Georgia

Report for the National Voluntary Presentation at the ECOSOC 2014 Annual Ministerial Review

Prepared by

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United Nations Children's Fund (UNICEF) Country Office

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USAID Georgia HIV Prevention Project (GHPP)

SECTION 1 Review of the Status of MDG Implementation in Georgia

Basic Country Information

Georgia is a country covering around 70,000 square km, lying on the southern foothills of the Greater Caucasus mountain range, and on the south-eastern shores of the Black Sea. It is bordered by Russia to the north, Turkey to the south-west, Armenia to the south and Azerbaijan to the south-east. Georgia has a population of 4.5 million (2013), the country has long been ethnically heterogeneous and 54% of population lives in urban areas.

Georgia is a lower-middle-income country, according to the World Bank classification. Over the last 20 years the country has achieved significant economic growth with GDP per capita rising from $690 in 2000 to $3597 in 2013. Poverty indicators decreased in parallel with economic progress, though unemployment remains relatively high at 15% as of 2012.

Demographic trends

The country population totalled 4,490,500 as of January 2014 (52.3% female and 47.7% male). The share of children under-15 comprising 17.0% is lower than Global and European regional averages. Percentage of 65 year-old and older population has slightly increased over the last 15 years and stands at 13.8%. Life expectancy at birth increased to 75.2 years by 2013 (females – 79.4; males – 70.9) exceeds the CIS average and is close to the European regional estimates. See Table 1 for selected demographic data of the country.

Table 1: Basic demographic data, Georgia

	2013	
	Total	Rate
Number of live births and birth rate per 1000 population	57 878	12.9
Natural population growth and rate per 1000 population	9 325	2.1
Number of deaths and mortality rate per 1000 population	48 553	10.8
Migration dynamics and rate per 1000 population	-2606	-0.6

Source: National Statistics Office of Georgia

Country's commitments to human development

Since its independence in 1991 Georgia has ratified core international instruments for human rights, including the Universal Declaration of Human Rights, Convention on the Rights of a Child (CRC), Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights.

In 2000 Georgia along with adoption of the Millennium Declaration made a commitment to integrate the Millennium Development Goals (MDGs) within its national development strategies and plans and to periodically report on the status of MDG platform implementation.

In 2014 the country developed an integrated, multi-sectoral Strategy for Human Rights that defines the overarching framework of action for the Government and main stakeholders how to enhance the protection and promotion of human rights, including the provisions envisaged by MDGs.

In 2013, the Government of Georgia launched its flagship programme on Universal Health Care (UHC) that ensured every citizen of Georgia with a basic package of out-patient, in-patient and emergency health services. Stemming from 2012 UN Resolution on UHC and the Global Vision of Universal Health Care by 2030, the programme has been another visible demonstration of Georgia's commitment to health-related MDGs and broader human development agenda. International partners, including the World Health Organization (WHO), The World Bank and US Agency for International Development (USAID) have been actively engaged in supporting the country in successful implementation of its UHC endeavor.

Section 2 presents status of implementation of the Millennium Development Goals in the country along with the relevant policies put in place as of April 2013.

SECTION 2 Status of MDG Implementation and Related Policies

Goal 1: Eradicate Extreme Poverty and Hunger

Targets	1. Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day, measured through trends in relative and extreme poverty rates. 2. Achieve full and productive employment and decent work for all, including women and young people, and 3. Halve, between 1990 and 2015, the proportion of people who suffer from Hunger, measured through prevalence of under- 5 children underweight

Georgia has enjoyed impressive economic growth from the early years of transition largely due to a wide range of reforms. GDP per capita has increased from 690 USD in 2000 to 3597 in 2013. Positive trends in economic development were challenged by the war with Russia in August 2008 and the world economic crisis, though the negative trends have started to reverse in 2010. Georgia's economy grew by 3.2 % in 2013.

Economic growth was paralleled with progress in poverty reduction. Extreme poverty level decreased from 19.3 in 2000 to 9.3 or 9.7 in 2012, while relative poverty (a level of income set at 60% of the median household income) decreased from 24% in 2004 to 22.4% in 2012.

Introduction and continued expansion of social protection schemes provided safety net for socially most vulnerable population groups, including families living under poverty, old-age pensioners and people with disabilities. In 2013 old-age pensions and social allowances have been increased from 2012 baselines by 50% and 100%, respectively. Overall the social allowance for old age pensioners increased 10.7 times from 14 GEL in 2000 to 150 GEL in 2013.

However despite the progress, poverty rates were not significantly reduced and both the incidence and severity of poverty remain of great concern to the country. According to UNICEF's 2012 Welfare Monitoring Survey, 77,000 children aged 0-16 years live below USD 1.25 per day and more than 200,000 (one fourth of the total child population) consume less than 60% of

medium consumption, which is approximately USD 2 per day. 2013 data from UNICEF supported survey revealed a declining trend in extreme poverty among children from 9.4% in 2011 to 6% in 2013. Children have benefited from doubled social allowances and increase old-age pensions indirectly; however 27% of children continue to live below 60% of the median household income.

Unemployment remains high at 15% as of 2012, with estimated youth unemployment exceeding 30% (Table 2). More than 70% of the population regard themselves as unemployed, as showed by National Democratic Institute (NDI) public opinion survey in 2012. Furthermore 70% of the population remains economically or socially vulnerable according to the 2012 UNDP study.

The Government of Georgia is developing new strategies and economic reforms to promote sustainable economic growth for 2014-2020 cycle. The Social and Economic Development programme focuses on encouraging private sector development, promoting professional education and local self-governance reforms.

Table 2: Employment trends, Georgia, 2000-2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Youth Employment rate, aged 15-24, both sexes	21.2	20.1	27.9	24.6	28.3	28.3	29.3	31.5	35.5	38.7	36.3	35.6	---
Employment-to-population ratio, both sexes, percentage	60.11	58.8	56.8	58.4	56.6	55.2	53.8	54.9	52.3	52.9	53.8	55.4	56.8
Employment-to-population ratio, men, percentage	67.3	67.1	65.1	67.4	64.2	62.6	61.2	63.1	61.1	61.1	61.2	63,7	65.6
Employment-to-population ratio, women, percentage	54.0	52,0	49.9	50.9	50.2	48.8	47.7	48.1	44.9	45.9	47.5	48.5	49.5

Source: National Statistics Office of Georgia

Prevalance of underweight in children remains low. According to the Multiple Indicator Cluster Survey (MICS, 2005) 2.1% of under-5 children were moderately underweight and the share of extremely underweight children was 0.3% (Table 3). Similar results were confirmed by 2009 Georgian National Nutrition Survey. Even if the underweight prevalence is low, UNICEF 2012 survey revealed high prevalence of micronutrient deficiency among pregnant women and

children that the Government started to address through targeted micronutrient supplementation programmes and regulations in 2014.

