced. There is no legal barrier for state organizations to contract NGOs, however, there are rigid tendering procedures restricting the participation of financially/organizationally weak organizations (e.g. a bank guarantee is required). An additional challenge is the technical capacity of the state organizations to develop tender specifications and to base the selection process at least on the second criterion apart from the financial proposal. The state recognizes this weakness and plans to enhance the relevant capacity. The situation might exclude from state tenders those NGOs which are not financially or organizationally strong, i.e. CBOs, but have valuable field experience in working with KP at grassroots level. Moreover, if the tender winner is selected based only on the financial criteria, the risk is a decrease in the quality of the services provided.

2.7 Human Rights, Stigma and Discrimination

Table 2. Existence of legislations specifying protection for key populations and vulnerable groups

Key Populations	Government	Civil Society
PLWHA	Y	Y
MSM	N	N
Migrants	N	N
Orphans and vulnerable children	N	N
People with disabilities	Y	N
People who inject drugs	Y	N
Prison inmates	N	Y
Sex workers	N	N
Trans-gendered people	N	N
Minors without parental consent		
Women and girls	N	Y
Young people	Y	N

Source: Thematic report: Stigma and discrimination, 2012 progress

Georgia is a member of the Dublin Declaration monitoring group for stigma and discrimination and the main mechanism for protecting human rights is through the Ombudsman's Office.

In June 2014 Georgia signed the Association Agreement with the European Union and in the preparation stage, the country tried to align its legal framework with the EU's. According to the agreement, the adaptation of the anti-discrimination law would help in moving ahead with visa liberalization. In May 2014 Georgia adopted the anti-discrimination law which bans all form of discrimination based on religion, ethnicity, or sexual orientation. However, some experts and NGO representatives are not satisfied with some of the wording and mechanisms. The country also has adopted the strategy against violence which focuses mostly on domestic violence, but it contains a section related to discrimination towards people with addictions. Moreover, the powerful Georgian Orthodox Church creates barriers on the application of such documents by direct or indirect opposition via faith community.

According to a report by the European Centre for Disease Prevention and Control (ECDC), a deep-rooted stigma surrounds marginalized and vulnerable populations thus limiting the Ombudsman's effectiveness²⁸ as people do not make their cases public as they are afraid of further stigmatization. The same report identified stigma and discrimination as a significant barrier to the use of HIV prevention and treatment services by most-at-risk populations. Stigma and discrimination also prevents migrants from seeking HIV services, although this is reported to be less important than other factors such as legal, linguistic and cultural barriers and lack of information.²⁹

As mentioned above, the NGO sector working in TB field is of recent establishment. The first patients' association was set up less than a year ago, therefore, TB patients are not yet aware about their health rights. There is no established inventory system for the TB stigma cases like it is in the cases of HIV. On the other hand, the stigma towards the patients with TB is traditionally high in the Georgian society and TB patients would rarely openly talk about their disease. However, respondents from the National Center for Tuberculosis and Lung Diseases (NCTBLD) described several cases of TB patients who were refused in provision of medical services.

Our interviews confirm the above points. Although there is no legal barrier to oversight and register stigma and discrimination cases, local CBOs state that PLWHA tend to avoid making their discrimination cases public. Local NGO and CBO networks working with PLWHA in Georgia reported a significant number of cases when medical personnel refused to provide services once the patient disclosed his/her status. Moreover, often medical personnel are quite inaccurate when providing the information about patients' HIV status. According to respondents, most of patients are not ready to bring cases to the court when their rights are violated, as they are avoiding disclosure of their HIV status, as it was explained by NGO representative. Unwillingness of most patients to disclose the status publicly indirectly indicates negative attitude of general population towards HIV or even TB patients. The social stigma towards HIV and TB could be explained by the lack of awareness and knowledge about how the diseases are transmitted and the real health risks they pose among the general population, and medical personnel as well. The continued privatization of the health sector has resulted in a limited control of the government over the activities of private clinics, where medical staff resist to provide services to HIV-positive patients or KP.³⁰

Georgia's restrictive drug policy creates serious barriers to the implementation of the HIV prevention program. Potential arrests of PWID and administrative penalties for drug use, even for people who try to access HIV prevention services or carry used syringe with drop of the narcotic, significantly interfered with the effective service implementation by NGOs. There are no legal documents issued by the Ministry of Health about the needle and syringe programs therefore the Georgian Harm Reduction Network (GHRN) implements this program without any legal basis. Interviews confirmed this information and NGOs described a number of cases when police arrested social workers for carrying used needles. Nowadays, the GHRN is only distributor of syringes and needles.

There are number of problems in the OST programs as well. Without a legal permission of the routine take-home methadone, OST patients face serious barriers for their social integration, normal cycle of work and leisure activities. As a result of existing practices, patients on OST also face significant obstacles in applying for a civil servant job or a driver's license.³¹

The GHRN is a leader in advocating for a change through the strengthening of community systems harm reduction, human rights and related policy/legislative reforms. The organization is

²⁸ Thematic report: stigma and discrimination, Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Eastern Europe and central Asia, progress report 2012. www.ECDC.europa.eu.

²⁹ Thematic report: stigma and discrimination, Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Eastern Europe and central Asia, progress report 2012. www.ECDC.europa.eu.

³⁰ HIV Program review in Georgia, March 2015, WHO.

³¹ HIV Programme Review in Georgia, March 2015; WHO country mission report.

represented in the inter-agency council on drug policy and actively promotes evidence-based drug policies.

Summary: Georgia has adopted number of progressive acts and polices against stigma and discrimination. However, the legislation regulating drug use needs improvement. Drug use is illegal in the country, and this creates barriers to the implementation of harm reduction programs and it impedes the early detection of HIV among PWID. The stigma towards HIV and TB-infected individuals and MSM is high. Significant attention is needed towards general medical personnel, in particular to enhance knowledge, awareness and attitude, as they often refuse services to MSM, PLWHA and TB patients. Doctors easily disclose the status of the patient, which is illegal. The patients do not bring such cases public avoiding further negative attitude from society.

2.8 Epidemiological Characteristics of HIV/AIDS

2.8.1 HIV/AIDS

General information. The first case of HIV in the country was detected in 1989. Since then, the number of new cases has been steadily increasing and by the end of 2013 it reached 10,9 per 100,00. According to the latest data from the Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC) at the end of 2014 there were 4,695 officially registered HIV cases, 73% of which were males. The proportion of females has increased from 25% to 31% in 2014³². In addition, 2,935 persons have developed AIDS and 981 have died. Based on latest Spectrum estimates conducted in July 2015, in 2014 the number of PLWHA was 6,580, which means that about 45% of them were not aware of their status.³³ The cumulative number of children infected through mother-to-child transmission was 81 as of end 2013, out of which 3 cases were registered in 2013.

Prevalence and Incidence. Georgia belongs to the group of countries with low HIV/AIDS prevalence, although it has a high risk of developing a widespread epidemic³⁴. In the past ten years, the rate of newly diagnosed HIV infections increased from 3.6 per 100,000 population (157 cases) in 2004 to 10.7 in 2014 (564 cases). This 197% surge is above the average increase for the European Region (80%) and it may indicate remaining weaknesses in the HIV prevention for key populations.³⁵

The estimated number of PWID in Georgia is 45,000.³⁶ Estimated HIV prevalence among PWID varies from 0.4% to 9.1% across geographic areas covered by the integrated bio-behavioral surveillance studies.³⁶ The share of transmission through injecting drug use (IDU) in the newly registered HIV cases has decreased from 43% in 2012 to 35% in 2013 while heterosexual transmission increased from 45% in 2012 to 49% in 2013. Both these trends indicate the growing risk of spreading HIV among the sexual partners of PWID.³⁷

Treatment Outcome. The loss of patients occurs at each stage. The analysis of engagement in the HIV care continuum shows that the major gap is at the very stage of HIV testing/diagnosis (see

³²World Health Organization. HIV/AIDS treatment and care in Georgia. Evaluation report, Prepared by WHO Collaborating Centre for HIV and Viral Hepatitis, WHO, September 2014.

³³ National AIDS Center data 2015.

³⁴HIV risk and prevention behaviors among Female Sex Workers in two cities of Georgia; Bio-behavioral surveillance survey in Tbilisi and Batumi. Curatio International Foundation, Tanadgoma. August, 2014.<http://www.curatiofoundation.org/uploads/other/0/292.pdf>

³⁵ National AIDS Center data 2014.

³⁶ HIV risk and prevention behaviours among People Who Inject Drugs in six cities of Georgia Bio-behavioral surveillance survey in Tbilisi, Batumi, Zugdidi, Telavi, Gori, Kutaisi in 2012, Study report, CIF, Bemoni, 2013. <http://www.curatiofoundation.org/uploads/other/0/103.pdf>

³⁷Population Size Estimation of Men Who Have Sex with Men in Georgia, 2014. Curatio International Foundation, Tanadgoma. August, 2014. <http://www.curatiofoundation.org/uploads/other/0/255.pdf>

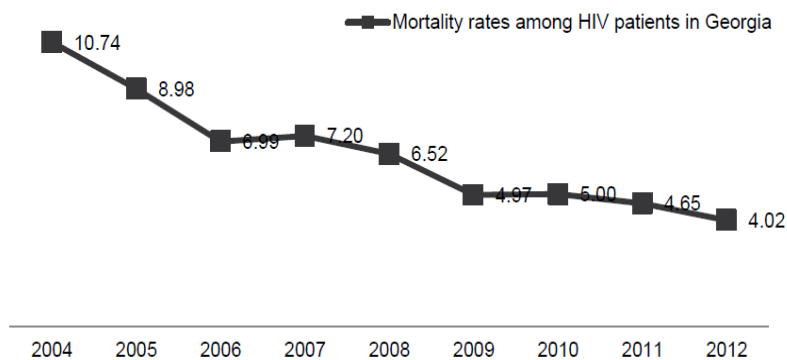
figures in 2.3 Service Delivery pg.38). Almost half estimated persons living with HIV are undiagnosed, which is the result of low HIV testing coverage of key populations. This has consequences on both individual and public health levels.³⁸ Delay in HIV testing leads to late diagnosis hence increasing the mortality risk. At the same time, individuals with undiagnosed HIV who continue to engage in risk behaviors can contribute to the transmission of the virus.

Mortality. Universal access to ART combined with clinical monitoring and adherence support allowed to substantially decrease the AIDS-related mortality in Georgia. Between 2004 and 2012 mortality rates have been reduced by more than the three times – from 6.49 deaths per 100 PY in 2004 to 2.05 deaths per 100 PY in 2012).³⁹ Mortality analysis over 1989-2012 period showed significant decline, with more than 3-fold reduction in AIDS-related mortality compared to 2004⁴⁰. According to the National Strategic Plan for HIV/AIDS 2016-2020, the mortality rate has decreased from 10.74 to 4.02 in 2004-2012, with slight fluctuations in 2006-2007 and 2010-2011 (Figure 1)

Key populations. According to the Georgian National Strategic Plan 2016-2018, HIV epidemic in Georgia is mainly concentrated among key populations: men having sex with men (MSM), people who inject drugs (PWID), and sex workers (SW).

According to the latest IBBS study (2014) conducted in Tbilisi and Batumi, the estimated population size for FSW is 6,525 people and HIV prevalence among them is 0.7%. There are some fluctuations in condom use rates in the two cities, with 90% and 98.8% of FSW reportedly using a condom during the last intercourse with clients and 67% and 90% of FSW consistently using condoms, in Batumi and Tbilisi respectively. This indicates the need for continuous outreach and delivery of prevention information and services. IBBS has also found a relatively low turnover of FSW with almost 70% of the sample having already participated in at least one of the previous IBBS studies. The street-based FSW population is ageing, with the mean number of years working in the sex business reaching 10 years in Tbilisi and 8.5 years in Batumi. It is likely that entering sex business is becoming less common among young women and those who become sex workers are involved in higher segments of sex business, with up-market establishments.⁴¹

Figure 3. Mortality Rates among HIV Patients in Georgia



Source: National Strategic Plan for HIV/AIDS, 2016-2018

³⁸ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

³⁹ Chkhartishvili N, Sharvadze L, Chokoshvili O, Bolokadze N, Rukhadze N, Kempker RR, et al. Mortality and causes of death among HIV-infected individuals in the country of Georgia: 1989-2012. *AIDS Res Hum Retroviruses* 2014;30:560-566.

⁴⁰ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

⁴¹ HIV risk and prevention behaviors among Female Sex Workers in two cities of Georgia. Bio-behavioral surveillance survey in Tbilisi and Batumi. Curatio International Foundation, Tanadgoma. August, 2014. <http://www.curatiofoundation.org/uploads/other/0/292.pdf>.

The MSM population is estimated as 17,200.⁴² The latest IBBSS study among this group has found alarming trends and practice, with higher rates and increase of HIV infection. HIV prevalence has significantly grown from 7% in 2010 to 13% in 2012. HIV transmission attributed to unprotected sex between men increased, reaching 9.3% in 2012 and 13% in 2013. The survey reported that only 67% of MSM used condom during the last anal intercourse; 17.4% of MSM were involved in a group sexual practice, and 69.3% had occasional male partner the previous year; 51.4% of MSM had a female partner in the previous months. The high prevalence of sex with female partners among MSM raises concerns about their bridging role in the HIV transmission to the general population.⁴³

HIV/TB co-infection. Georgia has the second lowest HIV/TB co-infection rate in EECA after Azerbaijan. Co-infection rate is about 2% with some fluctuations during the last few years (2,1% in 2013). Nevertheless, high prevalence of MDR TB rates and increasing trends create significant risk for PLWHA.

The proportion of HIV positive individuals among MDR TB patients is on the rise and it has increased from 3.9% in 2010 to 5.3% in 2013. Active TB is found in more than 16% of people newly diagnosed with HIV, and is the leading cause of death among PLWHA (21.3% overall since the start of HIV registration in 1989).⁴⁴

Since 2005 Georgia provides universal access to PMTCT services, including universal screening of pregnant women for HIV, use of ARVs among HIV positive mothers and their newborns. In 2013, 51,180 pregnant women underwent the HIV testing, and among them 22 HIV+ cases were found. In 2013, HIV testing coverage among pregnant women was 86%. Over the last years, HIV testing has increased among pregnant women. HIV prevalence among pregnant women and blood donors is lower (0.04% in both sub-populations) than in general population (0.07% in 2013).⁴⁵

HIV rates are relatively high in specific geographic areas that are closer to Black Sea (Adjara region, the city of Batumi) and frozen conflict zones (Samegrelo region, the city of Zugdidi bordering Abkhazia). This can be related to a greater mobility of the population in these districts as well as a higher drug use and sex work. The IBBS conducted in 2012 has found higher HIV prevalence rates among PWID in Zugdidi (9.1%) and Batumi (5.6%), versus the national estimated average is only 3%.

Although the HIV prevalence in general population is only 0.07%, there is still a significant risk of outbreak due to the growing HIV prevalence among PWID and MSM. Another risk factor is late detection, which remains a challenge in the country. In 2013 over half of people diagnosed with HIV (66%) were diagnosed at a late stage of infection (CD4 cell count <350), including a 40% with advanced HIV infection (CD4<200), which has a serious impact on AIDS incidence, effectiveness of treatment, mortality and further transmission of HIV.⁴⁶

As reported to the WHO Regional Office for Europe and the European Centre for Disease Prevention and Control (ECDC), 18,091 HIV tests (4.1 per 1,000 population) were performed in Georgia in 2013, a 26% decrease compared with 2004 (24,311). There is no available information about the

⁴²Population Size Estimation of Men Who Have Sex with Men in Georgia, 2014. Curatio International Foundation, Tanadgoma. August, 2014. <http://www.curatiofoundation.org/uploads/other/0/255.pdf>.

⁴³HIV risk and prevention behavior among Men who have Sex with Men in Tbilisi, Georgia. Bio-behavioral surveillance survey in 2012. Curatio International Foundation, Tanadgoma. February, 2013. <http://new.tanadgomaweb.ge/upfiles/dflitcontent/3/123.pdf>.

⁴⁴NTBCLD data 2014.

⁴⁵Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

⁴⁶HIV Programme Review in Georgia, March 2015; WHO country mission report.

number of tests by specific population group. Among key populations, 15% of PWID and 34% of MSM reportedly took the HIV test and received their results in 2013.⁴⁷

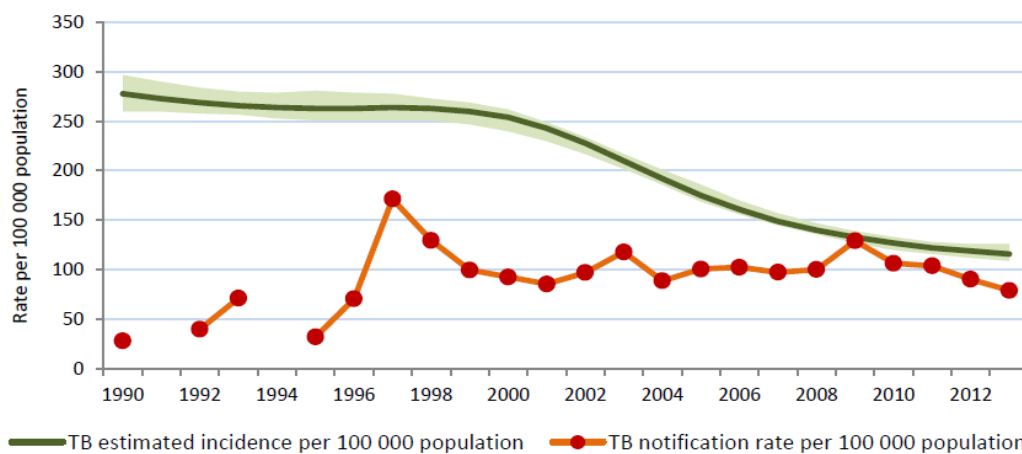
Summary. Georgia is a low HIV prevalence country with concentrated epidemic in KP. Recently, an alarming increase of HIV rate among MSM has been reported. Estimated HIV cases are more than twice the officially registered ones, which means that almost half of HIV positive people in the country are not aware of their status. HIV mortality rates are decreasing. Once the patients are enrolled into the treatment, the percentage of those who are linked to, and retained in care, who are involved in ART and are virally suppressed, is high.

2.8.2 Tuberculosis

General information. TB emerged as a serious public health problem after the country gained independence in the early 1990s. Nowadays, Georgia is one of the 18 high-priority countries of the WHO European Region’s plan to Stop TB⁴⁸ and one of the 27 in the world with the highest MDR-TB rates. It is also in the top 5 in the region for high incidence rates.⁴⁹ According to the recent evaluation of the National TB Program, Georgia significantly improved since the start of DOTS implementation in 1995 by establishing routine drug resistance surveillance since 2005 and providing universal access to drug-resistant TB (DR-TB) treatment since 2009.⁵⁰

Incidence. TB incidence has been steadily decreasing from 1990, the annual rate of decline between 2001 and 2013 was at an average of 5.8%. Males are 68-73% of all new cases and the proportion of females has been slightly increasing from 2010.

Figure 4. Estimated TB incidence rate and notification of incident TB cases (new and relapse) in Georgia, per 100,000 population (1990–2013)



Data source: Global TB database

Prevalence. There are no data from direct measurement on TB prevalence in Georgia and figures on TB prevalence is available only from WHO indirect estimates. In 2013, the estimated number of

⁴⁷ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

⁴⁸World Health Organization Regional Office for Europe. *Plan to stop TB in 18 high-priority countries in the WHO European Region, 2007–2015*. Copenhagen (http://www.euro.who.int/_data/assets/pdf_file/0005/68180/E91049.pdf).

⁴⁹ Global Tuberculosis Report, 2014, World Health Organization 2014
http://www.who.int/tb/publications/global_report/en/

⁵⁰Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014

prevalent tuberculosis patients in Georgia was 7,100 (3,400-12,000), equivalent to a rate of 163 (79-277)/100,000 population. TB prevalence steadily dropped from 1990. In 2005 Georgia already achieved the Stop TB Partnership target⁵¹ to halve TB prevalence by 2015 compared to 1990 prevalence estimate.

Mortality. Between 1990 and 2005 the mortality rate gradually decreased with some fluctuations from 8.9 to 7.0. A sharp decrease in 2005 up to 3.8 per 100,000 population was followed by notably increased mortality from 2007 through 2012. Such fluctuation in mortality rates is most probably artifacts related to the inaccuracy in identifying and reporting on death causes. By the end of 2013 the estimated TB mortality was 7.0, which is still higher compared to the Stop TB Partnership Goal to halve TB mortality by 2015 (compared to 1990 data). Thus, Georgia will not be able to reduce TB mortality according to Stop TB Partnership target of 4.5/100,000.⁵²

TB Notification. The TB notification rate varies widely in Georgia, depending on regions and settings. According to the National Statistics Office, in 2013 the lowest rate of tuberculosis was recorded in Samtskhe-Javakheti (44 per 100,000) while in the Adjara region the notification rate was over four times higher, 147 per 100,000 population. Between 2005 and 2013, the decrease notification of all TB cases was on an average of 5.4% annually.

