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GEORGIA:

Benchmarking Sustainability of the HIV Response among Key Populations in the Context of Transition from Global Fund Support to Domestic Funding

Eurasian Harm Reduction Association (EHRA)

2021

SOS_PROJECT

Alliance for Public Health

100%LIFE

CAAPL Central Asian Association of PLHIV

EURASIAN KEY POPULATIONS COALITION

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This document is a publication of the Eurasian Harm Reduction Association (EHRA). EHRA is a not-for-profit public membership-based organisation which unites 247 organisational and individual members from the Central and Eastern Europe and Central Asia (CEECA) region with a mission to create within the CEECA region a favourable environment for sustainable harm reduction programmes and for decent lives of people who use drugs (PWUD).

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Acronyms and abbreviations

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immune Deficiency Syndrome
APH	Alliance for Public Health
ARV	Antiretroviral
CBO	Community-Based Organisation
CCM	Country Coordinating Mechanism
CEECA	Central and Eastern Europe and Central Asia
CSO	Civil Society Organisation
EHRA	Eurasian Harm Reduction Association
EMTCT	Elimination of Mother-To-Child Transmission
EU	European Union
FSW	Female Sex Worker
GAM	Global AIDS Monitoring (previously GARPR)
GDP	Gross Domestic Product
GEL	Georgian Lari
GHE	Government Health Expenditure
GHRN	Georgia Harm Reduction Network
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HR	Human Resource
IBBS	Integrated Biological-Behavioural Survey
KAP	Key Affected Population
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer (or sometimes questioning) and others
M&E	Monitoring and Evaluation
MDM	Médecins du Monde (Doctors of the World)
MoH	Ministry of Health
MSM	Men-who-have-Sex-with-Men
N(N)LE	Non-entrepreneurial Non-commercial Legal Entity
NCDC	National Centre for Disease Control and Public Health
NGO	Non-Governmental Organisation
NSP	Needle and Syringe Programme

OAT	**Opioid Agonist Therapy**
OI	**Opportunistic Infection**
OOP	**Out-Of-Pocket**
PAAC	**Policy and Advocacy Advisory Council**
PEP	**Post-Exposure Prophylaxis**
PLHIV	**People Living with HIV**
PPM	**Pooled Procurement Mechanism**
PrEP	**Pre-Exposure Prophylaxis**
PSE	**Population Size Estimate**
PSM	**Procurement and Supply Management**
PWID	**People Who Inject Drugs**
PWUD	**People Who Use Drugs**
RG	**Reference Group**
RSSH	**Resilient and Sustainable Systems for Health**
STI	**Sexually Transmitted Infection**
SW	**Sex Worker**
TB	**Tuberculosis**
TB Rep 2.0	**Tuberculosis Regional Eastern European and Central Asian Project**
TG	**Transgender**
TMT	**Transition Monitoring Tool**
UHC	**Universal Health Coverage**
UN	**United Nations**
UNAIDS	**Joint United Nations Programme on HIV/AIDS**
UNDP	**United Nations Development Programme**
UNFPA	**United Nations Population Fund, formerly the United Nations Fund for Population Activities**
USAID	**United States Agency for International Development**
USD	**United States Dollars**
VCT	**Voluntary Counselling and Testing**
WB	**World Bank**
WHO	**World Health Organization**

Executive Summary

HIV country context: Georgia is a low HIV epidemic country with an estimated 0.3% HIV prevalence in the adult population. HIV infection is concentrated mainly among key populations, particularly among men-who-have-sex-with-men (MSM). An annual number of newly detected HIV cases has ranged between 600 and 700 during the last few years but it decreased to 530 in 2020. Per SPECTRUM modelling, the estimated number of people living with HIV (PLHIV) in Georgia by the end of 2020 was set at 8,300. Of them, 76% know their HIV-positive status. Out of all registered HIV cases, 86% were on antiretroviral (ARV) treatment and 94% of those on treatment achieved viral suppression.

HIV funding landscape: HIV services in Georgia are funded from two major sources: the state and the Global Fund. In 2020, the government accounted for 78%, and the Global Fund spending constituted 18%, of all HIV spending, respectively[1]. The contribution of other donors to the HIV response has been relatively small – in 2020, around 4% of HIV financing was received from UN agencies, including UNDP, UNFPA and WHO and other international partners, such as the EU.

Since 2002, the Global Fund has provided 5 HIV grants to Georgia with disbursements reaching USD88,341,418[2]. Per the Global Fund's Eligibility Policy revised in 2018[3], upper lower-middle-income countries are only eligible for support if the disease burden is classified as high. Thus, taking into account the fast-growing HIV epidemic among MSM (with an HIV prevalence above 20%), Georgia is still considered eligible to receive funding.

After Georgia was classified as an upper lower-middle-income country, Global Fund support started declining and the country currently is in the phase of transitioning from donor to domestic financing of HIV services. The Government of Georgia has declared its commitment to sustain and further expand the scope and scale of HIV interventions that have previously been financed by the Global Fund. It is obvious that the Government has been committed to ensuring the sustainability of HIV strategies and to progressively absorb the cost of key HIV prevention interventions. However, regardless as to the progress achieved thus far, a considerable portion of the HIV response continues to be dependent on the Global Fund support. To monitor the fulfillment of declared commitments of the state, the Transition Monitoring Tool was utilized during April-June 2021.

Purpose and methodology: The assessment of the fulfillment of key public commitments with respect to the sustainability of the HIV response for key populations in the context of transition from Global Fund support in Georgia was conducted based on the Methodological Guide and Transition Monitoring Tool (TMT) developed by EHRA[4]. The assessment aims to assist key

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[1] AIDS Spending data. UNAIDS GAM Reporting. 2020, prepared by the Ministry of Health.

[2] The Global Fund. Data Explorer: Georgia, Investments - Components. Geneva; Global Fund. https://data.theglobalfund.org/investments/components/GEO. Accessed June 1, 2021.

[3] The Global Fund. *39th Board Meeting: Revised Eligibility Policy*. Skopje, North Macedonia; The Global Fund to Fight AIDS, Tuberculosis, and Malaria, 9-10 May 2018. https://www.theglobalfund.org/media/7409/bm39_02-eligibility_policy_en.pdf. Accessed May 15, 2021.

[4] Serebryakova L. Benchmarking Sustainability of the HIV Response in the Context of Transition from Donor Funding. A Methodological Guide. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2020. https://eecaplatform.org/en/tmt/

affected communities to stay informed and engaged in the monitoring of the transition process and to thereby advocate for the sustainability of national HIV responses. Per the EHRA Methodological Guidance, the in-country review was carried out and led by a national expert - the National Reviewer and was supported by a National Reference Group (RG) composed of 22 members representing key affected communities, community-based organisations, state agencies, international development partner NGOs, and community activists.