Table 3: Prevalence of underweight in children under- five (%), Georgia, 2009

	Severe underweight	Moderate underweight	None (normal)
Total	**14 (0.5%)**	**25 (0.6%)**	**2981 (98.8%)**
Male	7 (0.4%)	19 (0.9%)	1599 (98.7%)
Female	7 (0.6%)	6 (0.4%)	1382 (99.0%)
Regions			
Tbilisi	3 (0.8%)	1 (0.3%)	360 (98.8%)
Ajara and Guria	2 (0.6%)	1 (0.3%)	337 (99.1%)
Imereti and Racha-Lechkhumi	1 (0.5%)	2 (1.0%)	204 (98.6%)
Kakheti	2 (0.7%)	1 (0.3%)	304 (99.0%)
Kvemo Kartli	2 (0.3%)	8 (1.1%)	751 (98.7%)
Samegrelo	1 (0.4%)	3 (1.1%)	272 (98.6%)
Samtskhe-Javakheti	3 (0.6%)	8 (1.6%)	490 (97.8%)
Shida Kartli and Mtskheta-Mtianeti	0	1 (0.4%)	263 (99.6%)

Source: Georgian National Nutrition Survey, 2009

Goal 2: Achieve Universal Primary Education

Target	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Georgia has a strong tradition of education, with almost universal primary school enrolment rates across the country. The country has maintained high primary school enrolment (96%-100%) since 2000 with gender parity index of 1.03 as of 2011.

Since 2005 Ministry of Education and Science introduced inclusive education and inclusive school concept. As for today all schools of Georgia are providing inclusive education with special attention to individual approach and individual, student centered curriculum. Inclusive education concept has raised the accessibility to all stages of general education system. The system is in the process of improving the quality of inclusive education in Georgia.

However, the quality of the education system has been a concern. According to the 2011 Trends in International Mathematics and Science Study (TIMSS) study, Georgian eight graders ranked 26th out of 28 participating European countries in maths and science. Furthermore, according to the Ministry of Education and Science 2,388 students dropped out during the school year 2009-2010 and there is a need for more and better data on out-of-school children and children at risk of dropping out.

The ongoing education reform process is primarily focused on improving the quality of education and ensuring accessible and affordable education at different levels. Georgia joined Bologna process at Bergen Summit in 2005 and the Ministry of Education and Science of Georgia initiated regulatory amendments to facilitate introduction of the Bologna principles in the higher education system.

Georgia is currently actively working on comprehensive reform of vocational education and training. UN agencies, including UNDP and ILO as well as EU have been assisting the country in the design and implementation of the systemic reforms for 2013-2020 to close the existing imbalance between the education system supply and the labour market demand.

Goal 3: Promote Gender Equity and Empowerment of Women

Target	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

The country even in the critical socio-economic transition of early 1990s has substantially advanced its gender equality agenda, with progressive implementation of commitments laid out by the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

As noted gender equality in education has not been a developmental challenge in the country. Georgia has maintained close to universal primary school enrolment both for girls and boys, with the latest data on gender parity index in primary, secondary and tertiary education standing at 1.03, 0.95 and 1.2, respectively. Education resource centers countrywide report 1.4 female-to-male ratio among public school Principals, and 4 out of 5 school teachers in Georgia are women.

The country made important progress in securing education rights of children in socially disadvantaged families. However, female students from ethnic minority groups remain under higher risk of drop-out. A recent study of Millennium Challenge Foundation also revealed barriers to girl's equal participation in STEP (science, technologies, engineering and mathematics) education programmes. In this respect the Government plans to intensify work on protection and promotion of women's rights in education and science. The Ministry is working with the US Civilian Research and Development Foundation (CRDF) and local scientific foundations to promote talented female PHD students and facilitate women participation in scientific research.

In March 2010 Georgia adopted the law "On Gender Equality" and established a Parliamentary Council on Gender Equality. Since 2010 the Council has completed two biennial cycles of strategic planning exercise for gender mainstreaming. Within the framework of 2010-2013 National Action Plan (NAP), the Ministry of Education in partnership with civil society, provided gender equality training to school teachers countrywide. The 2014-2016 NAP envisages public awareness-raising on gender equality, mainstreaming gender-aspects in education laws and promoting gender equality in STEP education programmes and vocational institutions.

In 2012 Georgia surpassed 10% threshold level for women representation in the Parliament from 5% baseline in 2000. Women hold key Ministerial portfolios in Justice, Education, Foreign Affairs and Environmental Protection and lead the National Security Council and the Central Election Committee of the country. Economic empowerment of women has been also visible since 1990s with 30% of women being primary breadwinners and 20% heading business enterprises.

Despite the progress, women are still under-represented at decision-making levels and their economic empowerment has to be further improved. According to the Gender Inequality Index, Georgia is placed 71 of the 137 countries surveyed. In 2012, the average nominal monthly salary of women in all fields of the economy and across the industry sectors was 60% of that of men.

Breakthrough in gender equality will only be possible as a result of the strong and coherent efforts of all stakeholders, including the government, civil society and development partners.

Goal 4: Reduce Child Mortality

Target	Reduce by two-thirds, between 1990 and 2015, the mortality rate of children under age of five years

According to official vital statistics (GeoStat), Georgia has substantially reduced under-5 mortality rate from 24.9 in 2000 to 13.0 in 2013. Similar declining trend has been reported by the administrative health statistics unit of the National Centre for Disease Control and Public health (NCDCPH), with U5MR decreasing from 27.2 in 2000 to 12.4 in 2012.

Even if the data discrepancy is high between the routine statistics and the Georgian Reproductive Health Survey (GERHS), significant progress vis-à-vis under-5 mortality reduction is evident and all data sources confirm the declining trend in child mortality (Table 4).

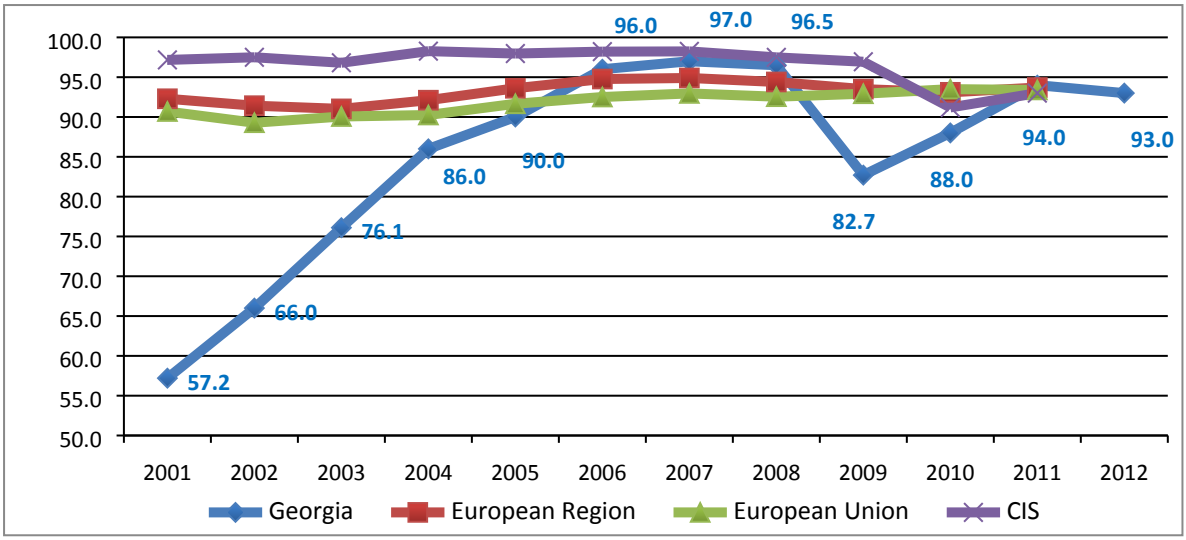
Table 4

Under-5 mortality, comparative data from vital statistics, health statistics and household surveys