Childhood TB. The proportion of childhood TB decreased from 8% to 6% and almost halved in absolute terms over the last eight years, dropping from 347 in 2006 to 182 in 2013.

HIV co-infection. The HIV testing coverage is 62% only, with 2.1% prevalence of HIV among TB cases. The coverage of antiretroviral treatment (ART) and cotrimoxazol preventive therapy (CPT) is 89% respectively and the treatment success rate among TB/HIV co-infected patients remains rather low at 63%.

TB in Prisons. In the last two years, since 2012, there was a substantial decrease of TB among prison population, from 21.2% to 5.3% out of the overall TB country burden. Nevertheless, TB rates among inmates remain 25.5 times higher than among the civilian population. In 2013-2014, there were no lethal cases among TB patients in prisons, compared to 50 deaths in 2011 and 21-in 2012. Such an impressive improvement is the result of the new leadership at the Ministry of Corrections level and the health reform initiated by the MoLHSA. The program in the prisons is funded by TGF.

Drug-resistant TB. From 2010, primary and acquired MDR-TB prevalence among notified TB was fluctuating, and since 2008 the proportion of MDR among new TB cases has varied between 9-11% and between 31% and 40% among previously treated cases. In 2013 Georgia notified the global TB database a total of 400 MDR TB cases versus the WHO estimated of 720. However, a recent evaluation by WHO states that the actual number of detected MDR-TB cases is much higher. The report lists a series of reasons behind the under-reporting of MDR cases including the fact that patients that were detected and notified in the previous year, but confirmed with MDR TB the following are not longer notified as MDR cases in the following year notification cohort. In addition the Georgian reporting practice is such that patients who are diagnosed with the MDR during the intake of treatment (acquired MDR) are not notified as new MDR cases. Therefore, MDR detection for Georgia is under-estimated if based on routine surveillance data.⁵³

Treatment outcome. Over the last decade, the significant progress has been achieved countrywide in the treatment outcomes of sensitive TB cases. The treatment success rate of all TB cases increased from 62.5% in the 2004 cohort to 78.0% in the 2013 cohort, and the proportion of patients interrupting the treatment during the same period has decreased from 16.3% to 10.7% (among new AFB-positive cases – from 12.7% to 7.5%). In the 2013 cohort the full treatment

⁵¹ Global Plan To Stop TB 2011-2015, World Health Organization.

⁵² Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

⁵³ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

results of new AFB-positive cases are the following: treatment success – 81.5%, default – 7.5%, failure – 3.7%, death – 3.5%, transfer out – 0.5%, not evaluated – 3.3%.⁵⁴

Summary. Georgia ranks among the 27 countries in the world with the highest MDR-TB rates and is among the top 5 in the region. However, the country has significantly improved since the start of the DOTS implementation in 1995. The program scored substantial results including the establishment of a routine drug resistance surveillance since 2005 and the provision of universal access to drug-resistant TB (DR-TB) treatment since 2009. The burden of resistant cases though remains high. In 2013 Georgia notified the global TB database a total of 400 MDR TB cases versus the 720 estimated by the WHO among the notified. Treatment is aligned with modern guidelines. In general the treatment success rates have improved the trend.

2.9. The Global Fund Grant Overview

Currently, the country is implementing two grants from the round 10:

1. Geo-H-NCDC Sustaining and scaling up the existing national responses for the implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care intervention in Georgia (ends on 31st December 2015, total signed to date US\$24,206,260)

2. Geo-TB-NCDC Sustaining universal access to quality diagnosis and treatment of all forms of TB including M/XDR-TB (ends on 30st June 2016, total signed to date US\$15,396,763).

As a lower middle income and low disease burden country, Georgia becomes eligible for the new funding model (NFM) in the band 4 group. Based on TGF board decision from March 2014, the country may receive US\$56.4 million for HIV, TB and health system strengthening. The amount includes all funds available from TGF as of 1st January 2014, including existing ones.⁵⁵

Following an extensive, inclusive country dialogue and the national strategic plan update process, Georgia has developed and submitted the HIV/AIDS concept note for the NFM window 6 in April 2015. Currently, the country is developing the TB control national strategy and is preparing to submit the TB concept note for window 7 in July 2015.

From 2004 and through the end of round 10, the Global Fund have provided almost half of the financial sources in the budget to scale up the national response to HIV/AIDS and national TB control program in Georgia. According to the data presented in latest NSP in HIV, the Global fund contribution to HIV program in Georgia was 34-54% of the total in 2010-2015. In the same period, state contribution varied between 28-48 % and by 2018 the state should gradually increase its share up to 62 %.

The current stake of state funding in TB is 56%, it will increase from 2015 and by 2018 is set-to cover 100% of FL drugs and 75% of SL drugs. According to latest NFM concept note, the state's financial contribution to TB program will be grow from US\$3,020,631 in 2015 to US\$11,906,737 by 2018.

The country has received 14 grants in total: five for HIV, six for TB and three for malaria. The total amount for HIV was US\$84,575,037 (rounds 2, 6, 10), and for TB- US\$ 48,757,940 (rounds 4, 6, 10).⁵⁶

Since 2004 the principal recipient of the GF grant has been the agency operating under the MoLHSA, the Georgia Health and Social Projects Implementation Center (GHSPIC). From April 2011

⁵⁴ NFM CN submitted on July 15, 2015.

⁵⁵ Country allocation letter NFM (from TGF to Georgian CCM).

⁵⁶ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

the Global Projects Implementation Center (GPIC) has become a PR. GPIC was Non-Entrepreneurial (Non-Commercial) Legal Entity (NELE), founded on 25 January 2011 (Identification Code 404885291) by core staff of the Global Fund Projects Implementation Unit of GHSPIC.

During the current R10 program implementation period the principal recipient of the grant changed and the CCM selected National Center for Disease Control and Public Health (NCDCPH) as new PR from September 2013. NCDCPH is an agency under the umbrella of the MoLHSA and it plays important role in HIV and TB surveillance and prevention. It is expected that the organization will consolidate state and donor finances and lead to the effective taking over of TGF program.

Summary. With the support of TGF funding, the HIV program in Georgia has ensured diagnostic, ART and adherence services to PLWHA. During the implementation, the harm reduction services, including needle/syringe distribution and OST, have significantly increased the geographical coverage and the number of beneficiaries. TGF has financed other prevention services for key population (FSW, MSM), also psycho-social and care and support services. For the TB program TGF has covered diagnostics, treatment and adherence services.

2.9.1 HIV

The ongoing HIV program(GEO-H-NCDC) provides substantial support to HIV prevention, treatment, case and support, with the goal of reducing transmission of HIV among key populations and mortality among PLWHA. Prevention services target PWID, SW, MSM and prisoners. The intervention for KP include community outreach, behavioral change communication, counseling and testing, needle, condom and lubricant distribution, methadone substitution treatment for the general public and the penitentiary system, STI diagnosis and treatment, prevention of HIV/TB co infection. The prevention component also covers PMTCT. During the implementation phase an advocacy component has been added to the project with a local established by affected people (KAP) tasked to carry out policy change activities on all levels.

The treatment services covered by TGF include: antiretroviral (ARV) treatment and monitoring, prophylaxis and treatment for opportunistic infections, hepatitis C treatment and monitoring. The program also provides care and support for chronically ill patients.⁵⁷

The NFM concept note covers the period between 1 January 2016 and 31 December 2018 and the proposed program foresees six key modules covering basic priorities and three complementary technical modules. Four of the key modules focus on prevention, one on treatment and care, and one on policy development and advocacy. Technical modules include health information systems and M&E (operational studies and epidemiological research to verify the directions of national response), and the administrative unit (program management). The key modules encompass HIV prevention, outreach, basic prevention and HIV detection among PWID, MSM, sex workers and their clients, and prisoners, including BCC, as well as strengthening of HIV care and treatment and removing legal barriers of access to the services. All modules are designed around the concept note's three strategic objectives:

Objective 1: Prevent HIV transmission, detect HIV, and ensure timely progression to care and treatment among the key populations;

Objective 2: Improve HIV health outcomes through ensuring universal access to quality treatment, care and support;

⁵⁷Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

Objective 3: Ensure sustainably strong response to the epidemic by enhancing the government's commitment, enabling legislative and operational environment, and supporting a greater involvement from the civil society.

Table 3. HIV grants received by Georgia between 2004 and 2014

Project Code and Title	Status	Period	Disbursed	Round and PR	Rating
1.GEO-H-NCDC-Sustaining and scaling up the existing national responses for implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care interventions	Ongoing	Apr 2014 Dec2015	Total committed \$13,771,977	Round 10 NCDCPH	A2
2.GEO-H-GPIC Sustaining and scaling up the existing national responses for the implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care intervention in Georgia HIV/AIDS. Global Projects Implementation Center	Financial Closure PR Change	Apr-2011- Mar2014	\$24,803,526	Round 10 GPIC NCDCPH from Sep.2014	A1
3.GEO-S10-G07-H Sustaining and scaling up the existing national responses for implementation of effective HIV/AIDS prevention activities, improving survival rates of people with advanced HIV infection by strengthening treatment and care interventions in Georgia	Administratively closed	Jan 2010- Mar2011	\$3,725,705	Round 6 GHSPIC	B1
4.GEO-607-G06-H Bridging the gap in the management of drug-resistant tuberculosis in Georgia HIV/AIDS.	Administratively Closed PR-Change	Jan2008 - Dec2010	\$8,047,101	Round 6 GHSPIC	B1
5.GEO-202-G01-H-00 Strengthening the existing National Responses for the implementation of effective HIV/AIDS prevention and control in Georgia (2003-2007).	Administratively Closed. Consolidated	Mar 2004- Dec 2009	\$14,363,254	Round 2 GHSPIC	A1

2.9.2 Tuberculosis

The ongoing TGF program (GEO-T-NCDC) is focusing on TB diagnostics and treatment and it covers 1st and 2nd medicines and adherence services.

The NFM concept note was submitted on 15, July, 2015, covers the period between July 2016 and December 2018 and it focuses on the priority interventions that cannot be covered by the domestic funding. The concept note is designed around the core three objectives stated in the national strategic plan for TB control, 2016-2020. These objectives emphasize universal access to early and quality diagnosis, timely/quality treatment for all forms of TB including M-XDR-TB, relevant supportive services and strengthening of TB control system in Georgia

Table 4. TB grants received by Georgia between 2004 and 2014

Project Code and Title	Status	Period	Disbursed	Round and PR	Rating
1.GEO-T-NCDC Sustaining Universal Access to Quality Diagnosis and Treatment of All Forms of TB including M/XDR-TB	Ongoing	Feb2014-Jun 2016	\$6,945,457	Round 10 NCDCPH	B1
2. GEO-T-GPIC Sustaining Universal Access to Quality Diagnosis and Treatment of all Forms of TB including M/XDR-TB.	Closed. PR Change	Jul 2011-Mar 2014	\$9,887,701	GPIC NCDCPH	A2
3.GEO-411-G11-T Expansion of DOTS implementation in Georgia.	Administratively closed. Consolidated	Apr 2011-May 2013	\$2,596,750	RCC1 GPIC	NA
4.GEO-611-G10-TBridging the gap in the management of drug-resistant tuberculosis in Georgia	Administratively closed	Apr 2011-Jun2012	\$864,160	GPIC	NA
5.GEO-607-G05-TB Bridging the gap in the management of drug-resistant tuberculosis in Georgia.	Administratively Closed. PR Change	Jul 2007-Mar 2011	\$9,192,634	GHSPIC	NA
6. GEO-405-G03-T Expansion of DOTS implementation in Georgia.	Administratively Closed. Consolidated	Apr 2005-Mar 2011	\$ 6,410,351	GHSPIC	B1

2.9.3 Grant Performance

As shown above, HIV grants mostly rank as A1, also A2 and B1. TB grants rank as B1 and A2.

CHAPTER 3. INTERNAL ENVIRONMENT

3.1. Stewardship (Political Support)

3.1.1 Stewardship Of National HIV AND TB Programs

Political will and expressed budgetary commitments. Improving the access to quality health services is a priority declared by the Government of Georgia which in 2013 introduced a universal health coverage (UHC) approach and increased the health budget from 1.7% to 2.7% of GDP. The universal minimum Basic Benefit Package coupled with the increase in public expenditure for health undoubtedly addressed the low utilization of health services and it was an important step to increase access to the health services.⁵⁸ By November 2014 the whole population was covered by different schemes – state, corporate or private. The Strategy of Social-Economical Development of Georgia approved by Government ordinance #400 on 17 June 2014 state that improving the health financing system is one of the priorities of the Georgian government. In December 2014, the Government approved the Georgian Healthcare System State Concept for 2014-2020 which defines the UHC a pillar for the development of the health system in the country and it prioritizes improving the prevention of communicable diseases.⁵⁹

⁵⁸ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

⁵⁹ The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, Government of Georgia Ordinance No 724, December 26, 2014.

The Concept includes TB control in its priorities and calls for improving the quality of TB services. The document highlights the importance to reduce late detection of infections, and also to decrease HIV/TB co-infection burden. The government is committed to gradually transfer the priority programs funded by external sources (including TGF-support to HIV and tuberculosis) to state financing. This can be achieved by developing financial sustainability plans, detailing the allocation of financial obligations, and reflecting these obligations in the government's financial commitments.

⁶⁰The start of this preparatory work is planned in the period covered by NFM program (2016-2018).

The funds required to maintain and expand the delivery of the necessary services are reflected in the Medium Term Expenditure Framework (MTEF) for 2016-2018. Furthermore, the governmental resolution from 17 June, 2014 highlights the need for improving the efficiency of state funding and for this purpose it offers the introduction of disease-related groups and the integration of vertical state programs (such as disease oriented ones like diabetes, TB, HIV etc.) into the universal health program.⁶¹ Interviews confirmed that the commitments are expressed in relevant strategic document and evaluated positively this fact. However, respondents think that sometimes there are some misalignment between declared commitments and financial contributions, and that the political support to HIV and TB programs is largely determined by the active involvement of TGF, by the donor conditions and its recent willingness to pay for the requirements. Some respondents doubt that the state will cover even the committed contributions in future, although the majority maintains that the state will definitely cover the treatment component.

In 2015 Georgia launched the Hepatitis C elimination program, supported by the Gilead Sciences, which aims at covering 5,000 patients in 2015 and then 20,000 a year during the second phase and it includes the screening of KPs. All stakeholders interviewed said that the program proves the government's commitment to the health sector in general. However, most of them note that the commitment is not always reflected in financial allocations. Interviewed experts suggested that linking TB and HIV rapid screening with the hepatitis-C program by adding additional state financing would make early detection of TB and HIV more effective. Early diagnosis remains a significant challenge as the health system currently is applying only passive detection methods of these infections.

The MoLHSA is responsible for the oversight and evaluation of the national disease programs, as well as for the regulation and overall strategic planning. HIV/AIDS and TB control are both vertical programs of the ministry.

Almost 95% of the country's health care system is privatized which limits the MoLHSA's leadership and governance powers over the private health care sector⁶² thus affecting, to some extent, the management of disease programs. Respondents mentioned several cases of primary health care providers refusing to consult or treat HIV-patients, or not placing TB-patients in separate wards after surgery, hence easing the spread of the infection. A recent review of the HIV program by WHO on the services' quality and equity defines the MoLHSA's scope of action very limited, and this is critical for HIV patients. "Even the National AIDS Centre, for example, is on privatized land and faces the constant uncertainty of being evicted," says the report⁶³. The GLC and WHO's recent evaluations of the TB control system also emphasize service barriers created by the privatization of hospitals and primary health care units which leaves no control to NCTBLD over the TB control processes countrywide.⁶⁴

⁶⁰The Georgian Healthcare System State Concept 2014 – 2020 "Universal Healthcare and Quality Management for Protection of Patients Rights", GoG Ordinance No 724, December 26, 2014.

⁶¹ The Georgian Healthcare System State Concept 2014 – 2020 "Universal Healthcare and Quality Management for Protection of Patients Rights", Government.

⁶²Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014

⁶³HIV program review in Georgia, March, 2015, WHO pg 10.

⁶⁴1. Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014; 2. GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report.

An overall legal environment to sustain HIV and TB programs is positive although there are significant legal barriers for implementing harm reduction programs. This information was available from a number of different strategic documents and reports assessed, and also were confirmed during interviews with both state and NGO/CBO representatives. Both studies and interviews refer to stigma and discrimination of PLWH, KPs and TB patients as creating significant barriers to the program implementation. Discrimination from medical personnel is the most problematic and it often leads even to refusing the service.

The majority of respondents said that traditionally Georgia features quite well-written NSPs in both sectors, but unfortunately these documents does not have a legal power, their implementation is not monitored and quite often commitments and objectives are not followed up. In other words, NSPs are often perceived as something nicely written on the paper, but not as real action plans guiding the state disease programs' implementation.

3.1.1.1 HIV

Aligning with the national strategies. Georgia has reached all three targets within the “Three Ones” principle by UNAIDS, therefore all HIV stakeholders act within the frame of the endorsed national HIV strategies that are regularly revised and updated.⁶⁵The latest National Strategic Plan (NSP) for 2016-2018 was endorsed by CCM in April 2015 and it served as a base for developing the NFM concept note (submitted to TGF in April 2015 for the 2016-2018 program). Currently, the HIV/AIDS response is guided by the NSP 2011-2016, which was endorsed by CCM in August 2010 after the evaluation of the World Bank's AIDS strategy and action plan (ASAP) group.

*HIV Program in Georgia (structure).*The HIV/AIDS prevention and control interventions in Georgia are integrated into the following state programs: 1.HIV/AIDS Prevention and Treatment;2. Safe Blood; 3.Prevention of Mother-to-Child Transmission (PMTCT). There is no structure in the management and/or reporting system for the HIV/AIDS national response program. The reporting is split out between different agencies –the National Aids Center reports to the NCDCPH for the diagnostic, to Social Service Agency (under the MoLHSA) for the treatment part, and to PR (NCDCPH) for all program elements covered by the TGF. The WHO's evaluation mission has recommended to restore inter-institutional coordination among key players in the HIV response.

HIV Program in Georgia (funding). Between 2008 and 2014 domestic funding has increased from 12% to 48%. However, the Global Fund remains the main funding source, providing 34%-54% of the total HIV budget in 2010-2015 (the lowest share was 34% in 2014). From 2011, funding from other International sources has steadily decreased, from 25% to -7%, reaching 3% in 2015. HIV program in Georgia has two main sources, the state and TGF.

According to latest NSP (2016-18) the decrease of external contributions should be balanced by a significant increase of the HIV allocation in the state budget. The funds required to maintain and expand the delivery of essential services are reflected in the Medium Term Expenditure Framework (MTEF) for 2016-2018.⁶⁵

Legal environment. The first Georgian law on HIV dates back to 1995 and it was revised, improved and amended several times (in 2001, 2009, 2010, 2015). While the law improved the overall legal environment for the national response, regulatory barriers for drug users and prisoners are still a problem. A strict drug regulation and restrictive laws on drug use are serious obstacles for the implementation of HIV preventive programs in the country.⁶⁶

There is no legal ground for the needle and syringe program. The OST implementation also has number of problems, i.e. without legal permission of take-home methadone dosage OST patients face barriers for their social integration and organize the normal cycle of work and leisure activities

⁶⁵ NSP HIV/AIDS 2016-2018.

⁶⁶Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

and they face significant obstacles in applying for a civil servant job or even for a driving license, etc. According to our respondents, there are hundreds of drug users who have been regular daily customers of methadone sites for about 10 years. The program link them to one site, so they can not even leave the town in case of emergency, i.e. in case of the death of a close relative or for a business trip or vacation. According to OST site managers, there should be a system in place allowing stable patients to differentiate and/or taking small dosages at home. Potential arrests of PWID and administrative penalties for drug use even for those who try to access the HIV

prevention services significantly interfere with the effective service implementation by NGOs.⁶⁷

“The State now listens to us and tries to understand the TB control related challenges...this is a big achievement in itself...before they were not even trying to understand the specifics of the Program and its needs.”

Key Informant

There is no regulation for sex work in the country and NGO representatives believe that this gap should be addressed in nearest future in order to eliminate potential ground for discrimination of FSWs by the police. Without a clear legal base, respondents say that police is free to manipulate the law and discriminate FSWs, i.e. they often charge FSWs with administrative fines for gathering in the streets.

3.1.1.2 TUBERCULOSIS

The National Center of Tuberculosis and Lung Disease (NCTBLD) is the leading facility for TB

control in Georgia and it administers and implements the state-funded tuberculosis program aimed at decreasing the dissemination of the disease. The NCTBLD is subordinate to the MoLHSA which is responsible for the overall TB control in the country. The activities are carried out through a network of specialized TB service institutions and primary health care services.

TB control is guided by the *National Tuberculosis Strategy and Operational Plan for Georgia 2013-2015*, approved by CCM in 2013. The document is well elaborated, it has specific targets and a baseline. The MoLHSA does not evaluate the results of the TB control and the strategy regularly. The monitoring and evaluation of the epidemiological situation is carried out jointly by the NCTBLD and NCDC. To date, the new strategic plan for 2016-2018 is under elaboration and should be approved by CCM in nearest period. In July 2015 the country applied to TGF NFM window 7 with the concept note, which is based on latest NSP (2016-2018). Previous NSPs in TB covered the periods 2007-2011, 2011-2013 and 2013-2015.