Key transition achievements: the state has already achieved significant progress in certain programmatic areas and some programme components have already been fully covered through public funding; for some components, the government is increasing its investment to absorb the total cost incrementally. Currently, the Government covers ARV treatment; treatment of opportunistic infections (OI), elimination of mother-to-child transmission (EMTCT), the blood safety programme; STI diagnostics and treatment for key populations; opioid agonist therapy (OAT); pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for key populations. First line ARV drugs are fully procured under state funding; and the share of public financing for 2nd line ARV drugs has been on the rise. The government has been relatively slow in investing in low-threshold harm reduction services targeting key affected populations. Nevertheless, starting from 2020, the state has invested some funds to support HIV counseling and testing services among people who inject drugs (PWID), and sex workers (SW), albeit with limited scope and scale.

FINDINGS OF TRANSITION MONITORING:

Domain: Results, Impact and Outcome: The transition progress achievement score for three commitments was above 100% which indicates that Georgia has overachieved its goal to control the spread of HIV among the general population and to reduce HIV incidence and AIDS-related mortality. However, progress achieved in terms of containing the HIV epidemic among key populations was impossible to monitor given that no integrated biological-behavioural survey (IBBS) among key populations were conducted during 2019-2020.

Health Domain 1: Financing: The average score for fulfilling commitments under the Financing Domain was set at 67% which implies that average progress was achieved by the government. However, the reliability of the financial data sources used may be questionable. Some indicators measuring the commitments may not capture the real picture in terms of increased financing; while the percentage share of public funding out of total HIV spending has been on the rise, government spending expressed in absolute numbers has declined over the last three years.

Health Domain 2: Drugs, supplies and equipment: The Government has achieved significant progress (with an achievement score of 85%) to ensure the uninterrupted supply of ARVs, OAT medications as well as HIV prevention commodities. However, the ARV prices procured in Georgia remain much higher than reference pricing. Taking into account the budgetary limitations for the healthcare system in Georgia, it can be assumed that overspending on ARVs may limit the fiscal space available for the HIV response. Thus, it seems to be critical to optimise the procurement of ARV drugs to avoid overspending and to make sure that limited resources available for the HIV response in the country are spent most efficiently. In addition, a few episodes

of stock-outs of HIV prevention commodities were observed in 2020 that may have been caused by external factors, namely the COVID-19 pandemic and restrictions in transportation and international shipping.

Health Domain 3: Service provision: A high degree of progress in fulfilling the commitments to increase access to HIV services for key populations was documented, with an overall achievement score of 98%. However, this assessment does not provide evidence that no risk to sustainability of services can be expected. The Global Fund support still plays a critical role in expanding or maintaining the scope and scale of HIV essential services provided to key populations, including PLHIV, MSM, PWID, and SW. So far, limited evidence (if any) is available to believe that low-threshold services run by civil society organisations (CSOs), specifically needle and syringe programmes (NSP), community outreach, care and support services, including material support services for key populations, will be sustained beyond the cycle of Global Fund support. There is a declared political commitment from the government about sustainability of all components of the HIV prevention programme, though this declaration has not yet been substantiated with commensurate funding for certain programmatic areas.

Health Domain 4: Governance: A fairly low degree of progress has been achieved by the Government in terms of good governance, with a transition progress achievement score of 27%. The current government, similar to the previous one, has failed to amend punishment-based drug legislation and to create a conducive legal environment. This may jeopardise the sustainability of harm reduction services that currently operate without any legal basis. Adoption, and approval, of HIV prevention service standards for key populations has not been fully realised: only service guidelines had been approved in 2020; approval of service protocols has been delayed; and the costing of HIV prevention services has not yet been developed.

Health Domain 5: Data and information: There is a declared political commitment from the Government about ensuring the sustainability of the second-generation surveillance studies among key affected populations; however, no investments have been made by the Government until now to progressively absorb the cost of IBBS/population size estimate (PSE) studies. Perhaps the Government has been slow to invest in research because there has been constant support from the Global Fund to cover the cost of IBBS and PSE among key population groups.

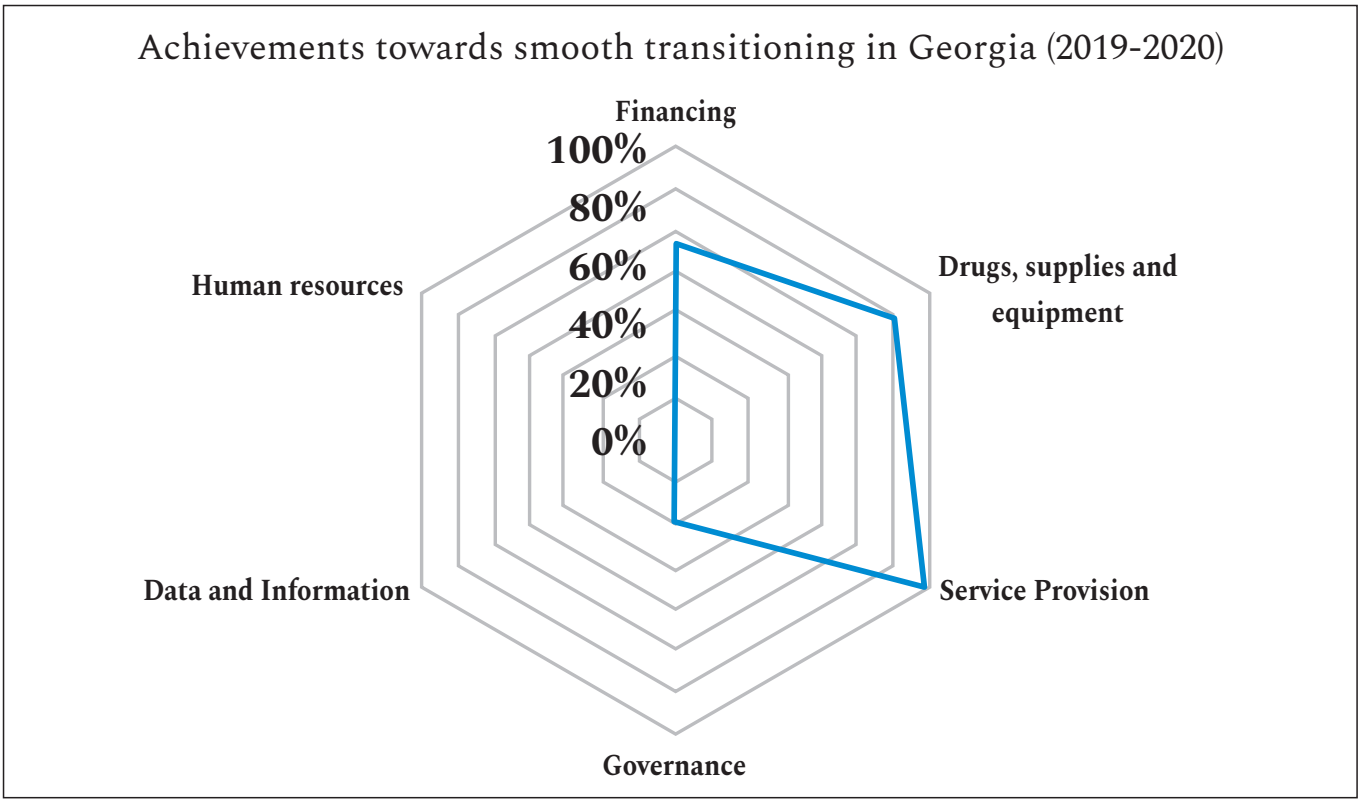
Health Domain 6: Human resources (HR): No progress (achievement score of 0%) has been achieved. It seems that addressing the challenges related to human resources in health, including in the HIV field, has not been perceived as a priority issue by the government. There were few interventions proposed in the Transition Plan, such as adopting a policy for the continuous professional development of human resources for HIV/AIDS; defining professional competencies and qualification frameworks for various specialists; and accreditation/re-certification procedures, etc. It should be noted that none of these objectives has been realised up to now.