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Health statistics (NCDCPH)	27.2	26.7	22.1	20.3	20.1	19.4	19.7	15.6	16.0	15.4	13.4	12.0	12.4	-
Vital statistics (GeoStat)	24.9	25.5	26.0	27.6	26.4	21.1	16.9	14.4	18.0	16.0	13.0	13.8	14.4	13.0
GERHS	45.8	-	-	-	-	25.1	-	-	-	-	16.4	-	-	-

After disruption of routine vaccination services in early 1990s, Georgia successfully restored and expanded coverage of the national immunization programme. Since 2000 the country has maintained over 90% coverage for the first Measles Containing Vaccine, reported 93% coverage by end of 2012 (Figure 1) and has further improved coverage to 96.5% in 2013. The data is close to the European Union and the European region averages, though further investment are needed for sustaining over 95% coverage for MCV 1 and high coverage with the second dose of the vaccine. The latter is particularly important considering the Measles and Rubella elimination goal set by the Member States of the WHO European Region for 2015.

Figure 1: Percent of 12 months-old children vaccinated against measles, 2001-2012



Source: NCDC Georgia & WHO HFADB

Despite the documented progress, child mortality in Georgia is still the second highest in Europe. The largest share in child mortality is still attributed to infant mortality (87.5%), the situation that has not changed much since 2000 when the Infant Mortality Rate (IMR) fraction in U5MR was 90%. Furthermore the 2010 Reproductive Health Survey indicated significant difference in child mortality rates in urban and rural areas. UNICEF's 2013 equity analyses of the excessive infant deaths in Georgia suggests that (a) infants outside Tbilisi were 1.4 times more likely to experience a death than infants in Tbilisi, and (b) infants born outside Tbilisi weighting 1,500 grams or more were 1.9 times more likely to die than infants in Tbilisi before the discharge from maternity and 1.5 times more during the post discharge period.

Goal 5: Improve Maternal Health

Targets	1. Reduce by 3/4 between 1990 and 2015, the maternal mortality ratio
	2. Achieve, by 2015, universal access to reproductive health

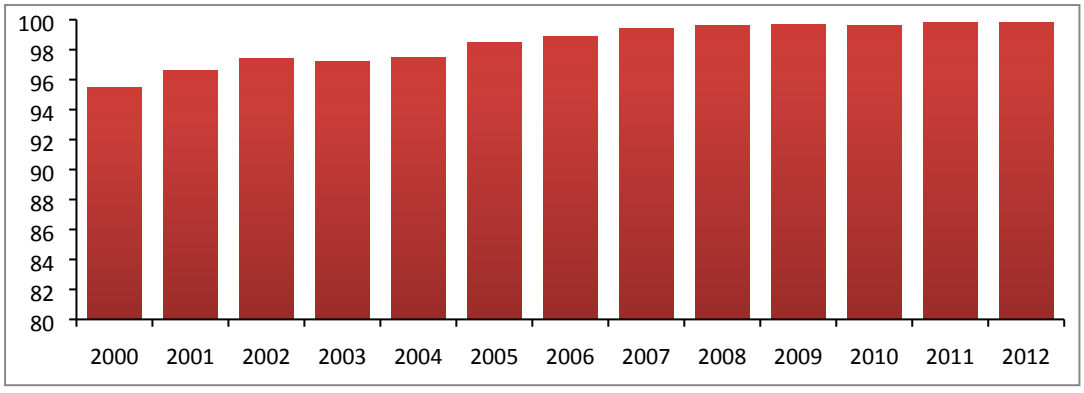
Georgia has reduced maternal mortality rate (MMR) by more than half from 49.2 in 2000 to 22.9 in 2012 (Table 5). The 54% reduction in MMR has been significant, however attainment of the ¾ reduction target set by the Millennium Declaration most probably will be missed by 2015.

Table 5: Maternal mortality rate, Georgia, 2000-2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Official statistics (GeoStat)	49.2	58.7	42.2	49.9	43.1	23.4	23.0	20.2	14.3	52.1	19.4	27.6	22.9
GERAMOS	-	-	-	-	-	-	44.0	-	-	-	-	-	-
MMS (Maternal Mortality Survey) 2011	-	-	-	-	-	-	-	-	-	-	20.6	-	-

Proportion of births attended by skilled health personnel, already high at the time of MDG platform adoption was further increased from 97.4% in 2002 to 99.8% in 2012 (Figure 2, Table 6).

Figure 2 Proportion of births attended by skilled medical personnel (%), Georgia



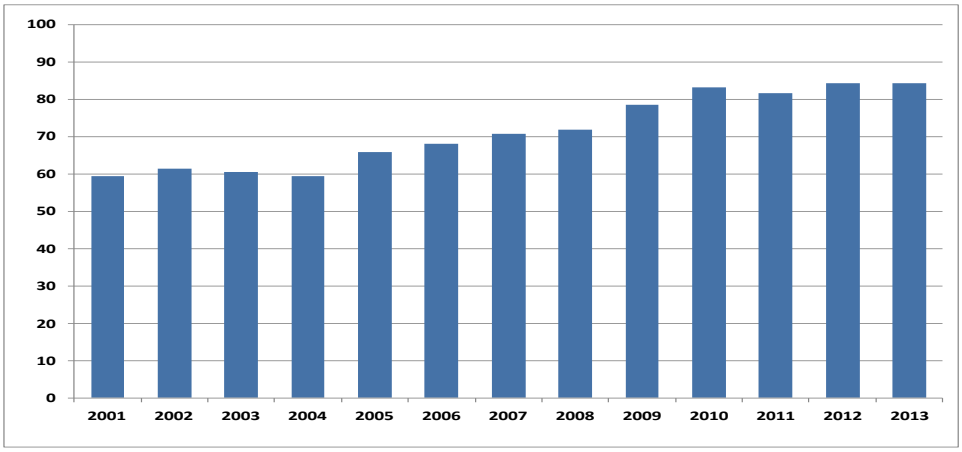
Source: National Center for Disease Control and Public Health

Table 6 Proportion of births attended by skilled medical personnel (%)

	1995-1999	2000-2004	2005-2009	2012
Health statistics	95,8	96,9	99,2	99.8
GERHS (Georgia Reproductive Health Survey)	92.2	92.5	98.8	-
MICS	-	-	93.8	-

Coverage with recommended four antenatal care visits among pregnant women has been also on rise and totalled 84.2% in 2013 from lower than 60% baseline in 2001 (Figure 3). The MICS 2005 reported 97.4% of pregnant women to have visited antenatal care institutions at least once. The high uptake of four antenatal care visits was confirmed by GERHS survey (98.8% in 2005-2009). Improved access to RH services since 1999 has benefited especially women living in rural areas as well as from low education groups. Per cent of pregnant women with no ANC in the two groups fell from 14% and 30% to 3% and 6%, respectively.