Georgia has taken on strong political commitment to protect its population from TB⁶⁸. Opinion vary among interviewed stakeholders about the TB control program, although the recent financial allocations for rehabilitation of TB pediatric clinic, the increase of TB personnel's' wages by 25% in Tbilisi, the establishment of the TB commission, the changes to postgraduate medical education rules for TB doctors and other steps signal the state commitment. Interviews with MoLHSA representatives showed that they realize challenges related to different segments of TB control system and are committed to implement changes.

The TB program has a vertical structure and delivers services at three levels: 1. National level – NCTBLD, 2. Regional level – regional TB facilities including TB dispensaries in Tbilisi, 3. District level – TB units and primary health care facilities. However, the described structure is rather chaotic, without clearly defined roles, responsibilities and information flow. This chaos is largely determined by the fact that 95 % of hospitals infrastructure in the country is privatized and TB units and primary health care facilities are located in private institutions without clear policies on how to manage a TB facility and what their communication and other obligations are. At the

⁶⁷HIV Programme Review in Georgia, March 2015; WHO country mission report.

⁶⁸ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

moment, all relations are rather personal, than formally described and approved. This situation is described in two recent evaluation reports by WHO and GLC groups, and was also confirmed during the interviews.

According to GLC, the NCTBLD in Tbilisi is responsible for the clinical management of patients in the country. However, it does not have any regulatory, supervisory, or enforcement capacity in the private health institutions that operate in the rest of the country, and it cannot ensure that its clinical recommendations are enforced. While on paper it may look like the center is able to do so, this assessment shows that it “has no power” over what is done in other private health care centers. And while about half of the patients with DR-TB in Georgia receive their initial care through the NCTBLD, most do not receive ongoing treatment in that facility. This situation is ethically complicated, as it is primed to drive inequities in the access to quality diagnostic and treatment services for people with DR-TB in Georgia.⁶⁹ Interviewees stated that some TB doctors do not report patients who have quitted from the treatment and still keep these patients registered as DOTs. The doctors would then store relevant drugs and use them to treat unregistered TB patients.

Relying more on market mechanism for the service delivery model and integrating the state TB control program in the general health system has made the management of the TB control system fragmented, the accountability and the mandate of key central institutions blurred.⁷⁰ According to the approved strategy, the NCTBLD’s director was appointed as a specific senior focal point accountable for TB control nationwide. However, some of the responsibilities are shared with the NCDC and there is no clear separation of authorities of NCTBLD with regard to the implementation of the national program – i.e. no clear dedicated authority on what and how to control the quality of the care, and how to initiate corrective or coordinate actions to improve performance. The lack of clarity in roles and responsibilities is also apparent in the NTP strategy 2013-15 (p6). The NCTBLD, which is supposed to coordinate in part the NTP at the central level, has to focus primarily on providing hospital services at the tertiary level and it can contribute to assess the providers’ performance, but it has a limited role in management and coordination of the program at regional and local level.⁷¹ In fact, there is no NTP in the country at the moment.

The government is currently discussing how to improve the TB control as well as the financial sustainability of the TB program, its legislative framework and institutional structure.⁷¹ The latter has been clarified through the governmental order (adopted on 11 November 2014) which creates the central coordination body for TB. The national TB Council is specifically in charge of coordinating the development and the implementation of a long-term strategy in line with international standards. However, a recent evaluation states that there is no consistent line for accountability in the organizational framework to monitor overall performance of the national TB control system.⁷¹ Currently many elements of the policy cycle are implemented occasionally and unpredictably and are not based on a clear, well-elaborated and stable institutional process. At the same time, there is no governance mechanism in place showing how to prioritize the expenditures financed from the saved funds and how to convert them into financing for ambulatory care. Respondents said that the National TB council is not functioning as it does not have an appointed coordinator and members’ roles and responsibilities are not defined.

The applicable legislation for the control of contagious diseases does not offer a sufficient legal basis for the management and control of TB and the Parliament is discussing a new draft law on TB control. The draft bill aims to define the necessary instruments “for the protection of individual and

⁶⁹ GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report.

⁷⁰ 1. Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014; 2. GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report.

⁷¹ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014

public health through effective control of TB (Article 1). According to the draft, basic human rights have to be respected. (Article 3.3)⁷²

TB services in Georgia are free of charge. According to the 2013 WHO data collection form, the share in the health public expenditure allocated to TB (not including the funding from external donors) seems to be very low, which was 0.9 % of the public expenditure on health and was 0.16 % of the total expenditure on health in 2012. At the same time, if we take into account the expenditures for TB funded by international donors along with the public expenditure on health, then the country spent 2.31 % in share of the public expenditure for TB and 0.42 % of the total expenditure. This level is very low compared with other high burden countries.⁷¹

The TB control program still heavily depends on international donors, mainly the Global Fund and USAID, which are biggest contributors together with the state. MSF also contributes with small-scale programs. In 2012, international donors financed 62 % of the total needs. The government covered only the wages, small parts of the laboratory supplies and equipment, the cost of hospitalization and other infrastructural expenditures. The current domestic funding for the TB program is not sufficient to fully scale up MDR-TB prevention and control activities and achieve a full MDR-TB country coverage as well as replace the funds of the external donors for 1st and 2nd line drugs. Spending for management and supervision as well as incentives to stimulate better performances seems to be limited and neglected.⁷¹ According to the NFM concept note, the state has committed to cover 100% of the 1st and 75% of 2nd line drugs by 2018.

Summary. In general, both HIV and TB programs are based on professionally developed NSPs. However, the overall structures are not clearly defined, which leads to unclear management and reporting responsibilities. The legal environment is mostly adequate, but the restrictive drug policy creates barriers to harm reduction activities, and therefore to HIV prevention in the country with a potential negative impact on public health. Programs largely depend on the donor funding and the state has committed to increase domestic funding by the end of TGF NFM program (details of the commitment are provided in the sections: TGF grant overview and funding).

3.1.2 Coordination Mechanism

The Country Coordination Mechanism (CCM) is the main platform to involve HIV and TB stakeholders at all levels in the decision-making process, to develop strategic documents and to resolve HIV-related issues. CCM has been established with support and requirement of the Global Fund in 2004. According Government Resolution as of June 2012 the minister of health chairs the CCM and it ensures quick dissemination and implementation of the mechanism's decisions at the highest governmental level. According this Resolution CCM is the single National Authority to plan and coordinate National response against HIV/AIDS, TB and Malaria.⁷¹ The CCM board features ministries' representatives, bilateral and multilateral agencies, universities, local NGOs and key affected communities, as well as the Georgian Orthodoxy Church. Recent requirements added by the GF influenced the member composition and most NGO and CBO representatives, who are also CCM members, said that inclusiveness and clarity have significantly improved.

In 2002 it was established an HIV Prevention Task Force (PTF), which unites professionals and NGOs working in the HIV sector and it ensures effective cooperation between CSO and the government. Initially, the group operated with the support of a USAID project, but it is now an independent and voluntary body with a charter and internal regulations. One or two members from NGOs provide secretarial assistance and they are elected periodically on a rotational principle. Some respondents perceive positively the PTF and said that its connections with the CCM serves as a link between CCM and CSO, while others see it as a rather formal entity which has become ineffective recently as it largely depends on the organization providing the secretarial support. A positive factor is the fact that the PTF's quota in the CCM has increased from 2 to 4 members.

⁷² 1. Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014;
2. Georgian law on tuberculosis control, 2015, draft version.

Once every two years the PTF elects its candidates the CCM. In the recent state health concept document the CCM is reported as best practice of inter-sector collaboration.⁷³ Most interviewed stakeholders, including CCM members, maintain that the MoLHSA should fund the secretariat, but for some respondents it is too early to speculate what will happen after three years of the NFM program implementation. All agree on that the national coordination body is needed.

Interviewed stakeholders consider the PTF and CCM connection as an important achievement and have no doubt that the mechanism should remain beyond the TGF program. Informal discussions are being held around the most appropriate format or composition, i.e. should it be more technical or kept in the same pattern. Most respondents say that in the future the ministry of health should lead and finance the CCM.

The National TB Council (NTC) is the body formally coordinating the TB control program at the central level. The structure was created according to TGF precondition and is supposed to fill the gap left by the lack of NTP program management in the country. Interviewees claim that after eight months since its establishment, the council still hasn't elected a coordinator, which should be a full time job. According to the draft NSP 2016-2018, the NTC should carry out strategic and operational planning, engage in mobilization of additional domestic and external resources for TB control, and facilitate the mainstreaming of legislation, regulations and standards in the field. The NTC will monitor and evaluate the progress towards achieving the NSP objectives and targets, and will be in charge of other practical tasks related to the NSP implementation. In reality the NTC does not have any technical nor legal power to conduct these functions; therefore, as the body is not yet functional it needs rethinking/restructuring.

3.1.3 Program Management Arrangements and Capacity

In September 2013 a transparent and competitive process led to select the National Center for Disease Control and Public Health as the principal recipient of TGF grants in Georgia for both HIV and TB. The implementation of the phase 2 of the current Global Fund's HIV program started in April 2014 and will run through 31 December 2015. The NCDCPH as PR and key responsible agency for disease surveillance is expected to better coordinate and consolidate state and donor funds. The NCDCPH is assisting the MoLHSA to prepare the transition strategy to ensure the successful takeover of the TGF programs by the government from 2016⁷⁴.

The NCDCPH has adequate administrative, managerial and technical capacity to manage TGF program. Recently the institution has undertaken several steps to improve the quality of disease surveillance and M&E of national programs of HIV and TB. TGF staff does not have top ups on their salaries, except for the three managers. The NCDCPH leadership maintains that the wage top up should not be an issue for retaining the staff, as the difference between TGF and NCDCPH salaries is not significant, so keeping the personnel will mostly depend on personalities rather than money, i.e. how committed M&E unit staff is to the public health work. Respondent has speculated that some staff might stay and others leave and it is hard to predict such issues now.

HIV/TB integrated service arrangements. This service foresees TB testing for HIV by referring them to NCTBLD while TB patients are referred to the national AIDS Center in order to get HIV examination. The referral system works in Tbilisi and is quite weak in the regions. The TB system review reports several cases of late start of the ARV treatment for TB patients which indicates the weakness of the referral system and the need to significantly improve it.

⁷³ The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, Government of Georgia Ordinance No 724, 26 December, 2014 pg 8.

⁷⁴ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

Health and Social sector arrangements. There are no particular social arrangements for TB and HIV patients. The social benefits are considered only by the state social system, which takes decision based on the person's income level. The patient would receive support if he/she falls under the socially unprotected group, but this support is not related to the disease. MDR/XDR TB patients receive financial incentives for transport, replacing the previous food voucher system. Incentives (including rates and funders) are described in details in other sections as well.

3.1.4 Partnership

3.1.4.1 HIV

The HIV and AIDS national response can count on the following key players: CCM, MoLHSA, NCDCPH, NCTBLD, AIDS and Clinical Immunology Research Center (IDACIRC). TGF, USAID, UNFPA, and WHO are the leading international partners and the network includes a considerable number of NGOs, CBOs and patients organizations. IDACIRC is leader in providing diagnostics and treatment services, it also performs the analytical task of processing HIV-related data plus advocating for important strategic decisions. Prevention services are provided by quite large network of local NGOs and CBOs. NGO sector has created the prevention task force group (PTF), which unites all Georgian and international NGOs working in the field of HIV and is a channel to bring CSO voices to CCM.

Stakeholders evaluate the partnership as participatory and quite effective. There are some concerns about how the partnership will function after phasing out of TGF as most CSO respondents believe that the Fund was always the main driver behind the cooperation. Representatives of the NGO sector think that since the TGF requirements and conditions to the state are always taken on board and followed, TGF should lead/push the process of developing the transition plan development and follow up on its implementation.

3.1.4.2 TUBERCULOSIS

Other players in TB control program partnership are CCM, MoLHSA, NCDCPH, NCTBLD, NTC, the ministry of Corrections and Legal Advise, The Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC), The Ministries of Economy and Sustainable Development, Finance, Education and Science, Regional Development and Infrastructure. There are also number of local NGOs and international donors/partners such as TGF, USAID, MSF, WHO.

Compared with the HIV partnership, the network of the organizations working in the field of TB is relatively new, hence not quite strong. The USAID program implemented by URC has established and strengthened, to some degree, the NGO network and patients organizations but ACSM activities are quite new and their future remains unclear once the URC program will phase out in October 2015.

Summary. Structural challenges of both programs creates some problems for the partnership development and strengthening as there is no body assigned to work in that direction. In the case of HIV, the NGO sector is strong enough to initiate some activities and campaigns, although they largely depend on donor support, but NGOs working on TB still lack such capacity. At the moment the CCM is the only body connecting all players in both HIV and TB sectors. Respondents did not have a clear idea about how partnerships should be sustained, and some stated that the requirements by TGF largely influenced the prioritization of HIV by the state. As to TB, the establishment of the NTC was also requested by TGF, although it is not functional yet.

3.1.5 Account Ability Mechanisms

Senior professionals involved in the implementation of the TGF programs CCM members consider the progress update and disbursement request (PUDR) forms and the dashboard a source of information about the program performance, although the latter is a relatively new innovation

introduced by CCM the activity started in late 2014 and the first presentation featuring recent developments and data was carried in June 2015.

It is obvious that there is no institutionalized channel to communicate program-related information to beneficiaries, civil society and other sectors. Information is disseminated ad hoc and it depends on a particular case and/or organization. The minutes from the CCM meetings are always available on the web-site. Organizations conducting different studies, i.e. IBBSS, PSE, run presentations for all stakeholders and reports are available on the web-sites of the local NGOs, such as Tanadgoma, Curatio International Foundation, and Georgian Harm Reduction Network (GHRN).

Interviews confirmed that a comprehensive TB program report is not regularly compiled, SRs and SSRs know only the program's components they implemented. Some respondents said that the reason may simply be a lack of interest towards the program. The CCM has recently encouraged inclusiveness of all beneficiaries into the discussions thus raising awareness among stakeholders about all the different elements of the TB and/or HIV schemes in the country.

There are no outlined strategies to secure and maintain public support (at least we could not find in any source and it was not mentioned by none of respondents). State representatives said that the advocacy capacity of the national programs is not strong and it should be enhanced significantly.

3.2. Financing

3.2.1 General Health Care Financing

Over the last two decades the financing system of Georgia's health care has undergone radical changes. During 2006-2007 the government launched a reform program with the overall goal to improve equity and financial access to essential health services, with a specific focus on poor individuals and households (targeted assistance). The state took on the responsibility of covering essential health services for the poor population and selected group of public servants and the program was managed by private health insurance companies. Since the beginning of 2009 the initiative widened with subsidies for private voluntary insurance covering the basic package of services (emergency care, urgent care and basic PHC). The expectation was that the scheme would promote affordable health insurance against catastrophic health expenditures.⁷⁵

At the end of 2012 after the new government was elected, a next wave of health care reform started. Georgia launched the universal health program. In first two phases (2013-2015) the state covered a series of services for the whole population: PHC, emergency care (70 – 100%), surgery up to GEL 15,000 (70%), and oncology up to GEL12,000 GEL (80%), antenatal and delivery services.

The National Health Accounts (NHA) of Georgia estimates that in 2013 the total health expenditures (from all sources) were GEL2.19 billion (about US\$1.32 billion). Direct out-of-pocket payments by patients / households accounted for the largest share (66.9%), followed by the state budget (23.8%), private health insurance (4.6%), other domestic sources (2.4%) and external aid (2.3%). With the expansion of Universal Health Care program in 2014, this breakdown is expected to change substantially, which would be evidenced once the 2014 NHA data become available⁷⁶.

Total expenditure in the health sector has increased considerably and steadily by 69.1% in absolute GEL terms– from GEL 426.4 million in 2012 to GEL 720.8 million in 2014. The share of health expenditures to the total state budget grew from 6.5% in 2012 to 10.0% in 2014 and the Medium-Term Expenditure Framework (Basic Data and Directions 2016-2018) foresees further increases in the government health spending to GEL 904.9 million by 2018. This increment is mostly a result of the increased expenditures within MoLHSA health programs, in particular the expansion of the

⁷⁵ Health insurance for poor: Georgia's path to universal coverage. Prepared by Curatio International Foundation, 2012.

⁷⁶National Strategic Plan for Tuberculosis Control in Georgia 2016-2020.

Universal Health Coverage program, which is planned to grow from GEL 338.5 million in 2014 to GEL 520.0 million in 2018 (by 53.6%)⁷⁷.

TGF is the only donor currently financing HIV and TB programs in Georgia since USAID has completed its health programs at the end of 2014 and the last two projects closed at the end of September 2015. Thus, in terms of external financing source TGF is crucial, and it is very important to ensure smooth and responsible transition of the funding requirements to sustain the public health gains.

Table 5. Health expenditure dynamics in Georgia 2007-2013

	2007	2008	2009	2010	2011	2012	2013
Health expenditure, total (% of GDP)	8.2	9.0	10.2	10.1	9.4	9.2	9.4
Health expenditure per capita (current US\$)	188.2	260.6	249.3	266.2	310.3	332.9	349.9
Health expenditure, public (% of government expenditure)	4.3	4.8	6.1	6.6	5.3	5.2	6.7
Health expenditure, public (% of total health expenditure)	17.7	19.8	22.3	22.8	18.1	18.0	21.5
Health expenditure, private (% of total health expenditure)	82.3	80.2	77.7	77.2	81.9	82.0	78.5
Out-of-pocket health expenditure (% of total expenditure on health)	70.8	64.2	66.5	69.1	64.9	64.7	61.9

Source: The World Bank Data Base, accessed July 15, 2015

3.2.2 Funding of National HIV Program

The overall funding need for the HIV response has and will continue to grow steadily due to the scale-up of prevention and care interventions. The annual cost of the national response to HIV increased from US\$5.2 million in 2006 to US\$8 million in 2008 and further to US\$16.77 million in 2014. A further boost is expected to support the planned expansion in coverage and improvements in service quality. An expected increase in ART coverage will not be associated with a significant increase in funding due to the ongoing optimization of the treatment schemes.

The analysis of NSP spending by strategic priorities show that the share of funds spent on treatment and surveillance are increasing with a concomitant declining share for prevention (see Table). However, this trend changed in 2014 as funds for prevention increased.

Table6. Funding of HIV response by Intervention area (in millions of US dollars)

Area	2010	2011	2012	2013	2014	2015	2016	2017	2018
Prevention and Detection	7.22	7.87	7.19	6.49	9.35	7.89	8.55	10.90	12.22
Care and Treatment	3.11	3.76	6.20	6.12	5.73	9.76	5.84	6.68	7.63
Leadership and Policy Development, program	2.47	2.71	3.00	3.08	2.33	1.97	1.52	1.87	1.76

⁷⁷ Ibid.

management										
Infrastructure		-	-	-	-	-	5.00	-	-	
TOTAL	12.80	14.34	16.39	15.69	17.41	19.62	20.91	19.44	21.61	

Source: National Strategic Plan for HIV/AIDS, 2016-2018

The decreasing share of external contributions defines the HIV spending dynamics for the next three years, and the increasing share of state funding required to ensure a sustainable response to HIV epidemic. In particular, in 2016-2018 the government will fully fund the procurement of 1stline ARV medicines, laboratory monitoring of treatment quality, and opioid substitution therapy.

Table 7. Funding of HIV response by source

Source		2010	2011	2012	2013	2014	2015	2016	2017	2018
Government (State)	Mln\$	4.36	4.56	4.55	4.95	7.98	8.34	6.18	11.55	13.1
	%	34%	32%	28%	32%	46%	39%	30%	60%	61%
Infrastructure (State)	Mln \$	-	-	-	-	-	-	5	-	-
	%							24%		
International	Mln \$	6.83	8.52	11.06	9.14	7.02	11.28	8.32	5.72	5.97
	%	53%	59%	67%	58%	44%	53%	40%	29%	28%
Household funds (Private Sources)	Mln \$	1.61	1.26	0.78	1.6	1.77	1.77	1.38	2.13	2.44
	%	13%	9%	5%	10%	11%	8%	7%	11%	11%
TOTAL		12.80	14.34	16.39	15.69	16.77	21.40	20.88	19.40	21.51

Source: National Strategic Plan for HIV/AIDS, 2016-2018

3.2.3 Funding of National Tuberculosis Program

As shown in the table below, the total level of expenditures for activities directly related to TB control in Georgia (from all sources) increased from GEL 21.5 million in 2012 to GEL 28.0 million in 2014 (by 30.4%), primarily following the increase in the government TB spending - from GEL 10.9 million in 2012 to GEL 15.9 million in 2014 (by 45.2%). In US\$ equivalents, based on the National Bank exchange rates, the government TB-related expenditures were about US\$ 6.61 million in 2012, US\$ 8.74 million in 2013 and US\$ 8.98 million in 2014. At the same time, the share of direct out-of-pocket payment for TB-related services is relatively low and has further decreased from 6.3% in 2012 to 5.0% in 2014⁷⁸.