Table 1 and Figure 1, below, present summary data as to the extent to which the government has realised its declared commitments in all 6 health domains. Scores are presented in a pre-defined, colour-coded, system for better visualisation.

Table1. Assessment of the fulfillment of state commitments: summary results for all domains

No.	Health Domains	Progress	
1	Financing	67%	Average progress
2	Drugs, Supplies and Equipment	85%	Significant progress
3	Service Provision	98%	Significant progress
4	Governance	27%	Fairly low progress
5	Data and Information	0%	Low (no) progress
6	Human Resources	0%	Low (no) progress

Figure 1: Visualisation of summary results for all 6 health domains



Recommendations and lessons learnt can be accessed below on page 41 of this document.

Country Context

Georgia is a country in the south Caucasus bordering the Black Sea. It shares borders with Armenia, Azerbaijan, Russia and Turkey. Georgia has a population of 3.7 million with 57.4% of the population residing in urban areas. The country is divided into nine regions, two autonomous republics and the capital city, Tbilisi. Two regions – Abkhazia and South Ossetia - are now de facto beyond the jurisdiction of the central Georgian authorities[5]. In 2019, the life expectancy at birth reached its highest level of 69.3 years for males and 78.1 years for females[6]; much of the gender gap in life expectancy can be attributed to lifestyle factors.

Georgia is an upper lower middle-income country with a GDP of USD4,275 per capita (2019)[7]. Poverty remains a pervasive problem for Georgia: based on World Bank (WB) data, 19.5% of the population lived below the national poverty line in 2019[8]. The COVID-19 pandemic has put additional pressure on the Government of Georgia and the health sector. The external debt-to-GDP ratio jumped to 120% of GDP by the end of September 2020[9].

The fragile economic situation in the country[10] may limit the ability of the government to further increase its domestic investments in the health sector, including in responses to HIV and tuberculosis (TB). Due to the country's income level, Global Fund support to the HIV and TB national programmes in Georgia is expected to decline in the upcoming years and transitioning from the donor funding to fully domestic funding is expected to be challenging.

Georgia health system context

After regaining its independence, the country's health system has moved away from the Semashko model[11]. The majority of health institutions, including primary healthcare institutions and hospitals, are privatised. Before 2013, most government spending on health was channeled through private health insurance companies which were paid to provide a standard package of benefits for households living below the poverty line as well as children and the elderly. In 2013, the newly elected government introduced Universal Health Coverage (UHC) aimed at covering almost the whole population, most of whom had no health coverage before 2013. Since then, financial access to care has improved and out-of-pocket (OOP) payments declined. Government health expenditures (GHE) in Georgian Lari (GEL, the currency of the country) increased 2.5 times from 2012 to 2017[12] ; GHE as a share of GDP has also increased from 1.6% in 2012 to 2.8% in 2018[13]; the GHE out of total health expenditure doubled from 2012 to 2018 During the same years, the share of OOP payments from total health expenditure reduced by 35%. Starting from 2019, the UHC programme became targeted and excluded households with an annual income of over GEL40,000 (about USD1,000 per month).

5 Richardson E, Berdzuli N (2017). Georgia: Health system review. Health Systems in Transition, 2017; 19(4):1–90.

6 https://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN?end=2019&locations=GE&start=1960&view=chart 23.05.2021

7 https://www.worldbank.org/en/country/georgia/overview

8 https://data.worldbank.org/indicator/SI.POV.NAHC?locations=GE

9 https://www.worldbank.org/en/country/georgia/overview#3 last updated on April 5,2021. Accessed on 28.07.2021

10 Richardson E, et al, Ibid.

11 AIDS Spending data, 2020, Ibid.

12 National Report on Health. 2001-2017. Ministry of Health. https://www.moh.gov.ge/ka/566/jandacvis-erovnuli-angariSebi

13 Ibid.

Table 2. Health Expenditure data 2012-2018[14]

Health Expenditure	2012	2013	2014	2015	2016	2017	2018
GHE per capita (current USD)	63.50	78.80	95.30	98.10	110.50	106.40	123.40
GHE (% of current health expenditure)	19.0%	23.5%	27.7%	35.6%	36.6%	37.2%	39.5%
GHE (% of GDP)	1.6%	2.0%	2.3%	2.8%	3.0%	2.6%	2.8%
GHE (% of general government expenditure)	5.5%	6.9%	7.8%	9.6%	10.3%	9.5%	10.3%
OOP expenditure (% of current health expenditure)	73%	69%	66%	57%	56%	55%	48%

Alongside the UHC programme, the health budget also finances 23 vertical programmes for priority diseases and conditions, including the HIV/AIDS programme, the Hepatitis C elimination programme, the Safe Blood programme and the TB programme, amongst others.

Hiv epidemiological situation overview

Georgia is a low HIV epidemic country with an estimated HIV prevalence of 0.3% in the adult population[15]. HIV infection is concentrated mainly among key populations, especially among MSM. Although HIV prevalence remains stable among PWID (2.3%) and female sex workers (FSW) (<2%), an alarming increase in HIV prevalence (21.5% in Tbilisi and 15.6% in Batumi in 2018[16]) has been observed among MSM over the last decade, which has stabilised since 2016[17].

As of May 16, 2021, a total of 8,823 HIV cases were registered. Of them, 6,584 were male (75%) and 2,236 female. The mean age of HIV positive persons at the time of diagnosis ranges from 29 to 40 years. Since 1989, 4,441 individuals have developed AIDS and 1,834 have died; a total of 5,517 people were on ARV, including 620 PLHIV residing in Abkhazia, Georgia[18].

SPECTRUM modelling has estimated the number of PLHIV in Georgia as of the end of 2020 at 8,300. Of them, 76% know their HIV-positive status. Out of all registered HIV cases, 86% were on ARV treatment and 94% of those on treatment achieved viral suppression. The annual number of newly detected HIV cases has ranged between 600 and 700 during the last few years but decreased to 530 in 2020[19]. The observed decrease in HIV cases may be attributed to COVID-19 related restrictions that have resulted in a reduction in HIV testing uptake and the downsizing in the scale of HIV prevention services in general.