Figure 3 Percent of women receiving at least 4 antenatal care visits, Georgia



Source: National Center for Disease Control and Public Health

Data on reproductive health services (apart from maternal and child health statistics) are mainly derived from household surveys. According to three GERHS surveys conducted in 2000-2010 period, total induced abortion rates have decreased from 3.7 to 1.6 with parallel increase in contraceptive prevalence rate (all methods) from 25% to 32% among all women of reproductive age (including from 41% to 54% among married women). Increase in contraceptive prevalence was mainly caused by increase in use of modern contraceptive methods (from 20% in 2000 to 35% in 2010 among married women). The GERHS data also documented reduction in the unmet need for family planning - for modern methods of family planning the unmet need decreased from 27% to 18% (Table 7). This could be attributed to partnership initiatives supported by USAID and UNFPA for ensuring the access to free of charge modern family planning methods as well as availability of socially marketed FP products, expansion of private sector partnerships and nationwide training of RH service providers.

Table 7: Unmet needs for Modern Methods of Family Planning (%), GERHS

	2000	2005	2010
Women aged 15-44	27	22	18

To further contribute to increased access to quality RH services and address one of the main causes of mortality and morbidity of women of reproductive age, the government in partnership with UNFPA has launched the breast and cervical cancer screening programmes, which provide free of charge services to women of target age in all regions of Georgia. Currently the joint efforts are underway to plan and pilot the organized cervical cancer screening programme in order to ensure increased participation rate and improved quality of the screening programme. Additionally, over 1400 primary health care providers were trained in breast and cervical cancer prevention and early detection with USAID SUSTAIN and UNFPA support.

Despite the visible progress, still 16 mothers have died in 2013 due to pregnancy related causes according GeoStat and NCDC reconciled data. The Ministry of Labour, Health and Social Affairs has intensified work for enhancement of reproductive health statistics in partnership with UN agencies (UNICEF, UNFPA), USAID and other international partners with particular focus on timely reporting and ascertainment of pregnancy-related deaths. With technical assistance of the USAID SUSTAIN Project JSI in collaboration with NCDC is conducting the "2014 Georgian Reproductive Age Mortality Study (RAMOS)" with the aim to study the mortality of women of reproductive age and to investigate the extent and causes of maternal mortality in Georgia.

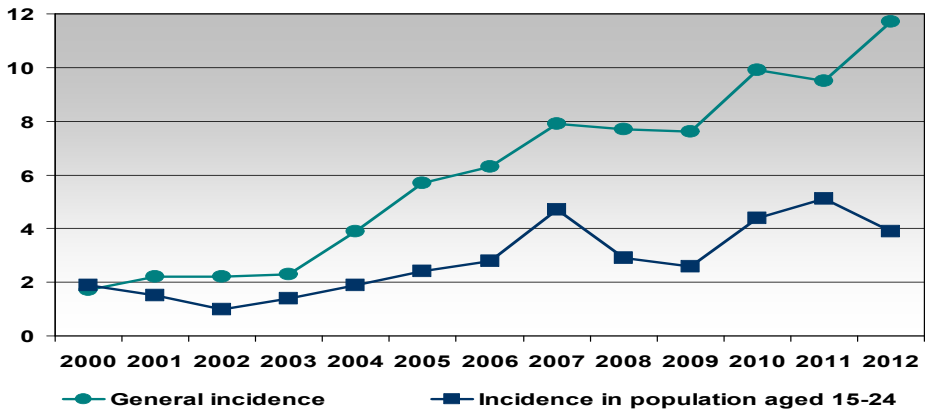
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Targets	1. Halt and begin to reverse, by 2015, the spread of HIV/AIDS
	2. Achieve universal access to treatment for HIV/AIDS for all those who need it
	3. Halt and begin to reverse, by 2015, the incidence of malaria and other major diseases

Georgia was one of the first countries in the CEE/CIS region to attain universal access to Antiretroviral Treatment (ART) in 2004 and the status has been sustained over the last 10 years. This has translated into substantial improvement of survival and quality of life of people living with HIV in the country.

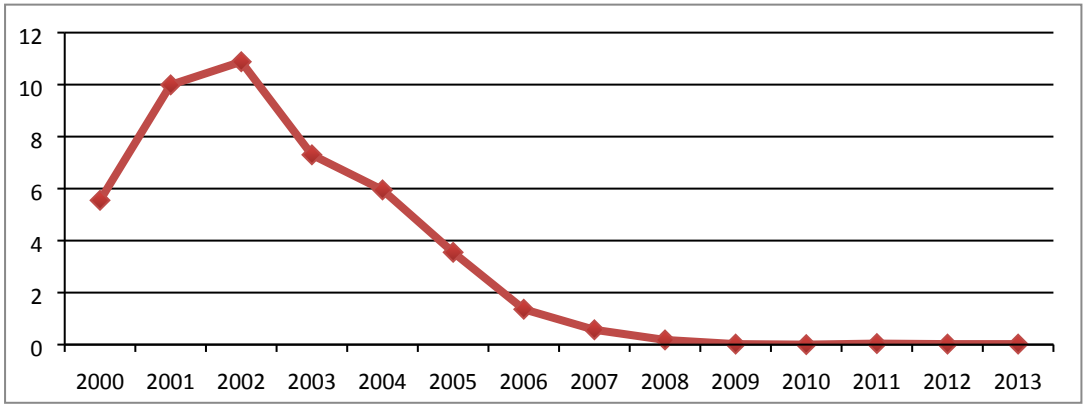
However the country is still challenged with a concentrated epidemic among high risk behavior groups, with a raise in HIV prevalence among MSM (from 3% to 13%) and over 5% prevalence among PWID in some of the Western Georgia cities. The number of new HIV infections among young people aged 15-24 is also increasing (Figure 4).

Figure 4 Incidence of HIV per 100000 population



The country has made significant progress towards the elimination of Malaria. Georgia documented reduction in Malaria incidence from 5.5 in 2002 to 0.02 in 2013 (Figure 5) and reported no autochthonous malaria case in 2013. As the signatory of 2005 Tashkent Declaration "Moving from Malaria Control to Elimination" Georgia is in the phase of prevention of reintroduction of malaria. In 2011 the country requested WHO certification as malaria-free.

Figure 5: Incidence of malaria per 100000 population



Source: National Center for Disease Control and Public Health

Georgia has also made significant progress in confronting Tuberculosis (TB) epidemic. The country has attained universal access to TB diagnosis and treatment since 2003, including MDR-TB control interventions since 2008. According to WHO estimations the overall TB incidence, mortality and prevalence rates in Georgia have been falling since 2000. The new TB cases per 100,000 population decreased from 96.5 in 2000 to 84.1 in 2012 and the prevalence in the same period fell from 133.4 to 110.9 (Table 8).