Table 8. Financial Contributions to National TB Program

Source		2012	2013	2014
Government spending	Mln \$	10,916,438	14,532,049	15,855,729
	%	50.9	53.8	56.7
External funding	Mln \$	9,196,993	11,069,433	10,720,171
	%	42.8	41.0	38.3
Out-of-pocket payments	Mln \$	1,352,698	1,385,163	1,412,866
	%	6.3	5.1	5.0
Total		21,466,129	26,986,645	27,988,766

Source: National Strategic Plan for TB control in Georgia, 2016-2020 (Draft)

⁷⁸Ibid.

3.3. Service Delivery

3.3.1 HIV

A numbers of state, private and non-governmental organizations provide HIV services in Georgia. The main referral institution for HIV diagnosis, treatment and care is the National AIDS Center, the state institution affiliated with public health department of MoLHSA. Dedicated departments in the infectious diseases centers/hospitals in Tbilisi, Kutaisi, Batumi, Zugdidi and Sokhumi provide specific clinical services. These facilities include AIDS in-patient departments with 39 beds (18 in Tbilisi and 21 in four regional sites) and out-patient departments. ART-specific services include adherence monitoring and support services, including clinic-based services and operation of mobile units that provide home-based services. All HIV treatment sites, except for Sokhumi, run mobile units.

The National HIV Program provides equitable access to essential medicines, vaccines and technologies of assured quality, safety, and efficacy that are governed by national protocols, which are based on latest WHO guidelines. The selection of treatment schemes is based on the public health approach outlined in 2013 WHO guidelines. According to a recent evaluation of the Georgian HIV/AIDS System by WHO, the clinical care and treatment program is staffed with a professional team at the National AIDS Centre consisting of personnel with complementary competences who have a good understanding of the issues and their challenges. The care component is highly prioritized to the benefit of the patients, which results in higher retention rates, also among PWID, than in many other countries in Eastern Europe. The emphasis on adherence support is high.⁷⁹ According to the data provided by the National AIDS center, PWID retention rate at 12 months after starting the ART was 71% in 2010 and increased to 87% in 2012, and after a slight drop to 80% in 2013 it rose 83 % in 2014. The same indicator among PWID at 24 months after starting the ART increased from 61% in 2010 to 80% in 2011 and stabilized at 74% in 2014. HIV-related key laboratory capacities are integrated within the laboratory facilities of the respective centers and provide all necessary services. The CD4 cell count monitoring is implemented in all facilities countrywide, while HIV viral load, drug resistance testing and PCR-based HCV analyses are performed at the National AIDS Center in Tbilisi.

Diagnosis. The state program on HIV/AIDS prevention aims at the early detection of new cases in order to reduce the spread of infection and provide timely access to ART. The program covers voluntary counseling and testing for high risk groups, including pregnant women, TB patients, STI patients, PWID, prisoners, patients with hepatitis B and C, patients with clinical signs of HIV/AIDS, persons having contact with HIV infected people, blood donors, MSMs and FSWs.

Although the rapid test could be performed at number of private medical institutions and by NGOs providing KP friendly services, the only institution where all HIV suspect cases have to be confirmed is the National AIDS Center. Along with reliability and quality, such centralization ensures accurate registration of new HIV cases. From 2012, for the very short period, there were two places tasked with confirming HIV suspected cases– the other one was the NCDC - but this system did not worked, as tracking of new cases became challenging and the system was changed.

The state program offers one test free-of-charge to all pregnant women and most of them use this opportunity. Universal access to PMTCT services in Georgia is in place since 2005 and rapid linkage to HIV care is functioning. In general, the PMTCT works effectively and in 2014 no child was born with HIV, although the virus was found in 54 pregnant women. HIV testing for all TB patients who are on treatment at NCTLD is mandatory and is carried out within the state program as well. The

⁷⁹HIV Programme Review in Georgia, March 2015; WHO country mission report.

state program on Safe Blood envisages mandatory testing of all blood donors on HIV, hepatitis B and C infections and syphilis.⁸⁰

HIV screening and follow-up rapid testing is provided by NGOs specialized in reaching KPs, namely FSW, PWID and MSM. Local NGO “Tanadgoma”, working with FSW and MSM, is providing primary screening during outreach services. They have a mobile laboratory, which is offering testing to KPs. The Georgian Harm Reduction Network (GHRN) is the only implementing partner for the HIV testing through harm reduction services and its outreach program checks PWID with rapid tests. The number of beneficiaries tested for HIV increased from 8,228 in 2013 to 20,543 in 2014, the latter being 46% of the estimated number of PWID in Georgia. Increased targets by TGF explained such rapid increase - 0,4 % (87 people) of tested PWID were confirmed as HIV positive, 16 were registered and 10 refused to provide their identification.⁸¹ According to the recent IBBSS study among PWID (2012), the testing practice is still low, despite a relatively good knowledge of the HIV test. Less than half were tested during their lifetime and a very small proportion was tested during the previous 12 month (an overall 14.7%, which is an almost three-fold increase since 2009. The worst HIV testing practice was observed among young PWIDs, those with primary/secondary education, with poor HIV knowledge and risky injection behavior.⁸¹

Although HIV rapid testing provided by NGOs as a part of their outreach services is an effective measure for early diagnosis, specialists at National AIDS Center Laboratories expressed concern regarding the low number of patients referred from NGOs for case confirmation. In 2012 95 % of new cases were referred from health-care based facilities and only 5% (28 persons) from community-based ones, in 2013 the share increased up to 8% (38 persons)⁸². Enrolment in care for HIV-positive patients in Georgia is high and well functioning (84%), especially for patients diagnosed at the National AIDS Center in Tbilisi.

However, one key reason for HIV epidemics remains undiagnosed HIV, as half of HIV-positives are not aware of their status. Identification of undiagnosed cases is the most critical component of HIV prevention in Georgia. HIV incidence estimation using recent infection testing algorithm (RITA) indicated that between 2010 and 2012 the number of new infections in Georgia exceeded the number of new diagnoses by at least 60%.⁸³ The main reason is the low or inadequate quality of the HIV testing coverage of key populations at risk and the missed opportunities to diagnose HIV in healthcare settings.⁸⁴

Treatment. Georgia remains the only country in the Eastern European region that has achieved and maintained universal access to ART using the network of healthcare facilities. The country updates the treatment guidelines on a regular basis. The latest recommendation issued by WHO in 2013 (new treatment initiation criteria of CD4 count ≤ 500 cells/mm³) was introduced in country at the end of the same year and, as it was expected, the number of patients on ART have since increased. Following up on a recent system review recommendation and in accordance with 2013 WHO guidelines, Georgia is gradually switching to a public health approach in terms of providing standard ART regimens, which should be completed by the end of 2015 (figure 3). Figure3, which presents absolute figures, shows an average 69% annual ART growth rate between 2004 and 2010, 35.5% in 2011, 31.7% in 2012, and 27.5% in 2013. The change is expected to support the rationalization of ART spending and allow more funding of prevention activities. The AIDS center practiced a more individualized approach to ART monitoring, meaning that patients would visit the facility every second or third month for the viral load and CD cell count tests. Although this

⁸⁰ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

⁸¹ HIV Programme Review in Georgia, March 2015; WHO country mission report.

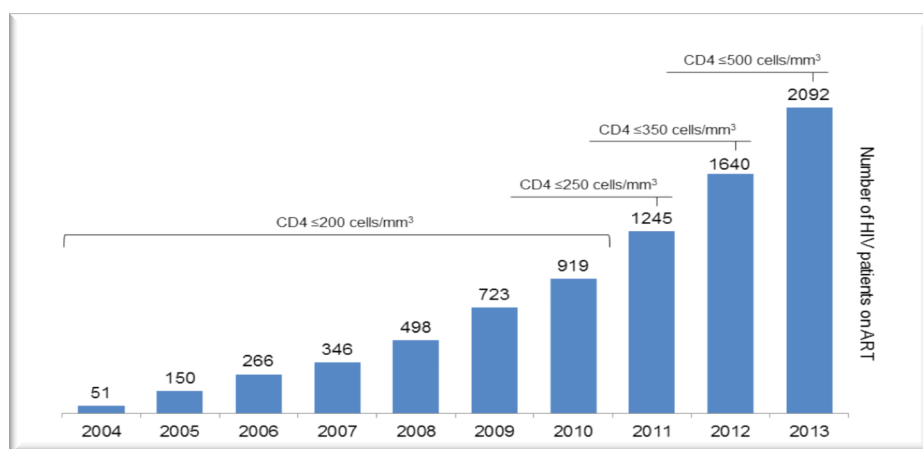
⁸² TGF NFM concept note, HIV/AIDS, submitted on April 15, 2015.

⁸³ Tsertsvadze et al. Estimating HIV Incidence in Eastern European Country of Georgia: 2010-2012. *Int J STD AIDS. In Press* (Accessed on 2 February 2014).

⁸⁴ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

approach guarantees a high quality of treatment monitoring, the WHO recommend fewer visits, once every six month, which is perceived as public health approach in ART, which allow optimizing the costs of the treatment.

Figure 5. Evolving ART Guidelines and Number of HIV Patients on ART in Georgia



Source: National AIDS Center, 2014

According to the HIV NSP 2016-2018, the correction of ART administration includes rationalizing and simplifying the utilized drug schemes, and optimizing the care. The latter will allow to significantly reduce associated costs and workload without compromising the quality of care. The optimization of HIV treatment will continue gradually and result in a considerable reduction of the numbers of possible treatment regimens in the first, second and third line,⁸⁵ meaning reduced cost as well. The treatment monitoring approaches include the monitoring of viral response every six months and immune status every 6-to-12 months.

At the end of 2013 a total 2,092 persons living with HIV were on ART, representing >90% coverage among those who are diagnosed and eligible for treatment. The spectrum-generated estimate suggests that in 2013 Georgia met 80% of the treatment needs, which is the universal access threshold defined by WHO but not yet in line with 90-90-90 call by UNAIDS.⁸⁶

Compared to previous years, 2012-2013 showed an improvement in survival/retention among patients initiating ART. For example, the 12-month retention indicator grew from 79% in 2011 to 86% and 85% in 2012 and 2013 respectively. The 24-month retention stands at 82%, suggesting a major loss within the first year of ART which is primarily a result of death due to a late HIV diagnosis. Retention rates are also high among drug users, reaching 80% at 12 months and 79% at 24 months. Overall 81% of those on ART had suppressed viral load, including 84% among those remaining on therapy for 12 months.⁸⁷ The evaluation of the continuum of care in Georgia (see figure below) shows the right side of the cascade i.e linking to care, retaining, ART involvement and viral suppression elements have quite good outcomes, whereas the left part, detection of new cases requires immediate action, as individuals with undiagnosed HIV who continue to engage in risk behaviors can contribute to the ongoing transmission of the virus.

PWID is the group which most frequently disengage from care. Comparing with other groups they are less likely to start the treatment (88% versus 80%), less likely to continue it (79% versus 67%)

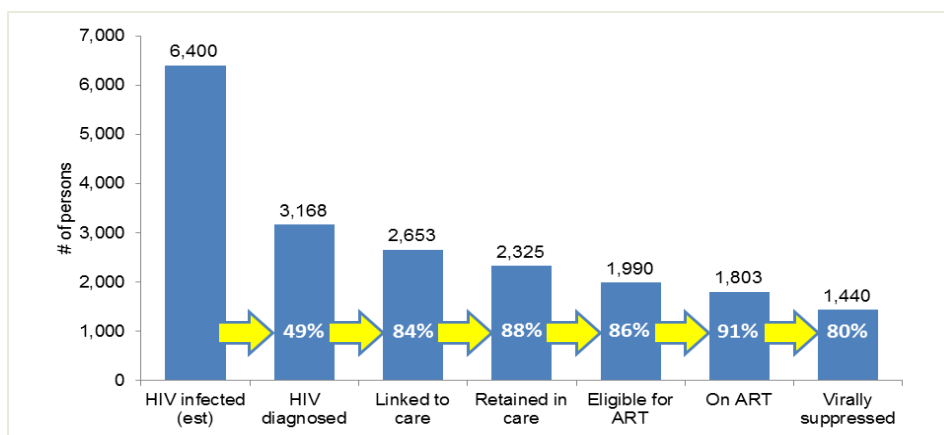
⁸⁵ NSP HIV/AIDS, 2016-2000.

⁸⁶ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

⁸⁷ 1. National HIV/AIDS Strategic Plan- 2016-2018; 2. The Cascade of Care in the Eastern European Country of Georgia. By N. Chkhartishvili, O. Chokoshvili, L. Sharvadze, J. DeHovitz, C. del Rio. & T. Tsertsvadze. In HIV medicine, Online, April 2014.

and to achieve a viral suppression (42% versus 36%).⁸⁸Therefore, the recent NFM concept note to TGF stated that PWID require tailored support services in order to facilitate their progression along the continuum of care and improve the treatment outcomes.

Figure 6. Engagement in the HIV Continuum of Care in Georgia



Source: National AIDS Center, 2014

TB/HIV Services. HIV testing for all TB patients is mandatory. Although WHO does not support mandatory testing, this procedure in Georgia aims to improve case detection. High TB/HIV mortality is a particular concern given that all co-infected patients have access to free medical care for both diseases. In 2013 88% of the estimated number of TB/HIV co-infected patients received treatment for both infections, which is a higher coverage than the EECA regional average of 71%.⁸⁹ However, high MDR TB rates in Georgia coupled with late diagnosis of both TB and HIV leads to an increased risk of death from TB⁹⁰. The national HIV/AIDS strategic plan for 2016-2020 suggest that additional efforts are needed to scale-up a timely case finding and to maintain universal access to the treatment for both infections.⁹¹ TB/HIV service functions well in Tbilisi, but is limited in the regions due to stigma and discrimination towards HIV patients.

Hepatitis C co-infection. Since 2011, and with TGF support, HIV patients have access to free treatment combining Peginterferon and Ribavirin with comprehensive laboratory and clinical monitoring— since then up to 422 HIV/HCV co-infected patients started the treatment⁹². This was the first case in the country of a specific population sub-group gaining access to free treatment. A preliminary analysis of the outcomes shows promising results, suggesting that the program will decrease liver-related morbidity and mortality among people living with HIV in Georgia. As previously mentioned, in 2015 Georgia initiated the HCV elimination program, which should cover up to 20,000 patients per year from 2016 (500 in 2015).⁹³

The National AIDS center’s director advocates for scaling up the HIV testing program by linking it to HCV elimination program. His suggestion is simultaneously testing for HIV all patients who will be checked for HCV. In phase 2 (commencing in 2016) the HCV elimination program will start the test among high-risk groups. Therefore, combining HCV/HIV tests, with a relatively low additional cost

⁸⁸ Chkhartishvili N, Sharavdze L, Chokoshvili O, DeHovitz JA, del Rio C, Tsertsvadze T. The cascade of care in the Eastern European country of Georgia. *HIV Med* 2015,16:62-66.

⁸⁹ HIV Programme Review in Georgia, March 2015; WHO country mission report.

⁹⁰ Chkhartishvili N, Sharavdze L, Chokoshvili O, DeHovitz JA, del Rio C, Tsertsvadze T. The cascade of care in the Eastern European country of Georgia. *HIV Med* 2015,16:62-66.

⁹¹ National HIV/AIDS Strategic Plan, 2016-2018

⁹² National AIDS Center data 2015

⁹³ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

for the state, would dramatically improve the HIV detection rate, which is a matter of significant concern at the moment, as described earlier.

Care and support services are recognized in Georgia as essential components of the comprehensive cure package for PLWHA. Currently, services for PLWHA operate in four out of the five National AIDS center's branches - Tbilisi, Batumi, Kutaisi, Zugdidi. These facilities serve as a base for non-governmental, community-based network of HIV self-support centers, the NGO, which is one out of 8 SR's of the GF grant in Georgia. The centers operate since 2004, employing 14 counselors and 2 psychologists (across the country), who are specifically trained to provide psychosocial support to PLWHA through peer groups and hot-line services. In 2014 the network provided more than 5,000 consultations – via the hotline or online and face-to-face meetings. In 14 years, the network has gained credibility among the PLWHA community and it remains the only way to provide grassroots support to PLWHA, to meet them or to implement the care and support program. Currently care and support for PLWHA services are supported only by TGF.

Palliative care services. Palliative care services have been available in Georgia since 2008 and are managed by the Georgian National Association of Palliative Care with TGF's financial support. The program delivers home-based services with palliative care mobile units in Tbilisi, Kutaisi, Batumi, and Zugdidi, reaching patients through the CBO network mentioned above. The list of services provided includes medical, psychological, and social support for chronically ill patients, and is implemented by health workers and non-health caregivers, including PLWHA. Over the last three years the program has been providing care for up to 40 patients on a monthly basis. The number of visits ranged from 1,461 to 1,689 per year⁹⁴.

Other community-based organizations (CBOs) operating in Georgia provide outreach services to PWID, FSW and MSM, also carrying out advocacy work on grassroots, state and policy levels. Respondents from international and/or state organizations underlined that CBOs often lack managerial and technical capacity, thus, in order to sustain their operations they need to focus on organizational development. According to our respondents, NGOs and CBOs should be more proactive in communicating and cooperating with state organizations, such as the ministry or its agency—documents prove the limited capacity of CBO/NGOs to produce good quality narrative and financial reports.

Voluntary counseling and testing services for KP. As of December 2014 there were 37 voluntary counseling and testing (VTC) sites in Georgia, 10 of which specifically targeted for MSM and FSW. These sites are located in Tbilisi, Batumi, Kutaisi, Zugdidi, and Telavi. 14 harm reduction sites (out of 18 in the country) are integrated with VCT. In addition, 11 cities (out of 14) offer specific services to PWIDs. VCTs serving the FSW and MSM are run by the local NGOs "Tanadgoma", while the Georgian Harm Reduction Network runs those targeting PWID.

Program in Abkhazia. Since 2008, the program is implemented by the AIDS center and its SSR organization, which is allowed to work on the territory of Abkhazia. TGF covers treatment, diagnostic, adherence service, consultation of patients, and treatment of hepatitis C co-infection. The AIDS Centre regularly monitors the program. As of 2015, the number of patients on ARV treatment is 345 and totally up to 600 patients are under the observation. The needle and syringe program covers 600-700 beneficiaries in Sukhumi and surrounding areas.

Interviewed stakeholders maintain that the laboratory in Sukhumi, the region's de-facto capital, needs improvement, since the testing equipment is often out of order, thus resulting in frequent trips to Tbilisi to transport the blood. In terms of sustainability they see no risks, as they believe that the Georgian government will take over the costs for diagnostics and ARV treatment, as it is stated in NFM concept note. Even if problems with transport will arise, respondents think that the implementing NGO in Abkhazia will be able to raise funds from international donors.

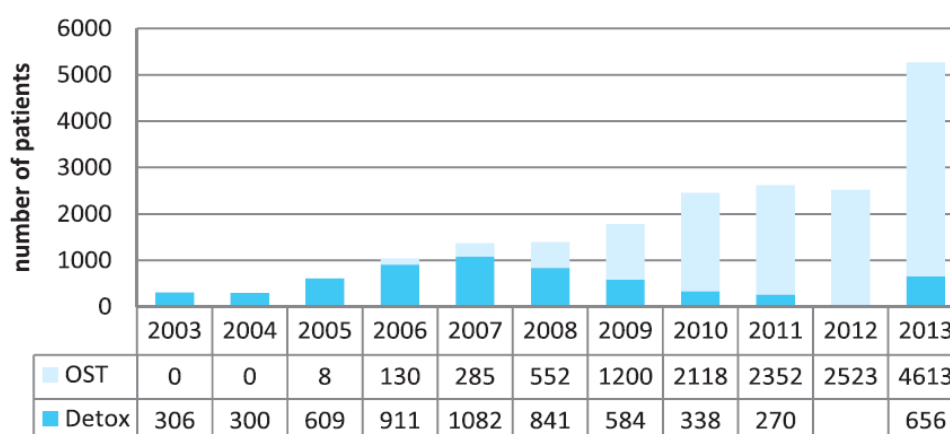
⁹⁴ NSP HIV/AIDS, 2016-2018

Harm reduction. Harm Reduction services were introduced in Georgia in 1999-2000 with the support of the Open Society Georgia Foundation (OSGF). OSGF, the Global Fund program, civil society and experts extensively lobbied for this approach to prevent HIV and other infections. As a result, in 2005 the Ministry of Health approved the state program targeting the drug users, aiming at reducing harm caused by drug use (Budget of the program in 2014 was 4,388.500 Gel which was about 2,580.000 USD in 2014).GHRN is the key actor to deliver low threshold harm reduction services to PWIDs in Georgia. Starting 2008 organization is sub-recipient of the GF grant.