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14 https://data.worldbank.org/

15 https://www.worldbank.org/en/country/georgia/overview#3

16 IBBS among MSM in Tbilisi and Batumi. Curatio International Foundation; Tanadgoma. Through the financial support from the Global Fund HIV program. 2019. Georgia

17 Georgia Country Progress Report. GAM 2020

18 https://www.aidscenter.ge/

19 Georgia Funding Request. The Global Fund C19 Response Mechanism. Submitted by CCM of Georgia. June 2021

Organisation of hiv services for key populations

A wide range of HIV prevention, support and care services have become available in Georgia since 2003 when the first Global Fund grant was awarded. Availability of funds enabled the country to strengthen its institutional and human capacity to deliver quality services. It has also promoted the development of civil society organisations and self-organised community groups to be engaged in HIV policymaking and service delivery. Per the National HIV strategy, the following key-affected populations have been prioritised in Georgia: MSM, PWID, sex workers and prisoners. Starting from 2022, after adopting a new HIV strategic plan (work that is in progress), transgender people will also be targeted with HIV services.

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

In the recent past, most prevention services largely relied on the Global Fund; although, over the last five years, the share of state funding for HIV prevention has been on the rise.

Table 3 summarises the services focused on HIV prevention for key populations that are currently available in the country. Notable is the availability of HIV diagnostic and treatment services for all groups, including individuals with Georgian citizenship or residence status.

Table 3. HIV prevention package for key populations

Services	MSM and TG	PWID	SW
Behaviour change communication and counselling services	√	√	√
Facility-based and mobile testing of HIV and hepatitis B and C	√	√	√
TB symptom screening and referral services		√	√
HIV self-testing	√	√	√
Condoms and lubricants	√	√	√
Safe injection supplies		√	
STI diagnostics and treatment	√	√	√
Community-based PrEP	√		
Facility-based PEP	√	√	√
Hepatitis B vaccination	√	√	
Psycho-social and legal assistance	√	√	√
Activities against violence and referral services	√		√

Services	MSM and TG	PWID	SW
Access to mental health services (though on a limited scale)	√		
Case management, including social accompaniment for those who test positive through HIV screening	√		
SIGMA vending machines – disbursing prevention commodities and HIV self-tests	√	√	
Overdose prevention		√	
OAT		√	

Services targeting MSM

HIV prevention services among MSM and transgender populations in Georgia are currently being delivered by three organisations: the NGO *Tanadgoma*, and two CBOs - *Equality Movement*, and *Identoba Youth*. Programmes have been operational in major cities, including Tbilisi, Batumi, Kutaisi and Zugdidi. Starting from 2021, outreach work has been carried out in other small cities as well (Gori, Khashuri, Marneuli, Borjomi and Anaklia) to expand the geographic reach of services being provided for MSM and transgender populations. A complete list of HIV prevention services is listed in Table 3. HIV prevention services targeting PWID, including low-threshold harm-reduction services, are delivered by NGOs/CBOs that are members of the Georgia Harm Reduction Network (GHRN) in 11 cities, including Sokhumi, in a breakaway region of Abkhazia (see Table 4 for the list of service providers). OAT services using methadone are delivered by the public institution and are available in a few large cities, while buprenorphine services are delivered by a private provider with very limited coverage.

Some of the interventions envisioned in the national strategic plan 2019-2022 were not launched, such as reproductive health programmes, including family planning services, for adolescents and young people who inject drugs. A complete list of HIV prevention services is listed in Table 3.

Table 4. GHRN organisations implementing HIV services among PWID

Nº	Georgian harm reduction network organisation	City
1	Georgian Harm Reduction Network	Tbilisi
2	Union, "New Vector"	Tbilisi
3	International Organisation for Women, "Akeso"	Tbilisi
4	N(N)LE "Hepa +"	Tbilisi
5	N(N)LE "New Way"	Tbilisi
6	Young Psychologists and Doctors Association - “Xenon”	Zugdidi
7	Union, "Step to Future"	Gori
8	Union, "Step to Future"	Telavi
9	Zurab Danelia named union, "Tanadgoma"	Sokhumi
10	Union, “imedi”	Batumi
11	Association, “Ordu”	Poti
12	N(N)LE "New Way"	Samtredia
13	N(N)LE "New Way"	Kutaisi
14	Union, "New Vector"	Rustavi
15	N(N)LE "Phenix-2009"	Ozurgeti

The SIGMA vending machine project was implemented by the NGO, Alternative Georgia, as a trial under 5% initiative funding which ends in June 2021. However, NCDC has been negotiating with the Global Fund to continue the SIGMA operation from July 2021. Sustainability of the syringe-vending machine programme is expected to be secured within the new Global Fund grant for the next funding period of 2022-2025. In total, 10 SIGMA machines have been operational in Tbilisi since 2019. Expanding the scope of SIGMA services, as well as geographical expansion, has been under consideration.

The national HIV response has never prioritised working with at-risk youth (presumably, due to low HIV prevalence among the general population). Thus, youth (not self-identifying themselves as MSM, sex workers or PWID) do not have access to free HIV services. Recently, advocacy work was intensified to focus on youth at elevated risk of HIV, such as non-injecting drug users. Over the last two years, a community-based youth organization, Mandala, has emerged and has started providing HIV/drug use awareness, overdose prevention and drug checking services to non-injecting drug using youth who frequently attend music festivals and nightclubs.

Till now, Mandala has not received support from the Global Fund or the state. Its work has been sporadically supported by small grants from other donor organisations or relies on volunteers. In May 2021, the NCDC in partnership with other civil society groups demonstrated its intention to assist the organisation during the next Global Fund round.

Services targeting SW

The NGO, Tanadgoma, has been exclusively working with sex workers in the five major cities of Tbilisi, Batumi, Kutaisi, Zugdidi and Telavi. A complete list of HIV prevention services is listed in Table 1.

Services targeting Prisoners

Availability and accessibility of HIV prevention services remains relatively limited in correctional settings. Available services include behavior change communication and counselling for HIV; integrated testing for HIV and viral hepatitis; TB screening; and a short course of opioid detoxification using methadone.

According to the national strategic plan for 2019-2022, interventions should have been expanded to include the following:

- Increased access to condoms and lubricants;
- Increased access to harm reduction services, including needles and syringes; and,
- The introduction of PrEP.

However, no evidence has been found to believe that harm reduction activities have been, or are going to be, scaled-up for prisoners. Engagement of CSOs in HIV prevention work within correctional settings has remained limited. Furthermore, a few years ago, the local CSO, Tanadgoma, was involved in HIV counselling and the training of prisons staff, namely HIV counsellors and social workers, on HIV related topics. Currently, HIV voluntary counselling and

testing (VCT) services are provided exclusively by prison staff. Condoms are provided by the AIDS Healthcare Foundation (AHF) that are supposed to be distributed among prisoners without any monitoring by CSOs. Syringes or any other injecting paraphernalia have never been distributed among prisoners in Georgia.

Other services

In addition to HIV prevention, care and support services provided to key affected populations, there are initiatives to advocate for human rights and gender equality issues, as well as to strengthen community systems. These interventions are largely supported by donor supported programmes, including regional projects, such as the TB Regional Eastern European and Central Asian Project (TB Rep 2.0).

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

The process of transition has created unique challenges for services targeting key populations, as well as amplified the challenges related to the legal, regulatory and policy environment of such services. The transition and sustainability plan endorsed by the Country Coordinating Mechanism (CCM) in 2017, covering the period until 2022, has analysed those challenges and recommended actions to address those challenges. As of now, reports on implementation of the plan are not available; although, the state has increased the allocation for the HIV programme, including for key populations and is piloting service funding models.