Table 8: Tuberculosis Incidence, Prevalence and Mortality per 100000 in Georgia

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Incidence	96.5	86.4	96.5	92.8	94.8	98.1	96.9	95	94.7	101.4	98.6	101.4	84.1
Prevalence	133.4	128.8	145.2	143.4	149.7	153.2	143.1	147.0	133.0	135.9	130.4	123.4	110.7
Mortality	-	-	3.1	3.5	4.3	5.3	5.4	5.9	5.2	4.6	4.1	3.5	3.9

Source: National Center for Disease Control and Public Health, Georgia

However despite the progress the country is challenged by high burden of multidrug-resistant tuberculosis (MDR-TB) (Figure 6). MDR greatly complicates Georgia's TB epidemic, since this type of TB requires nearly two years of treatment with more toxic, more expensive and less effective medicines. Georgia is one of the 27 countries with the highest burden of MDR-TB in the world.

Georgia through WHO support conducted the first-line anti-tuberculosis drug resistance survey (MDR Survey/DST) in 2004-2006. The survey revealed multidrug-resistant tuberculosis in 6.8% of smear-positive new cases and 27.4% of retreated cases. In 2011, multidrug-resistant form of tuberculosis was found in 10.9% of new cases and in 31.7% of retreated cases. TB remains to be a particularly severe problem within the penitentiary system.

Goal 7: Ensure Environmental Sustainability

Targets	1. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources 2. Reduce biodiversity loss, achieving by 2010, a significant reduction in the rate of loss 3. Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation

The Government of Georgia adopted the strategy and action plan on biodiversity preservation with Resolution #27 of February 19, 2004. The strategy covers the preservation of biodiversity for the period of 10 years, while the action plan is designed for a five-year term. The elaboration of forestry policy and strategy started in 2005.

According to the MICS 2005, 94.2% of population used an improved drinking-water source, with 78.9% of households having drinking-water piped into dwelling and 17.3% of the population needed less than 30 minutes to bring water. According to the GERHS proportion of population, to whom piped water, which properly met hygienic rules, is available has not essentially changed in the period of 2000-2009. For urban population, compared to rural, this indicator was increased by 30% (Table 9). According to MICS 2005, the vast majority of Georgian population (96.8%) lived in households with improved sanitation facilities and 56.3% of children aged 0-2 years were provided with toilets, which followed proper hygienic rules. Furthermore GERHS revealed 3.7% increase in availability of flash toilets in households in 1995-2009.

Table 9: Availability of piped water, (%)

	2000-2004	2005-2009
Reproductive Health Survey GERHS		
Urban	96.1	96.8
Rural	66.2	65.8
Multiple Indicator Cluster Survey MICS		
Total		94.2

Despite its rich water deposits, Georgia is still experiencing difficulties in supplying the population with safe drinking water in rural areas. The underground water deposits remain the main source of drinking water, providing 90% of the water supply system. Currently 84% of urban and 15.7% of the rural population is centrally supplied with drinking water.

In recent years Georgia experienced increasingly effects of climate change. The third national communication to the United Nations Framework Convention on Climate Change will include the updated greenhouse gas inventory and will discuss the ways of minimizing its emissions in the

main cities of Georgia. It will also assist the Government to better analyse Climate Change risks and to develop realistic scenarios for reducing its negative impact.

Georgia is developing strategies and action plans for increasing the national potential to effectively implement the requirements of global conventions on climate change including: biodiversity conservation, the fight against desertification, the elaboration of a national plan on implementation of the Stockholm Convention of Persistent Organic Pollutants (POPs), and Kura-Aras basin preservation and integrated management plan.

Goal 8: Promote Global Partnership

Targets	1. Develop further an open, rules-based, predictable, non-discriminatory trading and financial system 2. In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries 3. In cooperation with the private sector, make available benefits of new technologies, especially ICTs

Georgia has a one of the most liberal and competitive trade regimes around the world. There are no non-tariff barriers (prohibitions, restrictions, tariff quotas, licensing) in the Georgian legislation except those cases where health, security, safety and environmental issues are concerned. Since 2006 Georgia abolished import duties on almost 85% of goods and reduced the number of import duties from 16 to only 3 – 0%, 5% and 12%. After joining the World Trade Organization (WTO) in June 2000, Georgia started to harmonize its customs regimes with the commitments negotiated with the WTO. Georgia's joining the WTO resulted in the abolishment of the Jackson-Vanik Amendment by the USA and, furthermore, granted the country Most Favoured Nation status. Later, the country was granted the General System of Preferences (GSP) beneficiary status. Georgia is also a beneficiary of the following GSP schemes: Switzerland, Norway, Canada, Japan.

The EU expanded the Generalized System of Preferences (GSP) beneficiary status of Georgia, granted in 1995 to GSP+ that entitles more than 7,200 types of products with Georgian origin to enter the European Union market with zero customs tariff. In 2013, after the lifting embargo on

agricultural products by Russian Federation, such export products as wine, mineral waters, citrus, etc. have reentered on the Russian market.

Georgia has free trade agreements with CIS countries and Turkey. In November 2013 the EU-Georgia Association Agreement, including Deep and Comprehensive Free Trade Agreement (DCFTA), was initialed. It is expected to sign the agreement by June 2014.

In April 2011 Georgia became the 135th country to officially adhere to the Paris Declaration on Aid Effectiveness (PD) and the Accra Agenda for Action (AAA).

With regards to affordability of essential drugs, Georgia has been using the global procurement mechanisms for vaccines and biologicals as well as HIV and TB drugs through UNICEF, GAVI and Global Fund cooperation. The country is working on maintaining access to the affordable prices after graduation from GAVI and the Global Fund support after 2016. Furthermore in 2014 Georgia made a significant progress in affordability of Hepatitis C treatment, with 60% reduction of PEG-INF price in the local market for 11,000 beneficiaries.

Publicly funded health care programmes (such as Diabetes, Dialysis, Immunization) universally covers relevant medications and biologicals for the patients. Universal Health Care (UHC) and state health insurance programmes also cover priority medications for specific groups of beneficiaries as well as medications necessary for emergency care, elective surgery and cancer treatment. Recognizing high prevalence of hypertension in the country, Ministry of Labour, Health and Social Affairs works on policy options developed within USAID Health Care Improvement project to support improved financial access to chronic disease medications.

The country has also documented substantial progress in access to and uptake of modern Information and Communication Technology (ICT). Mobile cellular subscription stands at 107.81 per 100 inhabitants in 2012 from as low as 10.90 in 2002. As of 2012, 45.5 out of 100 inhabitants have been internet users in Georgia, from less than 1.59 in 100 using internet in 2002.