Both public and private institutions provide the following treatment services: outpatient and inpatient abstinence oriented treatment (detoxification), substitution treatment, short-term primary rehabilitation, and psychosocial rehabilitation. There are 4 sites run by GHRN (TGF-funded, free of charge): Tbilisi (2), Gori. and Batumi. 12 OST sites are state-run, 6 are located in Tbilisi and 6 in other big cities (Poti, Batumi, Zugdidi, Ozurgeti, Kutaisi, Telavi). According to a recent HIV evaluation by WHO, the geographical coverage of OST sites is quite adequate and better than in most EECA countries. A co-payment system is in place in the state-run OST services whereby patients make a monthly contribution of GEL 100(US\$ 51). This scheme might create significant risk for the program sustainability in future, as not all patients can afford to pay such amount. TGF funds OST in two penitentiary institutions in Tbilisi, including pre-detention facilities, allowing patients to continue therapy without interruption. According to the Ministry of Corrections, by July 201570 prisoners were on OST.

The recent WHO evaluation on the HIV system highlights a few factors contributing to the potential sustainability of the OST in Georgia. First, governmental institutions under the Ministry of Health and Ministry of Justice implemented and expanded the OST, and integrated it, to a certain level, into their regular services. Secondly, the state budget provided financial support for the therapy and the mechanism of co-payments increase the chances to continue the treatment, even if donor and government funding were inadequate. Thirdly, legal documents on OST exist. In addition the therapy is available in two prisons, hence continuity between community OST sites and jails is guaranteed ; and the OST is linked to HIV and TB services. For example, a weekly or similar supply of methadone is transported from the OST clinic and stored at the HIV center for dispensing as prescribed by an addiction specialist.⁹⁵ However, most experts and patients interviewed mentioned that co-payment would not support program sustainability unless adequate budget financing is provided.

Figure 7. Number of patients treated for substance use disorders in 2003-2013 (NCDCPH, MoLHSA)



Source: *The drug situation in Georgia, the annual report, 2013, USAID*

⁹⁵HIV Programme Review in Georgia, March 2015; WHO country mission report.

Some respondents expressed significant concern about the possibility of the state continuing the OST in the future as the program's current capacity does not provide all elements of continuum and it requires the integration of a psychosocial component. According to the experts, patients should have an opportunity to decrease Methadone dosages over the period of treatment and to get treated finally, but this would require additional services which are likely to be financed by the state, as it was said by the interviewed stakeholders.

There are six clinics specialized in abstinence treatment, providing in-patient and out-patient detoxification followed by short-term primary rehabilitation. Five of them are located in Tbilisi, two are governmental, and four are private. There are three out-patient psychosocial rehabilitation centers which are currently funded by TGF. These units serve clients on OST and AOT as well as ex-drug users, and employ individual, family and group therapies, art therapy, computer classes, religious activities, peer support, etc. These centers can only serve 50-60 individuals at the same time,⁹⁶ which is very low coverage taking into consideration the number of the PWID in need of such assistance.

In 2010 the needle and syringe distribution centers and the voluntary counseling and testing (VCT) centers were merged in the GF program managed by GHRN, which has 14 sites in 11 cities of the country. The program is implemented by 10 member organizations of the GHRN, it covers 10,000-12,000 PWIDs per month, and it offers different services. These include: distribution of sterile injection equipment, alcohol swabs, provision of condoms and distribution of educational material; anonymous testing on HIV, hepatitis B/C and syphilis, TB screening (via questionnaire) and referral to specialized clinics; medical, psychological and legal consultations; training on overdose prevention and distribution of Naloxone.

The strict Drug Law environment is an obstacle to the effective work of the needle-syringe program in the country. Due to the drug policy and punishment measures, the exchange of used needles and syringes is impossible, sterile injecting equipment for PWID is available only for distribution (and not exchange) and most of this equipment is not disposed properly as the disposal depends on the user's only and there is no control over the process.⁹⁷ Outreach workers cannot return those syringes because, according to the law, they can be arrested for any minimal amount of drug found in the used syringes, even just a drop. Interviews provided many details about staff and beneficiaries harassed by the police, i.e. cases of outreach workers arrested, or police catching PWID in areas close to OST sites. In addition, it has become a usual practice forcing a suspected drug user citizens to urinate and get him/her tested. GHRN has a system to document such cases to be used in advocacy activities.

Adherence services. Professionals at the National AIDS Center provide treatment adherence service with mobile groups comprising of three people (doctor, nurse, driver). Transport cost are currently funded by TGF. Teams operate in Tbilisi, Kutaisi, Batumi and Zugdidi, and serve surrounding districts. The state does not provide any specifically-tailored social support to HIV/AIDS patients apart from the testing, treatment, and care services described above.

3.3.2 Tuberculosis

Currently, a number of essential TB control functions depend on TGF and USAID-funded TB prevention programs. These include: capacity building, health system strengthening, procurement and management of health products and equipment for diagnosis, anti-TB and 2nd line treatment, central and regional supervision of TB service points, TB/HIV services, incentives and enablers for DOT and ACSM).

The laboratory network in Georgia was recently re-organized. The grid is managed by the NCDCPH and it consists of the National Reference Laboratory (NRL) in Tbilisi, the Regional Reference

⁹⁶ The Drug Situation in Georgia, Annual Report 2013, USAID

⁹⁷ GHRN-Program Briefer 2015.

Laboratory (RRL) in Kutaisi, nine laboratories for sputum smear microscopy in the civilian sector and two in the prison system. The nine smear microscopy laboratories are in the districts of Akhaltsikhe, Batumi, Poti, Gori, Ozurgeti, Telavi, Zugdidi, in the city of Kutaisi and Tbilisi. The Regional TB Reference Laboratory is located in Zonal Diagnostic Laboratory, in Kutaisi. National Reference Laboratory is situated at the NCTBLD in Tbilisi.

Case detection and diagnostics. The TB laboratory diagnosis is based on smear microscopy, GeneXpert and culture examination on solid and liquid media. The Drug Sensitivity Testing of *M.tuberculosis* for TB drugs is performed in the NRL. Molecular genetic tests have been used since 2011 and they are now a priority for rapid diagnosis of MDR-TB. All laboratories feature modern equipment. An external quality assessment (EQA) for the drug sensibility test (DST) for 1st and 2nd line drugs is conducted regularly. There are existing guidelines for quality assurance of smear microscopy. For peripheral level laboratories controls are used on new reagents, there is no regular maintenance for the microscopes. Controls are performed once per week, positive and negative controls daily.⁹⁸

The specimen is collected in 65 local TB offices and samples for smear microscopy are transported to peripheral laboratories as well as central and regional laboratories for culture and drug susceptibility testing. Currently, there is a significant problem related to the sputum transfer. The delivery is not prompt (the problem exists at the level of transportation), therefore, the sputum becomes invalid for the GeneXpert system and it should then analyzed on liquid or solid media. This procedure takes time to define sensitivity and it therefore delays the start of a timely and relevant treatment.

Countrywide, the sputum transfer follows a once-a-week schedule which causes delays in the TB examination and treatment, and, more noticeably, in the molecular tests and DST results that are only available in the two reference laboratories mentioned above. As a result, starting a specific treatment is delayed too.

The laboratory network is not distributed adequately according to population, number of patients and geographical coverage, inevitably limiting the access to the TB diagnostic investigations in remote areas and delaying the diagnosis.⁹⁸ NCTBLD staff members expressed the concern about the laboratories' coverage as well during the interviews. One suggested solution is increasing the number of GeneXperts at primary health care TB units, but the problem is that TB units are private and they might not be willing to provide the necessary space and conditions for the testing. Respondents also questioned the quality of the diagnosis performed in those units.

Treatment and case management. TB treatment is free of charge in Georgia and hospitalization is not mandatory as patients can choose between hospital and DOT. According to the NCTBPH, there are 422 beds available for TB patients countrywide of which 243 are assigned to drug susceptible TB cases, 159 to MDR-TB and a limited number to palliative care. 250 of these beds are provided by the NCTBLD. The average hospitalization is in line with the WHO recommendations, therefore there is an obvious commitment towards the out-patient community-based model. This has been confirmed by the recent evaluation report as well as by NCTBLD staff. The TB Management Guideline manages the TB treatment in Georgia as well as nine associated protocols, which MoLHSA endorsed in June 2013. Guidelines and protocols are in line with the recent WHO recommendations and are updated on a regular basis. Each update is followed up with training for medical personnel – training sessions are usually financed by donors, TGF in the past and, until October 2015, the USAID-funded URC program. According to interviewed experts, the training component should be maintained, otherwise, the forthcoming financial gap in this area might significantly affect the quality of the treatment in the future.

The 1stline treatment success rate for new cases and relapses was 85% in 2012. The MDR-TB cases who began the treatment in 2011 scored a 50% success rate while for the 19 XDR-TB cases the

⁹⁸ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

success rate was 11% (even though the cumulative success rate for the 149 XDR-TB patients registered between 2008-2011 was 29,5 %, that is 44 patients)⁹⁹.

Low success rate in MDR-TB (50%)¹⁰⁰ and high default remain a major worry. According to the recent GLC mission report, there is great concern that the current system for MDR-TB¹⁰¹ in Georgia is no longer adequate and serious changes are needed to improve the situation and to try and bring MDR-TB under control. Apart from the clinical implications, such poor outcomes affect health care providers as they no longer feel motivated to encourage patients in PMDT (Programmatic Management of Drug-resistant Tuberculosis) since they perceive it as having a “poor effect.” Such demoralization among staff could also influence the patients and lead to a dangerous vicious cycle.¹⁰²

TB/HIV co-infection. In 2013, the number of notified TB patients with documented HIV test result reached 2,698, accounting for 62% of notified TB cases. This was a 5-fold increase compared to the 12% of HIV testing coverage registered in 2004, which indicates an impressive improvement albeit still far below the regional target of 100% for HIV testing coverage.¹⁰³

The death rate of co-infected patients remains high and late start of ART is often the main factor. Out of 10 patients with the co-infection who were hospitalized in the NTBCLD, the level of CD4 at the start of ART treatment was less than 50 cells/mm³ in 6 cases (>50%); delay in starting ART in 3 cases and no ART for the remaining. These patients are eligible to start ART within two weeks after beginning the TB treatment.¹⁰⁴

Treatment, diagnosis and adherence services are fully covered by TGF but the state will start covering the cost of 1st line medicines from late 2015, which is a first precedent when state contributes funding for TB treatment.

Adherence Services. There is no financing for outreach services and case tracking in the state-run TB control program. TGF is providing financial incentives for DOTs patients with MDR/XDR forms, mainly to cover transportation costs which are a significant burden for patients who are below or at the poverty line.¹⁰⁵ From 2015 state is covering adherence support payment for 150 patients and it has commitment to provide it in the future. .

TB Services in Prison. This topic is described in section 3.8 Epidemiology

Active outreach and contact tracing. According to the GLC report, no one is still coordinating active outreach to identify new TB cases, even among the most vulnerable and at-risk populations, like IDPs, former inmates, and persons living in collective settings. Currently, the NFM concept note includes a plan to initiate active case detection from 2016. The current prevalence estimates come from data collected before the dismantling of the TB program. No organization nor medical personnel are aware, for example, of what has happened to the amnestied prisoners in terms of enrollment in care of DR-TB and treatment outcomes. The clinical service (NCTBLD) handed over the contact tracing to the NCDCPH and is now carried out by epidemiologists. These professionals however have minimal training in spotting TB symptoms and although they are able to list current household members and “refer” those with symptoms to physicians, it is unclear how many

⁹⁹ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

¹⁰⁰ GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report; NCTBLD data 2015.

¹⁰¹ Rates of resistant TB are provided in the section 1.8. Epidemiology.

¹⁰² GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report.

¹⁰³ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014

¹⁰⁴ HIV Programme Review in Georgia, March 2015; WHO country mission report.

¹⁰⁵ There is a state grading system in Georgia, which is evaluating poverty of the household based on questionnaire and observation. The grading system defines, who belongs to “below the poverty line” rate, i.e, is eligible for the state social support.

patients will actually see a doctor, especially given that they must present to PHC clinics first. The information provided in the report, was confirmed during the interviews with NCTBLD staff.¹⁰⁶

Summary. Once cases are detected, the quality of the ARV and TB treatment is satisfactory and fully in line with WHO's latest guidelines, which are updated on a regular basis. The patients' retaining in ARV is high, the GF funds a mobile team which provides outreach services and monitors the accuracy of the ARV treatment. The adherence to the TB treatment remains problematic and is causing an increase of drug-resistant TB rates in the country. The success rate of MDR-TB treatment is low. However, in both diseases an epidemic is yet under control, though on the raise, therefore specific attention is needed to case detection and early diagnosis as well as adherence services, which at the moment are fully funded by TFG.

3.4 Human Resources

3.4.1 General Overview of Human Resource Production, Deployment and Retention in the Health Sector (Where Applicable in Social Sector as Well)

In Soviet times, Georgia had high levels of medical staffing, particularly doctors, even compared with other USSR republics and this trend has continued after independence. Currently, the proportion of doctors is three times higher compared with the average figures in the European region – in 2013 the estimate was 456.3 per 100,000 population. The number of nurses is disproportionally low (328.2/100,000 inhabitants), due to traditional stereotypes (the profession is not considered prestigious) and lack of stimulation like professional promotion and financial incentives.¹⁰⁷

Regardless the large number of trained doctors in the country, there are visible problems related to their qualification and continuous professional development, which both officials and NGO representatives providing preventive and referral services confirmed.

In Georgia medical higher education has three levels: undergraduate, postgraduate and continuous medical education (CME).

Since 2004 the Ministry of Education (MoE) manages the higher education system and the Ministry of Health is not in charge of undergraduate level, it hence has no control or influence over the studies' planning. The quality control of undergraduate medical education also falls under the authority of the MoE and relevant universities. Postgraduate or specialized medical training is organized through residency programs for each of the specialties. The state has not provided financial support for residency education since 2005.

There is no mandatory CME system. Once the medical license is granted, it has a lifelong validity and there is no institutionalized system obliging doctors to enhance their professional qualification. Nowadays, the CME fully depends on the goodwill and internal management policy of the medical institutions. Unfortunately, most facilities/hospitals do not invest in capacity building and they prefer to employ specialists with low qualifications and on relatively low wages.

The MoLHSA is planning to implement policy changes and to introduce a mandatory CME system.

The proportional distribution of medical personnel across administrative regions is problematic. There is a high concentration of doctors and nurses in Tbilisi, but it is difficult to recruit and retain

¹⁰⁶ GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July 2014, Final Report.

¹⁰⁷ The Georgian Healthcare System State Concept 2014 – 2020 "Universal Healthcare and Quality Management for Protection of Patients Rights", GoG Ordinance No 724, 26 December 2014.

medical staff in the rural areas, creating concern on access and equity for those populations who are underserved.¹⁰⁸

The uneven distribution of doctors across specializations is another challenge, limiting the number of professionals in less popular areas, such as pulmonary diseases under which TB falls. According to the State Agency for Regulation of Medical Activities (SARMA) human resources planning is not centralized, and the number of residents admitted annually for particular specializations depends on the medical institutions. The MoLHSA tried in the past to take under its responsibility both workforce planning and institutional mapping, but the transfer has neither been completed nor implemented. In 2009 the WHO predicted that despite the overall excess of physicians, personnel shortfall could become a problem in the near future¹⁰⁹. The Georgian government recognizes the mentioned challenges related to health care professionals and this is fully expressed in the health concept documents developed by both the former and current governments.¹¹⁰

In 2013-2014, the Ministry of Health updated the list of medical professions, developed the residency programs in 48 medical specialties and four sub-specialties and is currently working on the document defining doctors' competencies and the procedure for recertification. Free of charge retraining/residency programs with up to 40 vacancies will be offered for those willing to work in remote rural areas or in understaffed specialties, i.e. such as pulmonary disease specialist.

The lack of specific knowledge about infectious diseases epidemiology, including for HIV and TB, among general medical staff leads to stigma and discrimination of the patients and professionals often refuse to provide services (i.e. dentistry, surgery and etc...). Higher awareness of primary health providers and/or other specialists would significantly improve referral practices which remain very weak, causing delayed diagnoses of both diseases.

Social work is a relatively new profession in Georgia. The Georgian Association of Social Workers (GASW) was founded by Western educated young professionals who later have supported state universities to establish academic education courses. Currently, two state universities offer courses at undergraduate (bachelor) and postgraduate (certificate, master and PhD) level. Most graduates work for state social agencies or NGOs operating in social assistance, i.e. foster care. NGO representatives working in HIV with key populations highlighted that graduates either do not wish or can not work with their beneficiaries due to lack of specific knowledge or experience. NGOs working with key populations (PLWHA, PWID, SW, MSM) prefer to employ community representatives and train them, or to retrain other professionals, who already have some knowledge in specifics of key populations. Some Georgian NGOs already have established an internal training/re-training system for the professional development of their own staff.

3.4.2 HIV Human Resources

According to recent evaluation of HIV/AIDS system in Georgia, the IDACIRC's clinical care and treatment program is staffed with a professional team consisting of personnel with complementary competences who have a good understanding of issues and challenges.¹¹¹ The center's management considers the staff number and qualification as adequate. Although there is no mandatory requirement for CME, the center is also committed to capacity building - it organizes regular visits to research and clinical institutions abroad and staff attends training sessions and conferences. In addition, the center's senior staff is routinely invited by WHO to participate in workshops devoted

¹⁰⁸ 1. Health Systems in Transition, Georgia, 2009, WHO Europe; 2. The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, GoG Ordinance No 724, December 26, 2014

¹⁰⁹ Health Systems in Transition, Georgia, 2009, WHO Europe.

¹¹⁰ 1. Georgia National Health Care Strategy 2011-

2015. http://www.nationalplanningcycles.org/sites/default/files/country_docs/Georgia/nhp_georgian.pdf accessed on 22 June 2015; 2. The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, GoG Ordinance No 724, 26 December 2014.

¹¹¹ HIV Programme Review in Georgia, March 2015; WHO country mission report.

to curricula revisions. The IDACIRC serves as resource for both Georgian and Abkhazian doctors to enhance knowledge in infectious diseases and HIV/AIDS and its doctors and managers routinely participate in International conferences and training.. Moreover, the center serves as a methodological support for the doctors countrywide to acquire expertise on HIV/AIDS specifics (which is an important endeavour having in mind the country's challenge in early case detection). The institution also develops various methodological guidelines, the most recent one being "Indications to conduct AIDS testing" aimed for general physicians. Promoting this guidance aims to increase the reference rate for HIV testing from different hospitals and medical institutions.

Currently TGF is providing training for general medical personnel to tackle stigma and discrimination.

3.4.3 Tuberculosis Human Resources

According to recent TB program review, currently there is not an HR development plan for TB services and no normative document outlining staffing rules which makes it difficult to evaluate how adequate is the system's workforce. According to the NCTBLD, four districts of Georgia do not have TB doctors at all. TB doctors' average age in hospitals is 56 years (52-62) and 40 years for nurses is 40, plus there are 11 doctors at TB dispensaries who are over 75¹¹². Doctors complain about the administrative paper workload, which indicates an insufficient number of nurses/assistants. This situation increases the risk lack of enough TB doctors in the nearest future.¹¹² Interviews showed that even when there are enough doctors in rural district, they are not there always available and reachable as most of them have several jobs) at different private clinics (doctors' monthly wage is GEL280. In addition, there are significant gaps in the managerial staff and insufficient technical qualified staff able to perform M&E activities.

The TB specialty is unattractive for young professionals due to high risks of infection and low wages. The ministry of health, together with the NCTBLD, has taken a few measures to motivate doctors; in February 2014 the specialization was combined with pulmonology and the expectation is that graduates/potential residents will find the broaden expertise more appealing. There are plans to subsidize residency in this field and to attract more students by introducing free-of-charge residency courses.

In 2015 the Ministry of Health increased the wages for TB personnel. According to the National TB center, the first hike (by 25%) targets specialists in the capital Tbilisi while the rural districts will be covered gradually in the next stage. The ministry is also exploring some options for additional incentives for TB doctors i.e. for successful completion of the treatment.

Lacking an official system of professional development and quality control, international agencies, such as USAID and TGF, have invested significant resources in TB staff trainings and professional advancement. However, the NCTBLD's director maintains that medical personnel, especially in rural areas, show low or no motivation and desire to acquire new knowledge despite many opportunities to use Internet-based TB curricula. The shortage of relevant computer skills and limited access to the Internet, especially in the regions, are additional barriers to self-motivated education. Another reason is not existing formal requirement for CME on the state level. However, the NCTBLD plans to develop an internal system and promote continuous self-education among staff.

Currently, the training of medical personnel working with TB-patients is covered by the USAID TB prevention program which is closing in October 2015 making the future of this component unclear. With the USAID funding coming to an end, continuous education is due to experience a significant financial gap.