The key challenges related to service delivery for key populations as identified during the interviews and data collection for this study are as follows:

Criminalisation of drug use: A major challenge for service delivery for key populations, particularly for PWID, remains the punitive drug legislation. The criminalisation of drug use drives drug users underground. Despite all of the efforts of civil society organisations for almost 2 decades, which, inter alia, included preparation of amendment packages to drug legislation, no progress has been achieved in this direction. Traditionally, the Global Fund was one of the major funding sources to lead the advocacy for changing drug policy in Georgia; after the Global Fund support ends, advocacy resources may also become limited. Thus, even though harm reduction services are available and accessible in Georgia, these services do not have a legal basis, and this may jeopardise the sustainability of harm reduction services, specifically low-threshold services, in the long run.

Stigma and discrimination towards PLHIV and vulnerable populations: MSM, transgender people, PWUD and sex workers continue to face barriers to access services. Though the magnitude of stigma within the healthcare system has not been studied in Georgia, there are a number of formative research conducted among key populations that show that the stigmatising and

discriminatory attitudes of medical personnel towards vulnerable populations are prevalent,[20,21,22]. In general, stigma attached to HIV affected populations may pose a substantial risk to the transition process, acknowledging that budgetary commitments are susceptible to pressures from society and public opinion, as well as to changes of elected officials.

Challenges in the delivery of HIV prevention services through public funding: Since the Government of Georgia has started funding HIV testing services for PWID, SW and MSM, NGO service providers have faced several major challenges, such as the requirement of a bank guarantee to participate in state tenders; changes in reimbursement policies – global budget/lump sum payment versus performance (unit price) based reimbursement; challenges in reporting; lower salaries for staff; a lower interest of service providers to provide services under state funding; NGOs becoming subject to income tax; and limiting the number of HIV tests per beneficiary within a year, etc. Nevertheless, despite the increasing trend in state funding for CSOs, the level of replacement funding remains beyond optimal.

Other challenges highlighted by civil society include (but not limited to) the following:

- Highly centralised system for HIV diagnostics and treatment[23];
- Geographic barrier to services, including for OAT[24];
- The lack of psycho-social support and mental health services; and,
- The heavy reliance on donor-funding for some programme components (procurement of condoms, injection paraphernalia, social and material support to PLHIV and other key populations; HIV surveillance research; and community systems strengthening, etc.).

In 2019-20, the COVID-19 pandemic had a negative impact on the implementation of HIV services that resulted in a reduced number of target populations being reached with prevention and testing services. In 2020, the HIV detection rate dropped by 20.6% (530 versus 668 cases registered in 2019) despite the efforts to maintain coverage. The coverage of key populations with HIV prevention services, which should have been further improved in 2020, remained similar (for MSM) or lower (for PWID and FSW) compared to that in 2019[25].

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20 Kurdghelashvili L, Tabatadze M, Tsereteli N. Behavioral Insights Study: Perceptions and views of PLHIV, Key Populations and healthcare personnel on the factors influencing HIV testing behaviours. Tbilisi; Center for Information and Counseling on Reproductive Health – Tanadgoma, with financial support of UNFPA, September 2020.

21 Tabatadze M, Kepuladze K. Stigma-Free Health Facilities. Manual. Tbilisi; Informational Medical Psychological Center Tanadgoma, with financial support of UNFPA, September 2020.

22 Sirbiladze T, Kurdgelashvili L, Tsereteli N. Reasons for low demand and uptake of HIV testing among youth. 2020. Tbilisi; Center for Information and Counseling on Reproductive Health – Tanadgoma, with financial support of UNFPA, September 2020.

23 Prevention Task Force: Position Paper on HIV national response. With financial support from MDM France. Tbilisi, Georgia, February 2020.

24 Georgia Country Progress Report, Ibid.

25 Georgia Funding Request. The Global Fund C19 Response Mechanism. Submitted by CCM of Georgia. June 2021.

Table 5. Impact of COVID-19 on HIV testing coverage by key population group[14]

Key population	Coverage in 2019	Coverage in 2020
PWID	56%	53.1%
MSM	26.8%	27.6%
FSW	40.5%	23.6%

The hiv service funding landscape

HIV services in Georgia are funded by two major funding sources: the state and the Global Fund. For instance, in 2020, the government accounted for 78% of the total HIV spending and the Global Fund spending constituted 18%[26]. The contribution of other donors to the HIV response has been relatively small – in 2020, around 4% of HIV funds were received from UN agencies – UNDP, UNFPA, WHO and other international partners, such as the EU. One of the key drivers of the increase in HIV-related public expenditure in Georgia has been the Hepatitis C elimination programme supported by the state since 2013 and classified under HIV-related expenditures.

Since 2002, the Global Fund has provided 5 HIV grants to Georgia with the total amount disbursed reaching USD88,341,418 (98.15% of the total committed, USD90,006,096)[27]. The Global Fund Allocation Letter issued on December 12, 2019, stated that Georgia had been allocated USD17,556,486 for HIV, tuberculosis and for building resilient and sustainable systems for health (RSSH) for 2022-2025.

The Allocation Letters[28,29], for the last two rounds of the 3-year funding period show that while funding for the TB programme component has reduced, the allocation for HIV was slightly increased. It should be noted that the Global Fund encouraged Georgia to plan for integrated HIV/TB grant programming. Therefore, implementation periods for both programme components were adjusted, with the HIV programme to be implemented for 3.5 years (versus the 3-year period for the TB programme component). Nevertheless, average annual allocations for the HIV component for the next funding cycle have slightly increased. Although a considerable portion of the Global Fund support in the upcoming years will be directed towards building resilient and sustainable systems for health (RSSH) as donor funding targeting key population groups is expected to be replaced with domestic funds.

Table 6. Summary of Global Fund allocations for Georgia for 2019-2022 and 2022-2025

Eligible disease component	Allocation (USD)	Allocation Utilisation Period
HIV	8,412,986	July 2019-June 2022
	12,076,771	July 2022-Dec 2025
TB	7,175,076	Jan 2020- Dec 2022
	5,479,715	Jan 2023-Dec 2025

26 AIDS Spending data. UNAIDS GAM Reporting, 2020, prepared by the Ministry of Health.
27 https://data.theglobalfund.org/investments/components/GEO accessed 01.06.2021.
28 The Global Fund: 2017-2019 Allocation Letter for Georgia. Geneva; The Global Fund, 15 December 2016.
29 The Global Fund: 2020-2022 Allocation Letter for Georgia. Geneva; The Global Fund, 12 December 2019.

The latest available AIDS spending data for 2018-2020[30] shows that the share of state spending for the HIV response increased from 65% in 2018 to 78% in 2020; this indicator achieved its highest level in 2019 (89%). Expressed in absolute numbers, the government investment reported as AIDS spending was the highest in 2019 (approximately 14,2 million USD) which reduced to 12,4 million USD in 2020.