SECTION 3 Progress and remaining challenges vis-à-vis health-related MDGs

The country has attained a number of historic gains vis-à-vis health related MDGs, including decreases in maternal mortality rate (MMR) from 49.2 in 2000 to 22.9 by 2012; reduction of infant mortality rate (IMR) from 22.5 to 11.1 (according to Geostat) and under-5 mortality from 24.9 in 2000 to 13.0 as of 2013. Abortion rates have also decreased (from 3.7 in 2000 to 1.6 in 2010) with parallel increase in contraceptive prevalence rate (from 20% to 53% in married women). Finally Universal Access to antiretroviral HIV treatment and TB treatment has been maintained since 2003 and Georgia is on the way towards Malaria elimination certification.

The current National Report synthesizes some of the main policy interventions that have helped the country in advancing the progress in health-related MDGs, remaining challenges, lessons learned and the vision for future interventions and partnership.

Goals 4 and 5
Maternal and child health

What has worked?

Progress in reduction of maternal, neonatal and child mortality has been attained through a number of facilitating factors, including political commitment, resource investment (both domestic and international), investment in quality of data and evidence-based policies across ante-, peri- and post-natal care services.

Political commitment

Improvement of maternal, newborn and child health (MNCH) outcomes has been positioned among the strategic health priorities throughout the national development plans and health sector strategies since 1999. The latest National Health System performance assessment and the 2014-2020 strategic framework "Universal healthcare and the quality management for the protection of patients' rights" also positions MNCH among 9 strategic priorities. Finally, maternal and child

health promotion stands out among core priorities of "Social-Economic Development Strategy, Georgia 2020". The Ministry also hosts Maternal and Child Health Coordinating Council that brings together all major stakeholders to ensure coherent analysis and action for improvement of MNCH policies and related health outcomes.

Resource Investments

Maternal and child health care services are integrated in the state programs to improve antenatal (ANC), peri- and post natal care as well as pediatric services for under-18 children countrywide.

The State programmes envisage 4 ANC visits, screening for Hepatitis B and C, Syphilis and HIV during pregnancy and interventions for prevention of mother-to-child transmission of the infections. Since July 2013 every pregnant women is guaranteed by state funding for maternity services, covering both physiological and C-section deliveries.

Reaching every newborn with quality care around the time of childbirth and the days immediately after birth have a critical role to play. Targeted interventions to newborns include essential newborn care, which is effectively used (95%) in maternity care practices countrywide. The state programmes for newborns include screening on hypothyroidism, phenylketonuria, hyperphenylalaninemia, cystic fibrosis and hearing.

In addition every child under-18 is guaranteed with a basic package of primary health care services (including immunization), emergency in-patient and outpatient care, elective surgeries and cancer treatment.

In addition to domestic resource allocation, international support in promotion of effective perinatal care has been an important catalyst of changes. USAID supported programmes implemented through John Snow Inc. (JSI) and SUSTAIN projects have facilitated scaling up of evidence-based perinatal care interventions nationwide and ensured training of perinatal care personnel. Both USAID and UNICEF support was critical in assessment of perinatal care facilities countrywide in 2013 and elaboration of the perinatal care regionalization plan for maternity services and newborn care.

Restoration and expansion of routine child immunization has been another significant achievement over the last 20 years. The current national immunization schedule includes BCG, Hepatitis B, DPT-HepB-Hib, DPT, OPV/IPV, MMR and DT vaccines. Support from UNICEF and USAID has been significant in funding immunization programme from 1993 through 2006. Vaccine independent initiative has been an important step for the country, when Georgia successfully phased out from UNICEF support in provision of traditional vaccine antigens and maintained self-sufficiency in vaccine and injection supply procurement since 2006. Support from the Global Alliance for Vaccines and Immunization (GAVI) and Vishnevskaya-Rostropovich Foundation (VRF) enabled the country to start MMR vaccination in 2003. GAVI with Technical Support from WHO is also supporting Georgia in introduction of new vaccines, such as Rotavirus from 2013 and Pneumococcal vaccine from 2014.

UNFPA support has been critical in building national capacities for provision of RH/FP services, including human resource development at primary level and perinatal care facilities as well as provision of free of charge modern family planning methods to the health sector during the last 15 years. These efforts contributed to substantial decrease in total induced abortion rate (from 3.7 in 1999 to 1.6 in 2010) coupled with increase in prevalence of modern family planning methods, as documented by GERHS (1999, 2005, 2010).

Investing in data quality for decision-making

While decreasing trends of maternal and child mortality is encouraging, discrepancy between administrative statistics and survey data remains a concern. Government has mobilized resources to tackle the problems related to MCH service fragmentation by preparing the background for the introduction of the new Maternal and Child Health Management Information System. The system will be (i) capable to track Mother and Child throughout the entire lifecycle (pregnancy, delivery and perinatal care, child care until child reaches the age of 6); (ii) well thought to ensure access to the lacking data; (iii) proficient enough to transform the raw data into useful information and serve as a powerful tool for MCH quality management with consequent evidence-based decision and policy making. UNICEF has supported the Government in this endeavor and as a result the instruments for data collection and data analyses have been developed.

Besides, based on the assessment of completeness and quality of death registration Survey, conducted by WHO support, the recommendations are provided for the harmonization of vital registration system among the key players (NCDCPH; Public Service Development Agency and National Statistics Office of Georgia).

For better monitoring of maternal and child mortality cases Ministry launched an emergency notification system in February 2013. The system ensures immediate notification of the Ministry on every maternal and under-5 deaths or a stillbirth case. The information is accumulated in the database, analyzed and presented to the MCH Board of the MLHSA on the monthly basis. The MCH Board based on the analysis discusses real time data and recommendations for improvement of the perinatal system performance. For instance, 2013 review revealed that in 2/3 of maternal death cases, pregnant women have not used antenatal care at all, or used only partially. The Board review also revealed high proportion of C-sections among maternal death cases that promoted introduction of relevant regulations.

Promoting Evidence-based policies

In order to improve the quality of reproductive health services, the government in partnership with international organizations (UNICEF, UNFPA, USAID, WHO) has initiated development/adaptation and institutionalization of clinical practice National Guidelines and Protocols. During the last years the clinical practice guidelines and protocols have been adapted and introduced in almost all major areas of RH and MCH.

Findings of research, surveys (such as GERHS, MICS, RAMOS) as well as routine monitoring data are analyzed and applied in evidence-based policy formulation. For instance in response to high proportion (30-35%) of caesarean sections reported through monthly monitoring of UHC programme, a national clinical guideline and a protocol on C-section was developed in 2013 with the support of UNFPA, USAID SUSTAIN and professional associations. The Ministry in partnership with WHO and UNFPA is also responding to still high induced abortion rates through development of evidence-based protocol on Induced Abortion Protocol. According to the results of the survey "Men and Gender Relations in Georgia" (UNFPA, UNDP, UN Women, Sida) 9% of sexually active women stated that have performed sex selective abortion. A comprehensive

study is underway through UNFPA support to reveal actual prevalence and underlying factors to - selective abortion, that will inform formulation of relevant policies and communication activities.

In addition the MOLHSA in partnership with USAID SUSTAIN and UNICEF works on the regionalisation of obstetric and neonatal care and the functional integration between the different levels of care that have been demonstrated to be of great importance to reinforce the effectiveness of MCH interventions.