¹¹²Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

3.5. Commodity Forecasting, Procurement and Supply Chain Management

3.5.1 General Overview of the Procurement and Supply Management System in the Health Care

State procurement system in Georgia. The Procurement Law of Georgia (updated in September 2013) regulates the procurement of all services and supplies, including for pharmaceutical products. There is no specific clause in the legislation about procurement rules for essential medicines. The recent State Procurement System was established in Georgia in December 2010 and it is based on the principles of transparency, non-discrimination, fair selection, facilitated procedures and minimum paperwork. The State Procurement Agency of Georgia manages the state procurement through an electronic system which is quite simple and transparent. The agency supervises and monitors the procurement procedures checking they comply with laws, regulations and principles, provides support to operations, and improves the legislation on competition and state procurement, ensuring its compliance with internationally recognized standards and best practices.

Drug Registration in Georgia. According to the Law of Georgia on “Drugs and Pharmaceutical Activity”, only registered drugs may be manufactured, sold, and used. The State Regulation Agency for medical activities (SRA), operating under the MoLHSA, issues the marketing authorization which is needed to include a medicine into the register. The list of registered drugs in Georgia is publicly available on <http://rama.moh.gov.ge>. Since 2009, new amendments¹¹³ significantly simplified the drug registration procedure which can be now done through two mechanisms - the national procedures, which are used for branded and generic medicines, and the recognition procedures. The national procedure takes up to three month, as documents submitted by a manufacturer need an administrative and technical review, and it costs GEL 500 (up to US\$ 209 as of September 2015). The recognition procedure covers medicines that are formally recognized by the European Medicines Agency, FDA and regulators of certain developed countries. The administrative procedure takes up to seven days between submitting the set of documents and adding the product to the registry, and it costs GEL 2,500 (up to US\$ 1,040 as of September 2015).

Currently the country does not have a practice/procedure to accept WHO pre-qualified medicines. The 2014 evaluation report on TB control states the, following consultations with the WHO, the SRA signed an agreement with the WHO PQP aimed at starting a fast tracking mechanism to register WHO Pre-qualified products in Georgia.

The State Regulation Agency for Medical Activities is responsible for the quality control of pharmaceutical products and their safety. At present, the existing provision on pharmaceutical manufacturing covers only some elements of the Good Manufacturing Practice (GMP) and there is no certifying agency in Georgia reviewing or providing GMP certification. Georgia has announced that it would adopt the GMP standards by 2016 (this implies including the GMP standards into the legislation and establishing a certifying body). The government is currently engaged in the development of policies and plans for adopting such a certifying agency. However, there is no information so far whether the new policy would adopt GMP standards from the EU and PIC/S member or the WHO's.

Procurement of TGF funded goods and medicines. The PR needs the approval to import goods/medicines prior the cargo arrival to legalizes the shipment, and it takes up to 20 days to obtain all the required permits. In order to ensure the timely delivery of drugs to recipients and avoid damages, an assigned group at PR conducts all the preparatory work for customs clearance. A Special Commission assesses the status and the quality of the anti-TB drugs, the compliance of the enclosed documents (airway bill, invoice, GMP certificate, CoAs, FPP, etc.) provided by the PR (NCDC) to the MoLHSA.

¹¹³ Decrees No 344/n and No 325/n of the Minister of Labor, Health and Social Affairs of Georgia, dated October 2009

Currently, all ART and anti-TB drugs are procured through the GDF mechanism and are exempted from registration thanks to a waiver issued by the MoLHSA. Starting from 2015, Georgia has to gradually transfer the procurement of ART and anti-TB drugs to the state funds, in line with the local national requirements. The country allows a parallel import system which, on one hand, it improves the availability of medicines/supplies and it positively stimulates market competition, on the other it increases the risk counterfeit drugs and lack of control on the drugs' origin and quality.¹¹⁴ According to the National AIDS Center, the lack of proper quality control is already a problem with regards to the test-systems procured in the country.

Quality control. Currently, all ARV and anti-TB drugs are procured in accordance with the requirements of the Global Fund Quality Assurance Policy from Pre-qualified sources (Pre-qualified by the WHO Pre-qualification Program), SRA or approved by TFG ERP. The GMP Certificate of the WHO standards, as well as Certificate of Analysis for each consignment certify a high quality of the anti-TB drugs.

As PR, the NCDC bears the responsibility for monitoring the quality of the delivered drugs. There is not a system in place for post-marketing quality control. In 2014 the WHO mission evaluating the TB system¹¹⁴ recommended to include into the GF NFM Concept Note a section about quality control of the drugs to be procured with grant funds. The same recommendation is valid for ART drugs and other supplies as well.

National AIDS and National TB Centers forecast the need for ART and TB drugs respectively, and other supplies, while SRs calculate their respective inventory needs.

Interviewed stakeholders said that they do not recall any stock outs with regards to drugs (ART/TB) and consequent interrupted treatment. As to supplies, delays are not rare and respondents explained that state procedures are time consuming, this was a case during turn over process between the former and new PRs in 2014. The new PR staff is considered more willing to learn the specifications of supply materials which also requires time, but NGOs representatives maintain that the problem will be eliminated.

All ART drugs used in Georgia arrive in the country through the Ministry's waiver as none of them is registered. The National TB center is actively discussing and forecasting all details regarding potential procurement problems (see below), while National AIDS Center representatives believe that the purchase will continue through the GDF system and at the moment there is no particular analysis of how GDF system procedures will match the state regulations, how this could eventually delay the purchase, and cause stock outs.

The 2015 WHO review of the HIV system review highlights the potential risk resulting from the state procurement regulations which select products based on their price.¹¹⁵ This practice might create problems in the selection of testing materials.

TB drugs procurement. Currently, the TGF grant is the only source for procurement of 1st and 2nd line anti-TB drugs and ancillary drugs for the TB program – both are purchased via the GDF by a direct procurement mechanism for 2014-2016. Most essential anti-TB drugs are registered in Georgia with the exception of the 1st and 2nd line anti-TB drugs.

The WHO evaluation of TB control reported that elaborating regulation mechanisms when importing anti-TB drugs into the country remains a priority question and it was widely discussed at the meeting with the SRA officials. The need for a mandatory registration of anti-TB drugs used by the TB Program, including new medicines, was taken into account. The report recommended that, by the time the government will take over, a procedure needs to be in place to ensure the procurement of quality assured fixed dose combinations and preferably through GDF

¹¹⁴Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014

¹¹⁵HIV Programme Review in Georgia, March 2015; WHO country mission report.

Given the relevance of the TB issue, the SRA representatives said, waivers for TB drugs for specific cases would not be a problem, but they stated that the government plans to introduce the relevant policy changes. The National TB center has already set up a special commission tasked with looking into the problem and potential delays. Respondents from the TB center said that one additional issue is that the list of 2ndline drugs, currently provided through the GDF, often change, due to WHO recommendations or other market reason. Therefore, it will not be possible to prepare a list and register all medicines just once, but there will probably the need for a continuous registration process or a waiver, which is time and cost ineffective and can cause delays and consequent stock outs.

Storage and distribution. The NCTBLD and the NCDC are responsible for the storage and inventory management of drugs and other health commodities supplied under the Global Fund financing. The central warehouse of the NCTBLD is equipped according to international standards. However, the concern is about whether the facilities located in other branches have appropriate conditions to storage drugs storage (as well as for TB proper services). There is a weak monitoring on drug consumption and management of the expiry dates., plus disposal procedures are not properly followed .

The anti-TB drugs distribution is not integrated into the national supply system for basic remedies. Anti-TB drugs, including medicines for treatment of ADRs, are distributed to all regions and PHCs through the NCTBLD (the central pharmacy unit) as well as via the regional TB coordinators as they are authorized to allocate the pharmaceuticals. The Regional NTP Units distribute drugs to TB services and PHC facilities once a month. When drugs are distributed to private PHCs, they need to be authorized by the management team of the general health financial system. Even drugs procured via the TGF grant and delivered to PHCs become a property of the private sector hence they cannot be re-distributed from one facility to another. Private facilities are not interested in the management of anti-TB drugs and it happens that when a TB patient dies or interrupts the treatment, the unused drug stock accumulates and expires.¹¹⁶ Interviews reported that there an excessive number of 1stline medicines in stock which is caused by patients dropping off the treatment. The NCTBLD is currently implementing measures to assess the situation and improve the procurement forecast, and stock management in general, which could decrease expenditure on the 1stline TB medicines.

Summary. Medicines in Georgia are procured through the GDF mechanism and all drugs are exempted from registration following a waiver issued by the MoLHSA. Starting from 2015, Georgia has to gradually transfer the procurement of ART and anti-TB drugs to the state funds in line with local national requirements. The current PR is a governmental agency, therefore, procurement through the state mechanisms are already operational. In future the same mechanisms will be used for ART/TB medicines procurement as well.

3.6. M&E and Information Systems

General. Compared with other countries in the region, routine surveillance systems are relatively well developed in Georgia. The National Center for Disease Control and Public Health (NCDCPH) is in charge to oversight the information flow and data collection process for TB and HIV. NCDCPH also has a leading role in the monitoring and evaluation of the national responses to HIV and TB. In this regards, the center analyzes data, compiles reports, assesses and evaluates the epidemiological situation, provide recommendations, and manages the HIV National web portal to ensure that all M&E products are collected and easily available to all stakeholders. In addition, the NCDCPH holds

¹¹⁶ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

the data quality control function to validate the M&E information and identify and correct the shortcomings of the surveillance system.¹¹⁷

The monitoring and evaluation plans are an integral part of the national disease strategies and the NCDCPH, together with the CCM, is responsible for coordinating the implementation of the M&E plans. However, despite well-set targets, indicators and use of the baseline data, the lack of a structure specifically responsible for the implementation means that M&E plans are often a challenge. This created a feeling that good plans always stay on a paper and there is no need to

implement them. In order to improve this situation.

“The information flows in both programs (TB and HIV), are not structured correctly. It is vital that the state understands that, these programs need centralized management and functions can not be split between several departments and sectors”

Key Informant

In 2013 the NCDCPH established an M&E unit comprising of a coordinator and officers assigned to follow up on the National M&E work plans. A specific working group with experts representing governmental and non-governmental organizations focuses on M&E issues. The key function of the M&E unit and the working group is to critically assess the system, to identify data flow gaps and to provide recommendations for improving the system.¹¹⁸

The NCDCPH compiles annual statistical data with core health indicators, including HIV and TB, and some analytical information, but apart from this report there is no regular publication gathering

and analyzing vertical systems-related information with the purpose to influence decisions on policy and financial allocation.

Stakeholders were asked to evaluate the three stages of the surveillance system: data collection, data analysis, and application of analytical findings in the decision-making process. Despite some gaps in the collection, this stage is considered satisfactory, but still in need of further improvement in terms of data segregation, data accuracy and quality control. Interviews show that the second analytical stage remains the weakest. While AIDS centers perform this function voluntarily for HIV, in the case of TB it is even not quite clear who is in charge of data analyses. Consequently the ministry of health does not appropriately use HIV and TB surveillance data in its decision-making. This problem shows that apart from the unavailability of analytical data, there is a lack of demand by decision-makers themselves.

Since 2002 Georgia has been conducting the second-generation surveillance studies in HIV on a regular basis and from 2008 GF is the major financing source. The NCDCPH recognizes the need to continue these studies after the end of the GF grant. According to NCDCPH director, the budget for surveillance in 2015 was increased to GEL750,000 (about US\$350,000) signaling the political support. However, the financial allocation might be at risk in future as their budget line is not secured. Precedents provide ground for this concern: in 2015, GEL300,000 allocated for various operational research was moved to cover the vaccination program, which experienced a financial gap due to the devaluation of the local currency.

Interviews indicate that the NCDCPH is committed to improve the surveillance system by eliminating all barriers that might exist for KP to start the testing. For example, in 2014 the

¹¹⁷ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

¹¹⁸ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

regulation requiring to identify PWID in order to access the HIV test through state program was changed. PWIDs avoid identification as KP, as drug use is illegal in the country.

3.6.1 HIV

The latest national HIV/AIDS monitoring and evaluation framework was adopted in 2011 and it is part of the national HIV/AIDS strategic plan for 2011-2016. This plan is a result of number of consultative meetings among various stakeholders, who agree on a core set of indicators. The framework contains three separate sections: 1. HIV national M&E system design, 2.M&E operations manual (which describes how individual components of the national M&E system works), 3.Operational plan setting the priorities for the first three years.¹¹⁹

The data flow starts in primary healthcare units, blood banks and other specialized institutions (such as prisons and narcological dispensaries) which send all suspected cases to the National AIDS Center for the confirmation. There are also NGOs working with KP offering rapid tests to beneficiaries and referring all suspected cases to the AIDS center. Data about confirmed case are then transferred from the AIDS center to the NCDCPH for registration. It should be mentioned that at this stage the data collection is not standardized and is aggregated. Data collection from regional

“It does not seem to me quite correct, when people apply to AIDS Center for HIV data, whereas NCDCPH is responsible for data collection and analyze in the country”

Key Informant

public health institutions remains a problematic and there are also limits in the disaggregation and quality assurance. HIV-related data are not institutionalized and are fragmented, as the AIDS center performing the analysis on a voluntary basis. There is no overall framework for the HIV surveillance system with appropriate standards and goals, which should be feeding information policy to decision-makers.

Despite the described gaps and weaknesses, stakeholders have access to strategic information that is essential for planning and implementing

an effective response. However, this information is available at the AIDS Center and not the NCDCPH which is the responsible organization in the country for managing and maintaining the surveillance system. Respondents said that data collection and analysis are not properly institutionalized and depend on one specific person at the AIDS center, which create risks in future in case the staff will change (along with people’s good will).

The NCDCPH coordinates activities for the HIV program monitoring and evaluation. Routine data collection, operational studies and second-generational surveillance activities are regularly implemented to identify needs of KP and to inform decision makers on HIV-related issues. However, the system presents barriers there is a need to further strengthening the surveillance, the program monitoring, and the evaluation process as underlined in the NSP 2016-2018. According to the document, improvements are needed in following sectors: regular use of the Unique Identification Codes, revision and adjustments in essential M&E definitions, triangulation of available data sources including program monitoring and periodic surveillance data, and disaggregation of program monitoring data according to the most epidemiologically significant segments of KP. The NSP also emphasizes the need to improve the data collection in the regions to set relevant targets at the regional/municipal level, to assess the drug scene and other essential contextual characteristics to respond to specific context changes. The plan acknowledges that these activities largely depend on external funding and will require an increased support from domestic sources to sustain after the donor phases out.

¹¹⁹ Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.

In 2008, Georgia started the reform of the HIV surveillance system. The TGF funded the pilot project with a modern real-time electronic database segregating data based on different parameters (gender, geography, KP, age etc). These criteria were based on the state guideline for HIV surveillance, which was developed following extensive consultations with all key stakeholders. Unfortunately, after two years the system was stopped and respondents are not aware of the reasons.

Summary. Overall the HIV routine surveillance system is well developed and it allows getting basic data to monitor the HIV situation. From 2002, Georgia also systematically collects second-generation surveillance information which allows tracking the KAP's status and responding accordingly. However, as the NSP for 2016-2018 points out, the system needs further improvements including disaggregated data by age, gender, geographical allocation etc. A separation of role between NCD and AIDS Center has to be clearly defined, especially with regards to who is in charge to produce analytical reports. So far, IBBS studies and other operational research were funded by external donors (GF, USAID) and no other source of funding for those surveys have been identified yet once the GF will discontinue the grant.

3.6.2 Tuberculosis

The National Center for TB and Lung Disease (NCTBLD) oversees the surveillance system at the national and tuberculosis cases are subject to compulsory notification. According to Government resolution # 150 as of April 2015 all cases has to be entered into e-Health National System¹²⁰. This is mandatory for all service providers. The paper-based system is maintained until now to ensure that data is not lost and test the electronic system. This registry allows to generate national surveillance statistics disaggregated by core variables, MDR notification and regular RR/MDR and XDR TB treatment outcomes.¹²¹

The TB surveillance system consists in three vertical reporting/administrative levels: national, regional and local TB units. Local TB units (including penitentiary system) are responsible for sputum collection, diagnosis, treatment monitoring, and reporting the information about the outcome to the regional centers on paper forms. The regional TB facilities collect the paperwork (on notification, treatment outcome and HIV) and enter the details into the electronic registry and monitor the quality of the data provided by local TB units. The aggregated data of the annual surveillance are posted on the NCTBLD website in forms of tables¹²² without any analysis, interpretation, or recommendations for further informed actions and decision-making.¹²¹ The NCDCPH collects the TB notification forms from institutions countrywide, the so-called immediate notification system forms. These figures are added on to the data provided by NCTBLD.

Since 2008 Georgia uses a comprehensive individualized electronic TB information system, which has been upgraded to accommodate the most up-to-date WHO recommendations and to use the new software platform. A well-established TB surveillance system is in place guaranteeing a smooth flow of data and information, a consistent use of standard recording and reporting across different level of TB system. The web-based electronic TB registry available countrywide coverage allows the generation of standard and user-defined reports. The penitentiary surveillance system is well integrated with the national TB surveillance and procedures on data quality assurance from the peripheral unit up to the national level are applied consistently. Limited access to the TB diagnostic services leads to a low case detection, suggesting that TB cases go under-detected by health care system. Thus, surveillance data cannot serve as direct measure of TB cases occurring in Georgia.¹²¹ Interviews endorsed findings in the review report which highlights cases of TB doctors treating patients without registering them as TB cases. Medicines are available from the stocks, as patients defaulted on the treatment, but drop-outs are not often reported.

¹²⁰ GoG Resolution #150, April 2015 – Regarding improvement of reporting of all State Funded Programs.

¹²¹ Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014.

¹²² <http://www.tbgeo.ge/index.php?a=page&lang=en&pid=204>.

To improve the existing electronic recording system, the USAID-funded Tuberculosis Prevention Project (TPP) has set up an electronic TB Health Information System (HMIS) platform, which was developed by a local IT company. The new software, currently piloted, includes five interlinked modules: registration, treatment monitoring, laboratory results, drug management, and statistics. The platform allows geographic allocation and it features time-tagging functions. The module will allow quick data exchange between clinicians and epidemiologists on newly registered patients, contacts to be screened as well as following DOT compliance. The electronic module is in line with the revised WHO recording and reporting framework. The new electronic recording system is expected to be used by a higher number of users. However, piloting of the software, distributing the IT equipment, training, plus internet connections and system maintenance are fully covered by the donor organization, which raises concerns for the project's sustainability and its continued maintenance.¹²¹

According to respondents, attempts are under way to link the TB surveillance system with the central HMIS system, and therefore collection of electronic data across country will become mandatory. In order to avoid losing data, during the first year of the new system's introduction the paper forms will be maintained.

According to the National Tuberculosis Strategy and Operational Plan, TB control is supposed to be monitored through a set of 55 indicators, the vast majority of which are adopted from the WHO regional M/XDR response plan and are sound enough to evaluate the progress of TB response in the country. The indicators cover all aspects of the TB control. However, there is no report available at national level on annual programmatic performance against the targets. There is lack of analytical capacity to support informed decision-making at state level.

The national TB centre serves as methodological centre for initiating research and operational studies as well as searching for funding opportunities. Respondents pointed at several challenges the TB surveillance system face: there is no staff assigned to data entry at the regional and TB unit level; and the data collection completely depends on good will of informally assigned professionals, mostly doctors or nurses. There is no requirement/assignment to analyze data.

Summary. Georgia has a well-established health information system, including HIV and TB surveillance and M&E, which nevertheless lacks analysis and capacity. HIV data is not segregated by gender and age. The data flow in both programs is in general well organized, but structural and managerial deficiencies could deteriorate the data collection process in nearest future. Moreover, data collection, especially in TB surveillance, depends on the well-established tradition to collect data for the WHO/GARP reports and the good will of the people in the system. Once these persons will be gone, this arrangement might not function in the same way as roles and functions within the system are not clearly defined and the whole practice is not institutionalized.

CHAPTER 4. ASSESSMENT OF TRANSITION READINESS

4.1. Transition Experience

Georgia has not yet started the transition process from TGF program. However some steps were taken and are described in the HIV and TB sections.

The discussion about the transition from the GF started in early 2014 when the NFM was introduced and the government received an official letter from the Fund about the changed funding conditions and the willingness to pay the requirement. The first state document mentioning that the government should assume the financial responsibility to gradually take over the Global Fund program is the Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”.¹²³

The preparation process for developing the concept notes for HIV and TB programs has followed the GF requirement; the government has conducted series of meetings with stakeholders as part of the country’s inclusive dialogue process and WHO experts were invited to evaluate the TB and HIV programs’ achievements and shortcomings. The national strategic plans for both diseases were updated following the recent WHO evaluations. The revised NSPs were the base for the concept notes, which fully expressed government commitments confirmed under the willingness to pay request. In parallel to the country dialogue, the CCM also has undergone changes. Specifically, the number of seats for NGOs, CBOs, and patients has been increased, an oversight committee has been established, changes in the manual aiming to cope with the conflict of interest issues have been implemented and the dashboard-monitoring system was created. Therefore, the concept notes are grounded in the latest data and state the need of an increased, though gradual, governmental commitment from 2016.