Table 7. AIDS spending by major financial source, [31]2018-2020[32]

AIDS Spending: 3 year summary			
Total of all spending categories: HIV prevention, treatment, care and support	**Public (USD)**	**The Global Fund (USD)**	**Total all financial sources (USD)**
2020	12,449,435	2,812,934	15,892,206
	78%	18%	
2019	14 159 868 USD	1 699 060 USD	15,897,791
	89%	11%	
2018	12 937 655 USD	4 811 765 USD	19,761,124
	65%	24%	

Funding landscape by HIV intervention: As mentioned above, the HIV response has been funded by various sources, though the share of domestic funding and Global Fund support accounts for around 95% of all HIV spending and the contribution of other partner organisations is minimal. Some of the interventions have been fully covered by the state such as the blood safety programme; prevention of mother-to-child transmission; STI testing and treatment for key affected populations; Hepatitis B vaccination for key populations; and testing and treatment for Hepatitis C, etc. HIV treatment services are largely funded by the government and only a small portion of second line ARV drugs are procured by the Global Fund. Management of opportunistic infections for PLHIV is fully covered by the State. Recently, PrEP and PEP services have been expanded through public financing. The Government provides funding to cover the HIV response in correctional settings, though the scope of services that can be accessed by prisoners remains limited. Starting from 2017, the government took over responsibility for funding OAT for PWID.

In June 2020, the government, first the time ever, contracted civil society organisations to provide HIV prevention services to PWID through funding HIV counseling and testing (HCT) at fixed sites and through outreach work. In 2021, state support was expanded to support HCT among SW.

[30] AIDS Spending data. UNAIDS GAM Reporting, 2020, prepared by the Ministry of Health.

[31] AIDS spending data for 2018 was reported in GEL; currency exchange rate 1 USD=2.66 GEL was used. Source https://mof.ge/5115

[32] AIDS Spending data. UNAIDS GAM Reporting, 2020, prepared by the Ministry of Health

However, as described below, public funding covers only a limited scope of prevention services, and a substantial volume of prevention services are supported by the Global Fund. HIV prevention targeting MSM is fully covered by the Global Fund, though PrEP and PEP is funded by the government.

Despite increasing public investments for HIV, most HIV prevention interventions targeting key affected populations still remain dependent on donor funding. HIV prevention commodities (syringes and other injecting paraphernalia, condoms and lubricants) that have been distributed to key affected populations at no cost have been procured with Global Fund support without any engagement of the state. Additional services, such as psychological and legal assistance, social support and care services, the provision of monetary support to PLHIV and socially disadvantaged key populations, have been supported by the Global Fund. The latter remains to be the sole funding source to support HIV surveillance studies and other HIV–related research in Georgia. Interventions aimed at strengthening the capacity of civil society organisations and community groups, and supporting community advocacy initiatives and community systems strengthening, are all exclusively supported by the Global Fund.

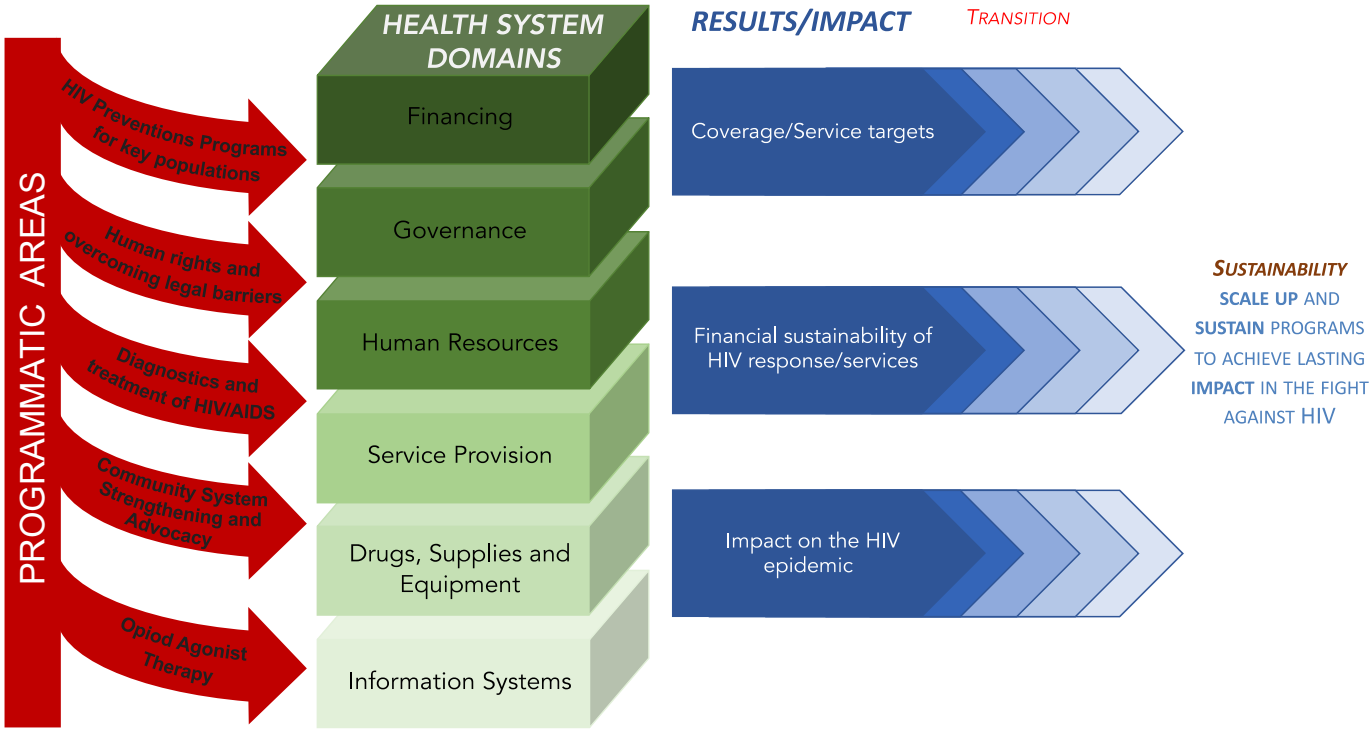
It is obvious that the Government has been committed to ensure the sustainability of HIV strategies and to progressively absorb the cost of key HIV prevention interventions, but regardless of the progress achieved thus far, a considerable portion of the HIV response continues to be dependent on Global Fund support.

Purpose and methodology

The assessment of the fulfillment of key public commitments with respect to the sustainability of the HIV response for key populations in the context of transition from Global Fund support in Georgia was conducted based on the Methodological Guide and Transition Monitoring Tool (TMT) developed by EHRA[33]. The assessment aims to assist key affected communities to stay informed and engaged in the monitoring of the transition process and to thereby advocate for the sustainability of national HIV responses.

The TMT has been designed to collect and evaluate the achievement of countries with regards to the commitments made and to benchmark those achievements among countries.

Figure 2: Conceptual framework for data collection and analysis



This Tool is primarily designed to trace commitments by governments which have been stated in public documents; however, the opinions of communities and experts are included in identifying priority commitments for the purpose of monitoring and for filling information gaps.

The National Reference Group

In accordance with the EHRA Methodological Guidance, the in-country review was carried out and led by a local expert, the National Reviewer, and was supported by a National Reference Group (RG) created for the purpose of this assignment. The RG worked closely with the National Reviewer to make the process transparent and to build consensus on what should be assessed and how, as well as to validate the evaluation report.