Effectiveness of MCH interventions is also fostered by promotion of quality improvement initiatives. USAID SUSTAIN program teamed with Joint Commission International developed the Perinatal Care Accreditation program which aims to ensure continues drive of health care facilities for improving the quality of perinatal care services and contributing to the reduction of maternal and infant morbidity and mortality

Another good example of international support in providing evidence based care for children is USAID supported Healthcare Improvement (HCI) Project in Georgia implemented by University Research Co. LLC. Pneumonia and other respiratory tract infections (RTIs), contribute to the highest morbidity among children under 5 in Georgia. USAID Georgia HCI project baseline assessment identified many important quality gaps in diagnosis and management of RTIs in children at all levels of care: irrational and excessive antibiotic therapy, unjustified utilization of non-evidence-based medications, diagnostic tests and specialist services. Namely, only 36.15% of children hospitalized for pneumonia were treated with evidence-based first-line antibiotic. To improve RTI diagnosis and management among children, from 2012, USAID HCI project supports participating ambulatories and hospitals of Imereti Region by creating quality improvement (QI) teams, providing intensive clinical/QI trainings, developing and distributing job-aids and other evidence-based tools on RTI management. Eighteen-months QI interventions resulted 68% ($p<0.001$)% attributable increase in justified antibiotic use, 33% ($p<0.001$) increased use of first choice antibiotic at hospital and 71% ($p<0.001$) improvement at ambulatories, compared to control facilities. These results show that scale up and institutionalization of proven QI methods/tools countrywide most likely will lead to decreased antibiotic resistance, death and disease burden among children and cost-savings for payers.

What are the remaining challenges and lessons learned?

While documented progress in maternal and child health is impressive, the country needs further investments to attain MDG targets. Along with increased access and uptake of services, quality of care needs to be comprehensively addressed. Results from USAID supported HCI Project Georgia study showed that QI interventions could raise the standards of the delivery of preventive, diagnostic and therapeutic services to maintain, restore, or improve the health outcomes of patients. Integration of QI into routine clinical practice should be taken into account. Regionalization of perinatal care facilities needs to be completed, a system of continuous medical education for maternal and child health personnel has to be implemented and further investments are needed in public awareness-raising activities.

More efforts and sustainable state investment are needed to maintain progress achieved and make further steps towards achieving universal access to RH services, including Family Planning, in order to reduce the total induced abortion rate and contribute to reduction of maternal mortality and morbidity.

Furthermore no comprehensive strategic planning exercise has been completed around maternal and child health programmes, that would enable formulation of a robust, results-based plan and harmonization and alignment of international aid. The latter might have under-utilized the potential of existing governmental investment and technical and financial support from partners for even a greater impact on maternal and child health outcomes.

Goal 6:
HIV/AIDS, Malaria and Tuberculosis Response

As noted in section 1, Georgia has attained historic gains in HIV, TB and Malaria response. The country has reached and sustained universal access to ART since 2004, universal access to diagnosis and treatment of TB (including MDR and XDR TB) and is moving forward to Malaria free certification.

What has worked?

Review of the progress in HIV, TB and Malaria response, similar to maternal, neonatal and child health area, reveals that political commitment, resource investment (both domestic and international) and engagement of international partners and civil society organizations in advocacy and technical support has been critical. In addition all three disease components have been guided by a comprehensive strategic planning exercises and coordinated resource mobilization that largely defined success of the programmes.

Political commitment

Political commitment to successful HIV, TB and Malaria responses has been declared in national development plans and health sector strategies since late 1990s. The global and regional political platforms, including the UNGASS HIV/AIDS Declaration, Stop TB Partnership and Roll Back Malaria provided robust overarching framework for action. The latest National Health System performance assessment and the 2014-2020 strategic framework "Universal healthcare and the quality management for the protection of patients' rights" both position the three diseases among 9 strategic priorities.

In addition to political commitment, since 2002 a national coordination body (CCM) has been established to bring together major stakeholders and to guide development of results-based national strategic plans for HIV, TB and Malaria. Comprehensive planning exercise supported by UN Country Team (UNICEF, UNFPA, WHO and UNAIDS) has been a critical contribution for HIV/AIDS strategic planning. UNICEF and WHO support was also significant in Malaria programming and similar exercise was conducted for TB through WHO, MSF and USAID support.

Resource Investments

HIV/AIDS prevention and control interventions are implemented through the HIV/AIDS Prevention and Treatment Program, the Safe Blood and Antenatal Care programmes that includes interventions for Prevention of Mother to Child Transmission (PMTCT) of HIV. The State program on HIV/AIDS targets at early detection of HIV through voluntary counseling and testing for high risk groups, TB patients, STI patients, Prisoners, Patients with hepatitis B and C, patients

with clinical signs of HIV/AIDS, etc. The state program on HIV/AIDS treatment covers outpatient and inpatient services, including ART. Government has substantially increased its allocation for Opioid Substitution Therapy. Finally the Safe Blood programme envisages mandatory testing of all blood donors on HIV, hepatitis B and C and Syphilis.

While the government has increased its resource allocations for HIV response from USD 39,718 in 2001 to USD 4,918,619 in 2013, the HIV/AIDS response in the country is still largely dependent on the Global Fund financial support. The efforts in the area of HIV prevention, especially among youth, are largely supported by international organizations (UNFPA, UNICEF, USAID). ART medications are provided solely through the Global Fund support. Overall the National Strategy-based applications to the Global Fund as well as USAID and UN support has been vital for scaling up of evidence-based HIV prevention and treatment interventions in Georgia.

The country's progress in controlling TB has required a major investment from the government and donors. The Government's contribution to TB budget has doubled since 2008. The State's contribution in an amount of 10.5 million GEL comprised 65% of the total TB budget in 2012. However despite the expansion of the state funding, till today a number of essential TB control functions (capacity building, procurement and management of health products and equipment for diagnosis, anti-TB and second line treatment side effect medicines, central and regional supervision of TB service points, incentives and enablers for DOT) are largely or completely dependent on the Global Fund project. The Global Fund grant ends in 2016 as does the United States Agency for International Development (USAID) TB Prevention Project, thus making 2013-2015 a critical window to determine which investments have brought the most value for money, and to determine how they can be sustained with domestic resources.

Investing in data quality for decision-making

The National Tuberculosis Program, supported by the Global Fund TB Project established a supportive supervision system for local TB providers to monitor TB related reporting and recording. The exiting TB data management system allows generating quality data on all key indicators necessary for national and international reporting. The current initiative for developing electronic TB data management system, supported by USAID, will significantly strengthen TB

surveillance system by allowing real time and quick data exchange to facilitate programmatic and policy decision-making.

Promoting evidence-based care

International experts regard the Georgian model of HIV/AIDS treatment and care as the leading experience among countries of former Soviet Union (FSU). HIV/AIDS treatment and care program is implemented by the Infectious Diseases, AIDS and Clinical Immunology Research Center (National AIDS Center), which along with four (Kutaisi, Batumi, Zugdidi and Sokhumi) affiliated regional facilities provides free medical services through the State HIV programme and the Global Fund supported projects.