The HIV concept note for the 2016-2018 program was submitted in April 2015 under the window 6 of the NFM. According to latest NSP and CN, in 2016-2018 the government will fully fund the procurement of 1stline ARV medicines, laboratory monitoring of the treatment quality, and opioid substitution therapy. Most respondents believe that the state will abide by its commitment, although a few doubt it will happen. The prevention component is reported to be at risk to be stopped: some interviewees said that government will not be willing to pay for prevention, especially for KP, while others think that government should not be financing prevention activities and additional resources should be raised by the NGO sector.

There is unprecedented case related to OST program transition. The GF-funded harm reduction (OST) program started in 2005. The sub-recipient of this particular component was the Open Society Georgia (OSG). The program staff and PRs were able to illustrate the program success to the government and in 2008, after extensive advocacy, the government adopted the relevant legislative changes, developed and financed a state program for drug addicts which is still running. The program covers detoxification, OST, storage and transportation of medicines (including with police escort), customs clearance and distribution-related costs. The scheme is based on a co-funding principle: the state covers Metadone cost and patients have to contribute. Out-of-pocket monthly payment per patient is GEL110 (US\$50), but it does not apply to PLWHA and people living under the poverty line. The program covers about 1,800 patients a month and there are 12 state-run OST sites across the country, out of which six are located in Tbilisi and other six in the regions - Poti, Kutaisi, Batumi, Zugdidi, Ozurgeti, Telavi). The state committed to continue financing the OST program. The latest health concept document states as essential the creation of an adequate infrastructure and an institutional mechanism for proper quality control of the treatment and the

¹²³ The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, pg.11, Government of Georgia Ordinance No 724, December 26, 2014.

implementation of modern evidence-based methods. Additionally, the treatment should be promoted as an alternative to punishment for drug users.

According to the recent report issued by USAID, there is no infrastructure for the psychosocial rehabilitation of individuals with substance use disorders – the lack of community-based rehabilitation centers and therapeutic communities create a gap in the development of the chain of continuous care. There are no reliable and valid national data on patients treated for substance use disorders and there are no regulatory mechanisms that define the notification of the Treatment Demand Indicator (TDI). Several clinical centers and medical facilities are not harmonized, which indicates a lack of standards for data collection and processing. In 2013 the NCDCPH introduced a special standard data collection form with segregated information - by gender, age-groups, number of first time and repeated visits, route of administration, type of primary and secondary drugs, poly drug use, and HIV testing/result. However, the collected data cannot be compared with the figures from the previous years.¹²⁴

The described case of OST transition is certainly a step in the right direction, especially taking into account the existing restrictive legislation on drug use. However, interviews and review reports have revealed weaknesses that might hamper its success. Therefore, it is important to consider the program's effectiveness and its improvements according to the recommendations within the NFM and ensure that that state fully understands and visualizes the positive public health impact of the OST interventions.

From 2015 the Georgian government has taken on the responsibility to finance the purchase of 1stline medicines for HIV and TB patients. This expense is already part of the state budget with designated lines. Procurement has not happened yet, because the programs still have supply in stock.

4.1. Program Continuity

Georgia is committed to keep the program going and this pledge was clear in the interviews with both state and NGO representatives. The fact that the PR and key implementing partners of diagnosis/treatment services are state institutions (NCDCPH, IDACIRC and NCTBLD) provides strong foundations for key stakeholders to the program's continuity. The only concern expressed by both state and NGO stakeholders is the possibility that the government might not be able to keep up to its financial commitments. In addition, in the case of TB, even if government will follow up its verbal financial commitments, there is already a significant financial gap in the figures presented in the NFM CN document. All respondents are worried about the preventive services for KP.

4.2. Organizational Capacity

In general, Georgia has adequate capacity to manage the transition planning and implementation, but significant financial concerns remain as well as some organizational gaps that need to be addressed properly for a success transition.

Most respondents are of the opinion that the CCM is an effective and functional structure, and in future a body with similar function should be kept in the country. While the format and technical capacity may change, in general nobody doubts that a coordinating mechanism is needed in the future. A few people interviewed think that it could function on a voluntary basis, without administrative costs, but the CCM members believe that administrative budget is necessary and that the MoLHSA should cover this cost.

¹²⁴The Drug Situation in Georgia, Annual report, 2013, USAID.

There is a political will and commitment to address the needs of the HIV and TB systems which are explicit in relevant strategic documents, such as disease-specific plans and state level health concept documents.

Significant improvements are required in the organizational structure and in the distribution of roles/responsibilities of the national disease programs. The structure of these programs needs to be outlined clearly and the roles and responsibilities of all composing elements of those structures should be identified respectively. Currently, both programs largely depend on the individuals in charge which put at risk their continuity and sustainability. Changes in the restrictive drug policy are essential, and the MoLHSA needs to be a more active role in order to raise awareness about the negative effect on public health caused by the current restrictive policy against PWID.

The financial management capacity is adequate and specific data on HIV and TB expenditure would allow to separate and track down the expenses related to the diseases within the health budget

The procurement and supply chain management are overall well defined and managed. There are several misalignments between the national and international purchasing system (GDF) requirements, but with timely identification and management it is possible to administer the barriers with the purpose of avoiding delays and stock outs of the required medicines and supplies.

The surveillance and M&E schemes feature weaknesses that are linked to structural problems of the disease programs(as described earlier). Surveillance lacks analytical capacity, information is not distributed to the public and analytical reviews are not used to inform the policymakers.

Human resources - number, capacity, coverage and age - are adequate in the HIV program, but TB staff is already experiencing challenges like aging and inadequacy in terms of coverage and number. General practitioners lacks basic knowledge in HIV and TB which is causing stigmatization and discrimination of the HIV and TB patients.

4.3. Transition Planning

The commitment to develop detailed transition plans for both diseases are included into the concept notes and plans development will start from 2016. According to most stakeholders, the involvement and clear demands from TGF are necessary to push government to abide by all financial promises. Most respondents, especially from the NGO sector, strongly believe that government's commitment mostly was created by TGF and conditionality NFM application process.

There are no concrete plans or even thoughts about which body will coordinate the strategic management of both disease programs once TFG will close.

4.4.1 HIV

No particular transition activities are implemented at the moment, but the revision of the treatment regimens and the switch to a public health approach would decrease treatment costs.

4.4.2 Tuberculosis

The steps already in place for the transition in the TB system include the NCTBLD's efforts to improve the TB control structure, the financial effectiveness and management optimization. The body is monitoring how efficiently purchased medicines are used, as proper planning and avoiding waste will decrease treatment cost. A special commission focusing on the procurement of drugs and certification issues is exploring optimal purchasing models to avoid stock outs and delay once the government will take over this responsibility.

The NFM application proposed activities aimed at creating the supportive environment and systems for an effective implementation of diagnostic and treatment interventions. These tasks include strengthening the key functions and processes in the health care system for TB control, like legal and ethical issues related to TB; capacity building; supervision and M&E of the national TB

program, and supporting ACSM and engagement of civil society for effective TB prevention, care and control.

CHAPTER 5. CONCLUSIONS AND RECOMMENDATIONS

In this section of the report we will try to summarize the findings arising from the country case study and separate some general findings, which resonate and align with the results of other studies¹²⁵ and lead to more general conclusions from those that are purely country specific. Consequently, both set of conclusions are detailed separately in respective sections.

5.1. Conclusions

The table lists the indicators used to assess potential risks for transition from TGF support for Georgia. Each indicator has been assessed according to the criteria and has been assigned a score for low risk, moderate risk or high risk. Scores from each component are summed into a final score of transition risk in a given country.

Table 2 Risk Assessment Table

Components		Disease	Indicators	Georgia
External Environment				
Political	P	B	1. Existence of political will to prioritize health investments 1.1 Increasing trend or stable high share of government spending on health out of General Government Expenditure 1.2 Increasing trend of the share of government spending on health out of Total Health Expenditure (THE)	1.1 The share of Government spending on health out of General Government Expenditure is low, decline was noted in 2011-2012 with increasing trend in 2013 1.1. The share of government spending on health out of THE is increasing.
	P	B	2. Existence of laws, regulations or policies that hinder effective prevention, treatment, care and support for KP and people living with diseases. 3. Strong Rule of Law	2. Restrictive drug policy, no legal basis for the needle exchange activities create certain barriers for HIV program. Legally not regulated sex work is considered as hindering factor. 3. Laws are not effectively enforced to protect KP from discriminations
	P	B	4. Government ability to contract with CSOs - Existence of general regulation for CSO contracting in the economy 5. CSO contracting is practiced in any sector	4. General regulations allowing CSOs contracting exist 5. CSO contracting is practiced in social sector
				4
Economic	E	B	1. Favorable economic indicators 1.1 Increasing in GDP 1.2 Increasing or stable high share of General Government	1.1 GDP per capita growth (annual %) is observed since 2010

¹²⁵Gotsadze T., Fuenzalida H., et al. Thematic review on transition and sustainability of Global Fund-supported programs. Curatio International Foundation, 2015.

Components		Disease	Indicators	Georgia
			Revenues as % of GDP	1.2 Share of General Government Revenues (excluding grants) as % of GDP is more than LMIC mean (25.7) in 2012 year
				2
Internal Environment				
			Inputs	
Financing	F	H	1. Budgetary commitment to disease 1.1. Increasing public expenditure on Disease Specific programs 1.2. Share of public funding in Disease Specific Program budget: 1.2.1. > 75% 1.2.2. 50 – 74% 1.2.3. < 49% 1.3. Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NSP	1.1 Public expenditure on HIV program is increasing 1.2 The share of public spending on HIV accounted for 46% of total AIDS spending 2014 1.3 There is a dedicated line in MTEF and aligned with NSP
	F	T	- Budgetary commitment to disease 1.1. Increasing public expenditure on Disease Specific programs 1.2. Share of public funding in Disease Specific Program budget: 1.2.1. > 75% 1.2.2. 50 – 74% 1.2.3. < 49% 1.3. Existence of dedicated budget lines for disease specific expenditures in MTEF or in national budgets aligned with costed NTP	1.1 Public expenditure on TB program programs is increasing 1.2 The share of public spending on TB accounted 56.7% of total TB spending in 2014 1.3 There is a dedicated line in MTEF and aligned with NTP
	F	H	2 Prevention priority 2.1 Increasing total public spending on HIV prevention for priority groups 2.2 Increasing share of public spending in total spending (donors and Gov.) on HIV prevention for epidemiologically priority groups	2.1 Total public spending on HIV prevention for priority groups not increasing - 2.2 Share of public spending in total spending for priority groups not increasing
	F	H	3 Allocative efficiency 3.1 Existence of allocative efficiency study 3.2 Allocative efficiency study informs budget allocations	3.1 Allocative efficiency study was conducted in Georgia. OPTIMA study proved that allocations in NSP and new CN are efficient in terms of possible impact. 3.2 The study was done in parallel with the NSP and CN development, so the study has not informed the allocations just proved they were right.

Components		Disease	Indicators	Georgia
	F	H	4 Treatment / input financing from public sources 4.1 Case detection / diagnostics 4.2 Drug procurement 4.2.1 First line ART 4.2.2 Second line ART 4.3 Adherence support	4.1 Case detection and diagnostics are partially funded from public sources 4.2 ARV drugs 4.2.1 First line ART partially funded by public sources 4.2.2 Second line ART-fully funded by TGF 4.3 Adherence support is fully funded by TGF
	F	T	- Treatment / input financing from public sources 4.1 Case detection / diagnostics 4.2 Drug procurement 4.2.1 First line drugs (FLD) 4.2.2 Second Line Drugs (SLD) 4.3 Adherence support	4.1 Case detection /diagnostics is partially funded from public sources 4.2 TB Drugs: 4.2.1 FLD-partially funded from public source 4.2.2 SLD/MDR-XDR-fully funded from TGF 4.3 Adherence support -partially covered from public sources
	F	H	5 Prevention financing from public sources 5.1 Funding of Low Threshold Services (excluding OST) from public sources 5.2 Funding of OST services from public sources	5.1 Low threshold services are not funded from public sources 5.2 OST services are mostly funded by public sources on a co-payment basis. There are challenges, i.e. psycho-social component is not included.
				5
Human Resources	HR	H	1. Sufficient human resources for a disease (quantities, geographic distribution and aging)	1. Sufficient. Inadequacy of human resources for HIV was not raised by stakeholders, or noted in any publications.
	HR	T	- Sufficient human resources for a disease (quantities, geographic distribution and aging)	With some limitations. There is a lack of TB professionals; aging of staff raises serious concerns; uneven geographic distribution of TB HR was noted by majority of stakeholders; low salaries of TB medical staff and hazardous work environment distract young people to work in the TB field.
	HR	B	2. Donor supported trainings for health personnel institutionalized in national education system 3. Existence of policy for production/training of CSO personnel (non medical, social service) 4. Donor funded HR salaries aligned with national pay-scale	2. TGF supported trainings for health personnel are not institutionalized in national education system 3. The policy for production/training of CSO personnel does not exist; 4. TGF funded salaries are aligned with the national pay-scale
				3
Health Information System	HIS	H	1. Advanced routine statistical reporting fully integrated in the national system 1.1 HIV testing 1.2 PMTCT 1.3 AIDS related mortality 1.4 Adult treatment 1.5 Pediatric treatment	1.1 HIV testing-integrated, partially advanced 1.2 PMTCT- integrated, partially advanced 1.3 AIDS related mortality – integrated, partially advanced 1.4 Adult treatment- integrated, partially advanced 1.5 Pediatric treatment – integrated, partially advanced

Components		Disease	Indicators	Georgia
Health Information System	HIS	T	- Advanced routine statistical reporting fully integrated in the national system 1.1 TB new and relapse cases 1.2 TB treatment registry 1.3 Pediatric treatment 1.4 MDR TB reporting 1.5 Care and support (incl. pediatric)	1.1 TB new and relapse cases- integrated, advanced 1.2 TB treatment registry – integrated, advanced 1.3 Pediatric treatment- integrated, advanced 1.4 MDR TB reporting- integrated, advanced 1.5 Care and support (incl. pediatric) – integrated, advanced
	HIS	H	2. HIV Second generation surveillance 2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS Funded by public sources 2.4 PSE funded by public sources	2.1 Rigorous methodology used for IBBS 2.2 IBBS Implemented timely (according to NSP) 2.3 IBBS NOT funded from public sources 2.4 PSE NOT funded from public sources
				4
			Governance	
Governance (Political support, Program leadership, Coordination)	G	H	1. Strong political commitment to diseases 1.1. NSP with legal and enforceable power in a given country context 1.2. NSP in preparation or without legal and enforceable power 1.3. HIV/AIDS as a priority in National Health Strategy document	1.1 Does not exist 1.2 NSP exists, however without legal and enforceable power 1.3 HIV/AIDS is prioritized in National health strategy document
	G	T	- Strong political commitment to diseases 1.1. NTP with legal and enforceable power in a given country context 1.2. NTP in preparation or without legal and enforceable power 1.3. TB as a priority in National Health Strategy document	1.1 Does not exist 1.2 NTP has no enforceable and legal power 1.3 TB is prioritized in National health strategy document
	G	H	2. Strong leadership 2.1. Legally empowered leading organization to manage given disease program effectively functioning 2.2. Individual leader(s) advocate for disease specific programs	2.1 MoLHSA's health department is responsible for overall management of all health programs including HIV/AIDS. National CDC and National AIDS center are legally empowered leading organizations to manage Preventive and Curative fields respectively. Both entities are affectively functioning 2.2 HIV/AIDS has an individual leader (National AIDS center) advocating for HIV program
	G	T	- Strong leadership 2.1 Legally empowered leading organization to manage the functioning of the given disease program 2.2 Individual leader(s) advocate for disease specific programs	2.1 There is no effectively functioning legally empowered leading organization 2.2 TB program Individual leader is not visible
	G	B	3. Strong coordination mechanisms 1.1 Coordinating body adequately placed within the government hierarchy and legally empowered	3.1 Coordination body (CCM) is well placed within the government hierarchy to assure adequate national coordination and coordination across different sectors – established by the Government

Components		Disease	Indicators	Georgia
			within the national Government structure to assure adequate coordination across the sectors 1.2 CSOs have a legally determined seat in the coordinating body 1.3 Coordinating body functions effectively	resolution; 3.2 CSOs have legally determined seats in Coordination body 3.3 Coordination body functions effectively
				6
Accountability	A	B	1. Program performance results are available and accessible through public domain: 1.1. EPI data including for KP 1.2. Programmatic data and/or reports 1.3. Program expenditure data 1.4. Program M&E reports 1.5. NSP/NTP and other periodic reviews -	1.1 EPI data including for KP - Available 1.2 Programmatic data and/or reports – partially available 1.3 Program expenditure data - NOT available 1.4 Program M&E reports - NOT available 1.5 NSP and other periodic reviews – partially available -
	A	B	2. Enabling Environment for Civil Society engagement ¹²⁶ 2.1. 0-0.38 – there are law and policies that restrict civil society playing an oversight role 2.2. EEI 0.39 – 0.50 – there are no law and policies that restrict civil society playing an oversight role, but in practice it is not accepted by the Government 2.3. EEI > 0.51-0.76 there are no laws or policies that restrict civil society playing an oversight role, and civil society is actively engaged in providing oversight	EEI for Georgia for 2013 was 0.50. There are no law and policies that restrict civil society playing an oversight role, but in practice it is not accepted by the Government.
				2
			Program	
	S	H	1. Treatment 1.1. Increasing coverage (%) trend for ART 1.2. Improving treatment outcome for ART (adherence rate at 12 months)	1.1 There is an increased coverage trend for ART 1.2 ARV treatment outcomes are improving.
	S	T	- Treatment 1.1 Improving treatment outcome – success rate for all TB cases 1.2 Improving treatment outcome – success rate for MDR TB	1.1 Overall TB treatment outcome success rate is improving. 1.2 MDR TB treatment success rate is low
	S	B	2. Integrated services: 2.1 Integrated PMTCT with PHC/Maternity care 2.2 Integrated TB in primary care 2.3 Integrated HIV and TB services	2.1 HIV testing for pregnant women is integrated in PHC 2.2 TB is integrated in primary care but there are

¹²⁶ <http://civicus.org/eei/>

Components		Disease	Indicators	Georgia
				challenges 2.3 HIV/TB services are integrated, but not well coordinated especially in regions
	S	H	3. KP reach with preventive services 3.1 Increasing coverage trend of epidemiologically most important KP with preventive services 3.2 Data based on IBBS studies with rigorous methodology	3.1 Coverage of KP with preventive services is increasing 3.2 Data based on IBBS studies with rigorous methodology
	S	B	4. CSOs contracting in health services 4.1 Existence of detailed rules and procedures for contracting CSOs for health service delivery (includes medical and other health related social services) 4.2 Government already contracts CSOs for various health service provision using public funds	4.1 Detailed rules and procedures for contracting CSOs for health service delivery DO NOT exist 4.2 Government already contracts CSOs to provide social services using public funds
				6
Organizational capacity (program management, financial management, contracting, procurement, supply chain management, research and M&E)	O	H	1. Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program management capacity assessment OR staff performance evaluation practice (at least once in every second year) 1.2. Closely integrated TGF PR and National Program Management	1.1 Capacity assessment not conducted OR staff performance evaluation not practiced in National Disease Program Management entities 1.2 National Program Management and TGF PR are closely integrated as the Entity responsible for HIV/AIDS prevention and control serves as a PR
	O	T	- Strong management of the National Disease Program Management Entity (not PR) 1.1. Existence of national program management capacity assessment OR staff performance evaluation practice (at least once in every second year) 1.2. Closely integrated TGF PR and National Program Management	1.1 There is no entity empowered to manage national TB program, therefore its capacity assessment has not been conducted 1.2 Relationship between PR and national disease management entity not defined at present due to the absence of such entity. PR manages GF funding and responsible for disease surveillance component of the National TB Program.
	O	B	2. PSM 2.1 TGF funded procurement is conducted using national system 2.2 Supply chain management integrated into the national system 2.3 Low frequency of emergency procurements for drugs (not more than one over for last year) 2.4 Rare stock outs for drugs (not more than once for last year) 2.5 If national procurement - paying not more than 5% above the international benchmark price	2.1 TGF funded procurement is conducted using national system 2.2 Supply chain management is fully integrated into the national system 2.3 NO emergency procurements were reported 2.4 NO stock outs were reported 2.5 Paying NOT MORE than 5% above the international benchmark price

Components		Disease	Indicators	Georgia
	O	B	3. M&E 3.1 Existence of analytical capacity at MoH/main public health agency reflected in availability of analytical reports that are produced with certain periodicity 3.2 Information use for evidence-based program planning and management e.g. NSP/NTP uses recent Epi, programmatic and expenditure data	3.1 There is limited analytical capacity. Analytical reports are not produced by public sector 3.2 The epidemiological data is available and used in NSP/NTP, although M&E data are not always used for program planning and budgeting
				4
Transition preparedness	T	H	1. Transition plan / elements 1.1. Legally binding and actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NSP -	1.1 Legally binding and actionable transition plan does not exist 1.2 There is no draft for the transition plan but there is a deadline when it should be developed and thinking is in place. 1.3 Transition elements (financial responsibilities) are embedded into the NSP, although the latter is not legally empowered
	T	T	- Transition plan / elements 1.1. Legally binding and actionable transition plan exists 1.2. Draft transition plan exists 1.3. Transition elements embedded into the legally empowered national program / NTP -	1.1 Legally binding and actionable transition plan does not exist 1.2 There is no draft of the transition however there is discussion regarding the plan and a deadline when it should be developed is set. 1.3 Transition elements (financial responsibilities) are embedded into the NSP, although the latter is not legally empowered
	T	H	2. Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Clearly outlines roles and responsibilities of a Transition process management 2.3 Incorporates M&E indicators for transition process 2.4 Incorporates budget for transition	N/A
	T	T	- Transition plan characteristics: 2.1 Clearly identifies time-bound activities to be implemented during transition 2.2 Clearly outlines roles and responsibilities of a Transition process management 2.3 Incorporates M&E indicators for transition process - Incorporates budget for transition	N/A
	T	B	3. Transition M&E 3.1 M&E is followed 3.2 CSO participates in the	N/A

Components	Disease	Indicators	Georgia
		transition updates	0
			Moderate to High risk
		Overall score (Total max score 76)	36 (47%)

EXTERNAL ENVIRONMENT

Economic development. Georgia is a lower-middle income country whose GDP per capita has gradually increased in the last decade, albeit its growth rate has significantly fluctuated. In general, the current economic situation cannot be considered an hindering factor for the sustainability of TGF program but it will be important to look at fiscal space for a more comprehensive picture of the country's financial possibilities.