The National Reviewer announced a call for membership of the National Reference Group through an email invitation sent out to Prevention Task Force member organisations, HIV community groups and activists in the field of HIV. The RG was composed of 22 members representing key affected communities; community-based organisations; state agencies; international development partner NGOs; community activists; and representatives of key populations not affiliated with any

[33] Serebryakova L., Ibid.

institutions. It should be noted that out of 22 members, 4 were from the governmental sector (NCDC; Ministry of Finance; Ministry of Justice; National AIDS Centre); 4 from NGOs (Tanadgoma; Curatio International Foundation; Step to the Future; MDM); and 14 members (63%) were representing community-based organisations or key affected populations (PWID, SW, LGBTQ+; PLHIV; TB patients). The National Reviewer has clearly communicated with the RG members that their engagement was unpaid, voluntary work.

Given the COVID-19 pandemic and restrictions on gatherings, the RG and the National Reviewer worked remotely using email communications and online (Zoom) meetings. Individual consultations on specific topics have also taken place.

The assessment process involved the following major steps:

- **Step 1: Scoping: Identify placeholders and their monitoring and evaluation plans (set of indicators) and budgets attached to these plans/programmes**

Country level documents pertinent to the HIV/AIDS national response and transition planning were reviewed: National Strategic Plans with corresponding budgets and indicators; transition and sustainability preparedness assessment and National Transition Plan; HIV/AIDS State programmes approved on an annual basis with budgets, and the Global Fund Allocation Letters. To assess the progress achieved towards fulfilling government commitments, the following documents were consulted: Georgia country progress reports - Global AIDS Monitoring (GAM) reports submitted to UNAIDS; HIV/AIDS Spending Matrix; official correspondence between the Ministry of Health and the Global Fund on co-financing requirements, etc.

Based on a consensus reached with the National Reference Group, a decision was made to focus on results from the last 3-year period starting from 2018 when Georgia adopted a new HIV national strategic plan. The decision was prompted after finding out that the targets from the previous plan and current one was inconsistent and did not match, making the calculation of progress scores misleading.

- **Step 2: Identification and Grouping of Commitments by Health System Domains in each Programmatic Area**

The key placeholders were scanned to identify commitments by the government with respect to transition and sustainability of the national HIV response. Specific indicators and targets related to government commitments starting from 2016 were identified and then grouped by health system domains. These domains are:

I.	Financing	III.	Service delivery	V.	Human resources
II.	Governance	IV.	Drug, supplies and equipment	VI.	Information system

- **Step 3: Prioritisation of the commitments**

Next most important and challenging process was the prioritisation of the commitments and their indicators given the very high number of national indicators (over 80 only in the national strategic

- plan). The RG selected 37 of the most critical commitments and relevant SMART indicators to be further assessed in terms of their fulfillment. Prioritisation involved mixed approaches. Initially, the goal of the prioritisation was described during the RG meeting. Given that not all working group members were familiar with the national strategic plan/transition indicators, some indicators were explained to facilitate informed decision-making on prioritisation.

Prioritisation was completed through a few steps: initial prioritisation involved excluding those commitments that were not considered important to the transition process. After initial prioritisation, a total of 47 commitments remained in the commitment matrix (Annex 3). This list was shared online with the RG and members were asked to take account of the national context and assign a priority score to each commitment per those pre-defined in the TMT scoring system: *"1 - not important; 2 - somewhat important; 3 – quite important; 4 – very important (must monitor); or 0 – cannot tell."*

Only a small number of RG members completed the prioritisation exercise online. The majority of community representatives and staff of CBOs did not respond. To make the voice of communities heard, an additional RG meeting was organised to prioritise commitments.

As a result, a total of 37 commitments were prioritised in the matrix (Annex 3) and a breakdown by each domain, as follows:

- Results, impact and outcome: 7 commitments
- Financing: 5 commitments
- Drugs, supplies and equipment: 4 commitments
- Service provision: 10 commitments
- Governance: 6 commitments
- Data and Information: 4 commitments
- Human resources: 1 commitment

The summary data about the commitments that have been removed, modified or added by the national Reference Group is described in the section below[34].

The period selected for monitoring purposes was from 2018 to 2020.

Annex 1 provides detailed information on the prioritisation process and its results.

- **Step 4: Data collection**

For almost all the commitments prioritised, targets were set in the national strategic plan. To monitor the fulfillment, actual results for each reporting year were collected. Major sources of data included GAM national reports submitted to UNAIDS every year; some indicators were obtained from programme reports; and the results under the domain – *Financing* are based on the AIDS spending matrix produced by the Ministry of Health as a part of GAM reporting. HIV prevalence data involving SPECTRUM estimates were requested from the AIDS Centre. This became

[34] More details about commitments that were removed can be seen in the TMT excel file.

necessary as the estimated number of PLHIV in Georgia has been recently updated and the data published by UNAIDS were no longer valid.

During data analysis, actual results for each commitment were compared to the targets set for the given year. Progress was measured in percentiles, called the 'Achievement Score'; the percentiles provide the answer to the question, 'to what extent has the government fulfilled its commitment?'. An Achievement Score equal to 0% shows that there was no progress made; 100% shows it fully met the commitment; and a value of more than 100% indicates overachievement. For better visualisation, the achievement scores are colour-coded.

Definition of sustainability	*Description*	*Achievement percentage*	*Color code*
Significant progress	A high degree of progress in fulfilling the commitments regarding planned indicators and/or baseline	85% - 100%	Green
Substantial progress	A significant degree of progress in fulfilling the commitments regarding planned indicators and/or baseline	70% - 84%	Light green
Average progress	The average degree of progress in fulfilling the commitments regarding planned indicators and/or baseline	50% - 69%	Yellow
Moderate progress	Moderate progress in fulfilling the commitments regarding planned indicators and/or baseline	36% - 49%	Orange
Fairly law progress	A fairly law degree of progress in fulfilling the commitments regarding planned indicators and/or baseline	26% - 35%	Light red
Law progress	Law progress of progress in fulfilling the commitments regarding planned indicators and/or baseline	0% - 25%	Red

- **Step 5: Developing findings in the present report**

The final findings were developed by the national reviewers based on their interpretation of the scores and insights on the broader context of the analysis.

Limitations

Per the proposed EHRA methodology, not all the Government's commitments were analysed. Due to large number, prioritisation of commitments was done by the members of reference group, and the judgement can be subjective. Thus, the conclusions and scoring for health domains may not accurately reflect the overall government progress with regard to the whole transition process.

Some commitments that have been already fulfilled by the Government, were considered no longer relevant and were not prioritized by the Reference Group. Thus, more importance was given to negative expectations regarding some challenging commitments, and positive experience was overlooked during the analysis. Thus, findings may be inclined towards negativity bias about the transition process. For instance, two commitments under the Health Domain – Governance were removed even though both were fully realized by the government in the timeframe within which the Transition Monitoring review was being conducted. If these two commitments were included in analysis, the final achievement score for the Domain – Governance would have been higher (47% instead of 27%).