Special attention is paid to adherence as an important determinant of treatment success. A program to promote and maintain antiretroviral adherence has been developed that includes patient education, adherence monitoring and counseling. Since 2008 home-based adherence support and monitoring program started countrywide through operation of mobile units.

Georgia is advancing towards eliminating vertical transmission of HIV by ensuring universal access to services for the prevention of mother-to-child transmission (PMTCT) of HIV. These services include HIV testing and prophylactic or therapeutic ART for HIV positive mothers and their newborns. Since 2005 there have been no cases of vertical transmission among babies born to HIV positive women receiving ART treatment or prophylaxis.

Georgia has implemented new laboratory technology for rapid detection of TB and drug resistance, allowing the country to identify 63% of the estimated MDR-TB cases among notifications in 2011.

What are the remaining challenges and lessons learned?

Low coverage of key populations at risk with prevention and particularly with HIV testing leads to high number of undiagnosed HIV or cases diagnosed at a later stage. This has major implications for controlling the epidemic. Persons unaware of their HIV status continue to engage in high risk behaviors thus unknowingly transmitting the virus. Late diagnosis

substantially increases the risk of mortality. Thus expansion of prevention and harm reduction initiatives has been of critical importance.

Stigma and discrimination of PLHIV continues to be a major barrier to effective HIV prevention and service utilization. Negative social attitudes and low public awareness also remain as a bottleneck. Beyond societal attitudes, state criminal laws, regulations, and policies relevant to drug use and preventive work among IDUs and prisoners are among limiting factors.

The laws on drug addiction prevention and control are not compatible with implementing effective interventions in public and penal sectors. Therefore, issue-focused and targeted advocacy efforts aimed at improving legal environment is essential for the future success of Georgian HIV policy and response.

The most recent analysis of the National TB response (May 2012) identified delayed case detection, lack of patient support system to ensure adherence and easy access to anti TB drugs in pharmacies (that promotes self-treatment) as the main challenges. Ongoing fundamental health care reforms have changed the context for TB control. In 2012, TB dispensaries were absorbed into private general medical facilities and TB control responsibilities were assigned to various public and private agencies with varying degree of TB related expertise and experience.

A truly functional integration of TB services into the private network, if successful, should lead to improvements in the early detection of TB cases, referral and regularity of patient follow-up, and most importantly, in quality of treatment. At the same time, there are potential pitfalls that need to be addressed in order to achieve success, including reinforcing infection control measures and bringing the physical infrastructure for TB services up to internationally acceptable standards relating to space and air flow. The integration of TB services into the general health facility has some potential to decrease TB-related stigma. At the same time, stigma reduction must be balanced with appropriate IC to ensure that a paradoxical increase in stigma does not occur.

There is also need to understand drivers for stigma and to develop advocacy, communications, and social mobilization materials that target stigma related to TB in specific communities and population groups.

SECTION 4 Conclusions from the experience in implementing health-related MDGs

While analyzing Georgia's achievements to health-related MDGs a number of common facilitating factors become evident. The same catalysts have to be taken into account in planning and supporting implementation of the MDG agenda beyond 2015.

Effective Coordination of Policies and Programmes

Positive results and trends are documented in areas, where National Coordination Councils or relevant inter-agency coordination mechanisms have worked. The mechanisms have ensured coherent advocacy and successful advancement of AID, TB and Malaria agenda through CCM. Inter-Agency Coordination Council for Immunization (ICC) has been operational since 200 and has ensured consensus platform among all key stakeholder om the national vaccination programme policies and action. Progress has been also evidence in MNCH since operationalization of the MCH Board. However, the experience of the Maternal and Child Health Board is relatively limited and needs further observation and analysis.

Robust National Policies and Plans

Robustness of national policy and programme planning has been critical in developing evidence-based and results-oriented strategies and effective alignment and harmonization of international aid in disease-specific programmes (e.g. Immunization, HIV, TB and Malaria national response). However with an increasing global advocacy for integrated Universal Health Care agenda and health system strengthening platforms, the international community has to invest more in provision of comprehensive guidance to low- and middle income countries around national health strategic planning. The latter is critical both in promotion of results- and evidence-based policies, effective allocation and use of limited domestic resources as well as harmonization and alignment of international aids to robust national policies and plans.

Civil Society Engagement

Engagement of civil society partners and representatives of affected constituencies, academia and media have played a critical role in consensus building and coordinated actions around AIDS, TB

and reproductive health. Patients' engagement was also critical in attainment of ART gains the latest initiative of Georgia for 60% reduction in treatment cost for Hepatitis C .

International Cooperation

International developmental assistance, including both financial and technical assistance has ensured timely initiation of life-saving interventions in communicable diseases such as HIV, TB and Vaccine Preventable Diseases among children. Support from UN agencies and specifically UNFPA together with USAID has been substantial in strengthening national SRH response and generating data for decision making through 3 rounds of Reproductive Health Surveys (RHS). Till today, Georgia largely replies on the Global Fund support for ART and anti-TB drugs as well as harm-reduction interventions for most-at-risk-groups. UNICEF, USAID, GAVI and VRF support has been invaluable in supporting revitalization of immunization programme in early years of transition and continuous expansion of the national immunization schedule with new and under-used vaccines.

Government's Commitment to Financial Sustainability

Sustainability of donor-supported programmes is critical for maintaining the hard-won gains in the public health outcomes. Governments need additional guidance and support for ensuring successful transition in vaccine independent initiatives or phasing out from major global PPP support for AIDS, Tuberculosis and Malaria. The latter is especially critical for middle-income countries of the CEE/CIS region that are scheduled to graduate from GAVI, the Global Fund and are increasingly less eligible for international development aid.

Need for a Broader Global Health Vision beyond 2015

The global community since adoption of the 2012 UN resolution on Universal Health Care has agreed on the new global health vision for 2030. The UHC vision has been recently reinforced by a High-Level Meeting hosted by the World Bank in partnership with UN Secretariat and WHO. Therefor Universal Health Care has to be stronger positioned in post-2015 MDG agenda, as the programme provides an essential platform for securing human rights to best attainment standard of health care as well as a platform for an integrated health system strengthening efforts at the country levels.

The post-2015 development agenda for MDGs 6 and 8 has to target increased access to affordable and effective antiviral treatment for Hepatitis C, as the disease has been accounting for a major disease burden, especially among middle-income countries. The newly emerging Directly Acting Antiviral (DAA) drugs is an important hope for millions affected by HCV and the global health partnerships building on the experience of the Global Fund and UNITAID has to target establishment of a sustainable mechanism for ensuring affordable pricing of HCV treatment.

Finally, Non-communicable Diseases (NCD), accounting for the majority of adult morbidity and premature death in low- and middle income countries (cardio-vascular, oncology, health promotion, etc.) must be placed at the heart of future human development. The 2011 Political Declaration and Health 2020 agenda provide strong platforms to build on. Through donor and technical support (USAID, WHO) Georgia made important gains to plan and implement population and facility level interventions to improve access to high quality NCD prevention and control practices, though consistent technical support and international aid will be essential to scale up the best NCD practices countrywide.