Political Commitment. The Government' has showed a clear political commitment to the health sector and it has increased the share of public spending on health and total health expenditures over the last few years. In 2013 the government started the Universal Health Coverage reform and it declared health care one of its priorities. The response to HIV/AIDS and TB is prioritized in the state health concept and is guided by well-developed National Strategic Plans. Although the overall legal environment in the country protects the rights of HIV and TB patients, there are still medium level risks for the programs as the laws are not effectively enforced to safeguard KP from discrimination. A restrictive drug policy and no legal basis for the needle exchange activities create barriers to the HIV program. Sex work is not legally regulated, thus hindering prevention activities.

INTERNAL ENVIRONMENT

Financing. Both HIV and TB National Programs are vertical plans with significant, and increasing, state financial contributions. In 2014 the public expenditure on HIV and TB was respectively 46% and 56.7% of the entire programs spending. There are dedicated MTEF budget lines for both diseases, which are aligned with NSP and NTP. However, the total share of state expenditures on prevention remains low and this component largely depends on donor funding, which is primarily TGF for both diseases. The latter fact creates high risk for program sustainability.

Human Resources. The HIV program can count on sufficient and qualified human resources, while the staff employed in the TB control is not adequate, and the average professional is over 40. Low motivation and meager wages of TB doctors/staff are the leading problems in the sector. Lack of general knowledge about the diseases among general practitioners builds barriers, it creates stigmatization, and discrimination towards the patients and it can often lead to the refusal to provide the needed service. Continuous medical education is not mandatory in Georgia and it completely depends on the good will of the doctors and managers/owners of the medical facilities. The USAID-funded program is coming to an end in 2015 and the future of training and updates for TB staff on treatment schemes and medications remains unclear. TGF-funded salaries are aligned with the national pay scale.

Information Systems. The HIV and TB M&E systems are integrated into the national reporting systems, however challenges remain in the standardization of the data collection standardization and data disaggregation. The routine surveillance system provides the necessary data for the program management and M&E but it lacks adequate analysis. Second-generation surveillance studies in the HIV field are conducted regularly and follows rigorous methodology, but they

completely depend on donor funding and there is a high risk that this component will be discontinued.

Governance. The Government is committed to take over the financing of HIV and TB programs, especially the diagnostic and treatment components. The future of the prevention activities, especially among KP, is unclear. The CCM is well-coordinated and managed with equal representation of all sectors and groups, although the structure of the national disease programs is not defined, which means that roles and responsibilities of all involved stakeholders are not clearly specified. The fragmented program structure creates significant risk to program's continuity and sustainability in the future, since its success depends more on particular leaders rather than on the system's efficiency.

Program. Despite the Government's strong political commitment to sustain the national responses to HIV and TB, additional efforts are needed in order to manage a smooth transition. In particular, early diagnostics and timely link to treatment remains challenging for both diseases. Adherence support and prevention to KP completely depend on TGF funding, which increases the risks for the transition process. Although the OST services are state-financed, they lack a psychosocial component which might put at risk effectiveness and efficiency of the contributions.

Organizational Capacity. The agency under the Ministry of Health, NCDCPH, is currently the PR for the GF HIV and TB grants. The organization for the service delivery, the M&E, and the procurement and supply chain management are adequate, which creates an enabling environment for the transition. The risks in the process are high though, due to the blurred structure and management of the national disease programs.

Transition preparedness. Although the transition has not started yet, the Government's commitment to take over the financial responsibilities and gradually increase the programs' domestic funding shows some readiness. Several steps have already been taken like the financing of the 1stline medicines in HIV and TB starting from Autumn 2015, the co-financing system for the TB adherence payments from 2014, and the state-funded OST program. However, an assessment of the transition readiness indicates a medium risk.

5.1. General Recommendations

Based on the findings of the transition and sustainability assessment discussed in previous chapters, this section provides bold recommendations that can guide the Government and key stakeholders towards an easy transition after external funding ends.

Transition plan. While country is discussing and actively working on the elements of the transition, there is no overall plan governing this process. Adequate conceptualization of and careful planning for the transition would most likely be of benefit. Other country experiences prove that planned transitions reduce/minimize transition challenges, while rushed transitions cause more problems and undermine sustainability. Therefore, developing time-bound and actionable plans, which have sufficient legal power and adequate indicators to monitor the plan implementation, seem to be necessary first steps for the country to consider. Finally, effective implementation of the plan would also require sufficient resources (human and financial) to achieve transition objectives.

Gradually reducing financial dependence on the Global Fund. Experiences prove that the transition process become smoother and odds for sustainability increases, when the Global Fund's contribution to the national response is not significant, e.g. less than 25%. Consequently, the country has to strive to gradually reduce its dependence. The first and most important area for transition to consider is commodity procurement, so that national procurement mechanisms function adequately and allow for such a transition. The most challenging area seems to be transition of preventive interventions, especially those delivered by the NGOs/CSOs, which could be left for the latter phases, provided that sufficient preparatory work is done during the lead-up time to transition date (see CSO contracting for more details).

Many countries give lower priority to prevention compared to treatment. In many instances, the lack of national budget allocation (even with small amounts) has challenged transition and undermined sustainability prospects. While prevention could be last element to be transitioned, it seems important to start developing prevention budget lines/allocations during the transition process, which may eventually drive increased budget allocations when the country stops receiving Global Fund support. In other countries, legally empowered national programs that already reflect a gradual reduction in donor dependence in their budget have often served as an effective instrument in other countries.

CSO contracts. The overall legal environment is not conducive for NGO/CSO contracting and the country lacks detailed contracting procedures for CSO contracting in the health sector. Georgia would benefit significantly if these rules/procedures were developed during transition and institutionalized.

A similar situation was observed in the countries that graduated from the Global Fund without having such rules in place and facing transition challenges. Based on other country experiences, such detailed contracting rules/procedures are at least expected to address at least the following: service definition, service pricing and/or methodology to estimate quoted prices, which on one hand helps evaluate the value for money for the submitted bids during tendering/national procurement process and on the other, and most importantly, helps the government to estimate overall program costs for a given disease and adequately budget during the budgeting process; tendering procedures that are aligned with the national procurement laws and regulations; bid evaluation procedures for both quality and value of the bid; procedures for monitoring quality and/or volume of services delivered by CSOs, etc.

Effective national coordination, with or without the CCM as a coordinating body, is essential for effective management of the national response and for implementing the transition process, which leads to sustainability. One of the greatest benefits that the Global Fund has delivered worldwide is creating the space for governments and civil society to jointly engage in the national/global response planning and coordination^{127,128,129}. In most states CCMs, or similar structures, that formally provide a seat and voice for NGOs/CSOs in the national coordination, have been critical in achieving the gains observed globally. Consequently, retaining and/or enhancing effective coordination structures proved to be important in many countries after the Global Fund support. Therefore, it seems important for the country to consider retaining and enhancing the national coordination structure/function, which would allow for continuous NGO/CSO engagement. For such coordination to be effective the production, availability, transparency and easy access to information should be ensured for the development of an evidence-based (or informed) responses.

Enhancing public accountability during and after transition will be critical to assure quality partner engagement e.g NGOs, SCOs, journalists and development partners. This would require the routine production of information describing results of the national response e.g. disease program specific epidemiological and financial expenditure data; the results of program performance, including outcomes and challenges. During transition, the country (perhaps with the Global Fund support) should strive to assure (maybe contractually and/or through legislative action) that this information is not only routinely produced but is also freely accessible for all stakeholders involved, government and civil society alike.

Addressing human resource challenges should be viewed in two parts: a) assuring adequate quantity and re-distribution of the needed human resources and b) continuous education of the

¹²⁷ Spicer N., Aleshkina J., et al. National and subnational HIV/AIDS coordination: are global health initiatives closing the gap between intent and practice? *Globalization and Health* 2010, 6:3.

¹²⁸ Kapilashramia A., O'Brien O. 2012. The Global Fund and the re-configuration and re-emergence of 'civil society': Widening or closing the democratic deficit? *Global Public Health: An International Journal for Research, Policy and Practice* Volume 7, Issue 5, 2012.

¹²⁹ Duvvury N., Cornman H., Long C. 2005. Participation of Civil Society in Global Governance: Lessons Learned from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. www.icrw.org.

professionals involved in the national response – service provision. The latter has been extensively supported by the Global Fund grants, and not only in this country¹³⁰. However, the sustainability of these trainings raise concerns due to the lack of institutionalization achieved during the grant implementation. Consequently, the transition period has to be explicit about what could be achieved, in terms of preparing the necessary human resources and how this function can be institutionalized and eventually funded and delivered by the government. The question of human resources goes well beyond the disease response and results from health sector policies, education policies and the overall socio-economic environment in the country. It also affects the whole health care system of the country. Instead of addressing these challenges as a transition issue, therefore, it is necessary to look at these challenges more holistically and outside of the transition process.

5.3 Country Specific Recommendations

Table 9. Country programs specific recommendations

	HIV	TB
Coordination	<ul style="list-style-type: none"> - Resolve structural, coordination and stewardship challenges related to disease programs. - Ensure that National Strategic Frameworks has legal power. - Ensure there is an assigned body to coordinate, manage and control its implementation. 	
Program Management	<ul style="list-style-type: none"> - Create a clear structure with evident and defined roles and responsibilities across all levels. - Ensure that disease programs are led by effectively functioning and legally empowered organizations that could also play a bridging role between CSO and government. - Ensure that program data reports, M&E reports, other periodic updates and financial data are available. - Enhance the MoLHSA’s capacity to manage tenders by making sure that officials are able to develop technically-sound specifications for any tender related to TB/HIV programs. 	
Partnership	<ul style="list-style-type: none"> - Strengthen the partnership between state and non-state actors for coordinated service provision, transition planning and implementation of the transition plan. - Create an enabling environment for strengthening the capacity of local CBOs, who are currently involved in implementing of TGF program. 	
Legislation and regulation	<ul style="list-style-type: none"> - Ensure the current legislative acts to decrease stigma and discrimination towards HIV/AIDS and TB are implemented. 	

¹³⁰Bowser.D.,Sparkes.SP., et al. 2013. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. Health Policy and Planning 2013;1-12.

	<ul style="list-style-type: none"> - Review and amend the legislation related to KP in order to ensure avoiding stigma and discrimination. - Develop legal documents creating the base for the needle exchange program in the country and its regulation, as after phasing out TGF, this particular activity can become illegal. - Liberalize the restrictive drug policy in the country by clearly emphasizing that drug use is a medical and public health problem and it should not be considered as a crime (with MoLHSA leading the process) and at the same time ensure that Ministry of Internal affairs fully understands all public health related risks of such a restrictive drug policy 	<ul style="list-style-type: none"> - Ensure that the TB law is approved, introduced and enforced during the planned period.
	<ul style="list-style-type: none"> - Ensure that the existing legal documents and policies are enforced and followed up. - Ensure that rule and procedures for contracting CSOs for health service delivery are developed and introduced. 	
Guidelines	<ul style="list-style-type: none"> - Continue the optimization of the ARV treatment schemes and switching to the public health approach. 	<ul style="list-style-type: none"> - Ensure that the revision of treatment guidelines are ongoing and necessary financial sources are available for continuous training of the medical staff.
Accountability	<ul style="list-style-type: none"> - Make sure that M&E data and health expenditure information, in particular for HIV/AIDS and TB programs are available. 	

	HIV	TB
Finances	<ul style="list-style-type: none"> - Ensure that adequate funding from public sources is available for prevention programs (especially to cover low threshold programs for KAP's) - Ensure that the share of public spending is adequate to cover the needs of HIV/AIDS and TB programs after TGF. - Ensure that allocations are made based on existing epidemiological data. - Look for alternative sources of funding to cover the gap. - Increase public spending on HIV prevention for epidemiologically priority groups. 	

	HIV	TB
Service Delivery	<ul style="list-style-type: none"> - Prioritize and address low detection rate related problem. - Re-design OST program by missing psycho-social element added, in order to make sure, it is a ready-to-replicate model for the state to take over without any doubts in its effectiveness. 	<ul style="list-style-type: none"> - Address challenges related to low case detection, late diagnostics and weak adherence support. - Strengthen engagement of local NGOs in service delivery. -
	<ul style="list-style-type: none"> - Strengthen coordination between HIV and TB programs and other integrated services, especially in rural areas. 	

	HIV	TB
Human Resources	<ul style="list-style-type: none"> - -Ensure that TGF-supported trainings for health personnel are institutionalized in the national education system. - Initiate the integration of the HIV and TB training modules into the undergraduate and postgraduate education schemes. - Develop the policy for production/training of CSO personnel. 	

	HIV	TB
Supply Chain	<ul style="list-style-type: none"> - Develop the capacity of the social services agency (under the MoLHSA) in planning the purchase process and in providing detailed specifications for the medicines and supplies in the purchase orders. 	<ul style="list-style-type: none"> - Specify the status, scope of work, roles and responsibilities of the central pharmacy unit at NCTBLD - Strengthen the human resources capacity at the central and regional levels in the area of inventory management through training and monitoring. - Identify administrative regulations to allow redistribution of medicines between facilities, which will allow to use efficiently the existing medicines and avoid waste.

	HIV	TB
Surveillance and M&E systems	<ul style="list-style-type: none"> - Develop analytical capacity of the NCDCPH in analyzing HIV data by making it ready to use by decision-makers as a strong evidence. 	<ul style="list-style-type: none"> - Produce annual analytical surveillance report and disseminate it for better use of data for decision-making and advocacy purposes. -

<ul style="list-style-type: none">- Ensure that IBBS studies are implemented on a regular basis and funding is allocated from public sources or alternative funding is secured.
<ul style="list-style-type: none">- Increase analytical capacity of the disease programs and ensure data use for the program and budget planning, for the evidence-based decision-making and advocacy purposes.

ANNEXES

ANNEX 1: LIST OF DOCUMENTS REVIEWED

- 1 Global AIDS Response Progress Report, Georgia, January 2012 - December 2013, National Centre for Disease Control and Public Health, Tbilisi, 2014.
- 2 Global AIDS Response Progress Report, Georgia, January 2010 - December 2011, National Centre for Disease Control and Public Health, Tbilisi, 2012.
- 3 Global AIDS Response Progress Report, Georgia, January 2008 - December 2009, National Centre for Disease Control and Public Health, Tbilisi, 2010.
- 4 The Georgian Healthcare System State Concept 2014 – 2020 “Universal Healthcare and Quality Management for Protection of Patients Rights”, Government of Georgia Ordinance No 724, December 26, 2014
- 5 Extensive review of tuberculosis control, prevention and care in Georgia, mission report, 6-14 November, 2014
- 6 GLC European Region Consulting Mission: PMDT in Georgia, 17-20 July, 2014, Final Report.
- 7 HIV Review in Georgia, March 2015; WHO country mission report
- 8 Country Coordinating Mechanism Georgia. The Georgian National HIV/AIDS Strategic Plan for 2016-2018, CCM Georgia, 15 April 2015
- 9 The Georgian National HIV/AIDS Strategic Plan for 2011-2015, CCM Georgia
- 10 World Health Organization. HIV/AIDS treatment and care in Georgia. Evaluation report, Prepared by WHO Collaborating Centre for HIV and Viral Hepatitis, WHO, September 2014.
- 11 Georgia Health System Review. Health Systems in Transition, The European Observatory on Health Systems, Chanturidze T, et. al, 2009.
- 12 Law of Georgia on the structure, powers and order of activity of the Government of Georgia
- 13 Rukhadze: An overview of the health care system in Georgia: expert recommendations in the context of predictive, preventive and personalised medicine. The EPMA Journal 2013 4:8.
- 14 Population Situation Analysis (PSA) Georgia, 2014, Final report, UNFPA
- 15 DFID Georgia Primary Health Care Reform Support Programme 2003-2008, Oxford Policy Management, Volume 1
- 16 Thematic report: stigma and discrimination, Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Eastern Europe and central Asia, progress report 2012. www.ECDC.europa.eu
- 17 HIV risk and prevention behaviors among Female Sex Workers in two cities of Georgia Bio-behavioral surveillance survey in Tbilisi and Batumi. Curatio International Foundation, Tanadgoma. August, 2014. <http://www.curatiofoundation.org/uploads/other/0/292.pdf>
- 18 National AIDS Center data 2014
- 19 National AIDS Center data 2015
- 20 NCTBLD data 2015
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ANNEX 2: LIST OF PEOPLE INTERVIEWED

#	Name	Affiliation
1	TengizTsertsvadze	General Director , Infectious Diseases, AIDS and ClinicalImmunology Research Center, CCM member
2	ZazaAvaliani	Director,National Center of Tuberculosis and Lung Diseases, CCM member
3	AmiranGamkrelidze	General Director, NCDCPH, CCM member
4	Lela Bakradze	UNFPA, Assistant Representative, CCM member
5	IzoletaBodokia	HIV/AIDS Patients Support Foundation, CCM member
6	David Ananiashvili	Director, Georgian Plus Group, CCM member, chair of oversight committee (OC)
7	Tamar Gabunia	URC LLC USAID-funded Georgia Tuberculosis Prevention Project, Chief of Party, CCM Vice-Chair
8	RusudanKlimiashvili	WHO Georgia, Headof Country Office
9	David MikheilShubladze	Director, LGBT Georgia (CBO) CCM member
10	Tamar Sirbiladze	USAID, Health and Social Development Office, Director, CCM member, member of OC
11	LashaTvaliashvili	Executive Director, Real people, Real vision (CBO), CCM member
12	KhatunaTodadze	Center for Mental Health and Prevention of Addiction, TGF-funded methadone substitution therapy program, CCM member
13	Irma Khonelidze	TGF program manager, PR, NCDCPH
14	TamusiaSirbiladze	Director, Bemoni
15	George Soselia	M&E Officer, TGF program, NCDCPH
16	Nikoloz Chkhartishvili	Deputy Director, Infectious Diseases, AIDS and Clinical Immunology Research Center
17	IvdityChikovani	Director of Research Unit, CIF
18	MakaGogia	GHRN, TGF program manager
19	Nino Tsereteli	Director, Tanadgoma
20	Nino Lomtadze	TGF program coordinator, NCTBLD
21	Tea Jibuti	Former LFA, M&E specialist
22	Lela Kurdgelashvili	TGF program coordinator, Tanadgoma
23	Maya Baratashvili	Director, Tanadgoma-Sukhumi
24	PaataSabelashvili	GHRN, former program manager
25	AkakiLochoshvili	Former Program Manager, TGF, former PR
26	ZurabSikharulidze	Clinic Uranti, manager of OST program, TGF
27	Maya Kajaya	Project coordinator, Health Research Unit, NGO (TB)
28	Galdava George	Director, Dermato-VenerologistsAssociation
29	FatiGabunia	Consultant, TGF Abkhazia program, National AIDS Center
30	NikaKochishvili	Program Manager, EU delegation, CCM member

31	TsovinarSakanyan	FPM for Georgia, TGF
32	EkaKavtaradze	TB Program Manager, TGF, NCDCPH
33	Marina Darakhvelidze	Head of the public health department, MoLHSA
34	Irakli Katsitadze	LFA, UNOPS
35	TemurPirvelashvili	State Agency for Regulation of Medical Activities, MoLHSA
36	DavidMacharashvili	State Agency for Regulation of Medical Activities, MoLHSA

expenditure)														
Health expenditure, private (% of total health expenditure)	83.0	82.2	83.9	85.2	84.7	80.8	78.9	82.3	80.2	77.7	77.2	81.9	82.0	78.5
Out-of-pocket health expenditure (% of total expenditure on health)	82.5	72.3	71.2	77.1	77.4	76.8	72.2	70.8	64.2	66.5	69.1	64.9	64.7	61.9

Source: The World Bank Data Base, accessed July 15, 2015