The TMT methodology allowed the members of Reference Group to modify and/or add some commitments if they were considered as of critical importance to the transition monitoring process. Therefore, it may not seem fair enough to keep the government accountable for those commitments that were proposed by HIV community/reference group but have never been endorsed by the government itself.

It should be also acknowledged that completely new commitments added were excluded from the analysis. For instance, the RG proposed to add 4 new commitments about transgender population throughout different health domains, however, none of these commitments were included in data analysis, and thus, had no influence on the final scoring.

Few commitments were modified, and operational definitions were proposed by the Reference Group, that were not endorsed by the Government. However, these commitments were obvious to consider (i.e. uninterrupted supply of ARVs, OAT medications, and prevention commodities) and thus, they were analysed while calculating the achievement scores.

During the Transition Monitoring review, some data ambiguity/discrepancies were spotted (i.e, AIDS spending in various spending categories), however due to limited scope and timeframe of the TMT, further exploration of genuine reasons was not possible. For such issues, correspondin5recommendations were made.

Findings

Overall status of transition

Since 2003, when Georgia received its first HIV grant from the Global Fund, the country has received generous support and the total amount disbursed for the HIV component has reached USD88,341,418. However, after Georgia was classified as an upper lower-middle-income country, the Global Fund support started declining and the country currently is in the phase of transitioning from donor funding to domestic financing of its HIV services. The Government of Georgia has declared its commitment to sustain and further expand the scope and scale of HIV interventions that have been financed by the Global Fund, and the state has already achieved significant progress in certain programmatic areas that are briefly summarised in this section.

Currently, first line ARVs are fully procured under state funding, and second line drugs are purchased by both the government and the Global Fund. In 2020, 60% of total ARV costs incurred in the country were covered by the state[35]. All other costs related to diagnostics, treatment and monitoring of PLHIV are covered by the Government. The blood safety programme, and the elimination of mother-to-child transmission (EMTCT) programme are fully financed by the Government. In addition, the government started financing STI testing and treatment services for key populations that were originally launched within the USAID funded STI/HIV prevention programme (2002-2009) and then supported by the Global Fund until 2017. Hepatitis C diagnostic and treatment became accessible for PLHIV co-infected with Hepatitis C through the Global fund and, since 2016, this programme component has been integrated within the State-funded Hepatitis C elimination programme. HIV prevention and treatment services in correctional settings are now fully financed by the government.

HIV stakeholders and civil society have never doubted that the Government would take over lifesaving treatment as well as safety of donated blood and/or EMTCT, although there was some skepticism regarding the sustainability of HIV prevention and harm reduction services targeting key affected populations. Thus, special emphasis should be placed on the fact that the government has started to progressively absorb the cost of OAT for PWID and, since 2017, the programme has been fully funded by the state. Furthermore, access to OAT has been expanded, reaching its highest level of coverage in 2020 in which a total of 14,300 PWID were receiving OAT, which exceeded the national strategic plan target set for 2022 by almost 30% (14,300 in 2020 versus 11,000 PWID by 2022).

Significant progress has been achieved in terms of transitioning of PrEP from donor funding to domestic financing. Over the last couple of years, the Government has managed to further scale-up programme coverage: in 2019, a total of 258 MSM received PrEP at least once during a year and this number has almost doubled in 2020, reaching 487 (versus the target of 500).

[35] Soselia G. Analytical Report: Procurement of HIV/AIDS Antiretroviral Medicines in Georgia. Tbilisi, Georgia; 2020.

The government of Georgia has been relatively slow in investing in low-threshold harm reduction services targeting key affected populations. Nevertheless, starting from 2020, the state invested some funds to support HIV counseling and testing services among PWID and SW, albeit with limited scope and scale.

Despite these achievements, there is a considerable part of HIV prevention interventions that have never been supported by the Government such as procurement of HIV prevention commodities, needle-syringe programmes; psycho-social, legal and material support for disadvantaged key populations, disease surveillance research, etc. The government has declared its commitment to ensure the sustainability and scale-up of all essential services of the HIV response through the incremental increase in domestic investments in years to come. Therefore, regular monitoring of the fulfilment of government commitments toward transitioning from donor funding to domestic financing is of utmost importance, and the support of EHRA/the Global Fund to carry out the first ever transition monitoring exercise has been timely and a critical contribution to the transition process in Georgia.

PROGRESS ON IMPACTING THE HIV EPIDEMIC AMONG KEY POPULATIONS

Under this domain, key epidemiological indicators were monitored to assess the extent to which the national HIV response has contributed to controlling the HIV epidemic and in improving the health and wellbeing of PLHIV. A set of 7 commitments were prioritised with a corresponding 7 SMART indicators. Data only on three commitments were available for 2019-2020. Up-to-date figures for HIV prevalence among key populations - PWID, MSM and SW - were not available as no IBBS were carried out during 2019-2020. HIV prevalence data for transgender people (I.7 in Table 8, below) does not exist in Georgia. Thus, only 3 out of the seven commitments were monitored.

Table 8. Assessment of national targets on the impact on the HIV epidemic

No.	Results, impact and outcomes	Indicator	Achievement 2019	Achievement 2020	Average Impact
I.1	Reduce HIV prevalence rate per 100,000 population	HIV diagnosed person per 100,000 (target less than:)	100%	100%	100%
I.2	Reduce AIDS-related mortality	The number of AIDS related death per 100,000 population (target - less:)	100%	111%	106%
I.3	Contain HIV epidemics among MSM	Percentage of MSM who are living with HIV (target - be contained under <X%)	NA	NA	NA
I.4	Contain HIV epidemics among SWs	Percentage of SW who are living with HIV (target - be contained under <X%)	NA	NA	NA
I.5	Contain HIV epidemics among PWID	Percentage of PWID who are living with HIV (target - be contained under <X%)	NA	NA	NA
I.6	Prevent HIV spread among general population	HIV Incidence rate per 1,000 population (target - to be contained under <X)	112%	94%	103%
I.7	Prevent HIV spread among transgender persons	Percentage of TG living with HIV	NA	NA	NA

For all three commitments, average values were above 100% which indicates that Georgia has overachieved its goal to control the spread of HIV among the general population and reduce HIV incidence and AIDS-related mortality. However, it should be stressed that the progress achieved to fulfill the commitments to contain the HIV epidemic among key affected populations was impossible to monitor given that no IBBS surveys among key populations were conducted during 2019-2020. Nevertheless, HIV prevalence among PWID and SW has been contained under the 5% threshold for a concentrated epidemic for more than a decade. MSM remain the most affected population with 21.5% HIV prevalence in Tbilisi and 15.6% in Batumi[36]. However, the latest available IBBS data suggests that HIV prevalence among MSM has been stable since 2015.

Conclusion: Although the overall HIV-related situation might not be worsening in the country, the lack of timely information on the situation among key populations limits the possibility to draw any conclusions regarding the impact of HIV control measures or transition, per se, on key populations.

Health Domain 1: Financing

Average performance score: 67% - average progress has been achieved.

Under ***Domain 1*** - ***Financing***, five commitments were prioritised and monitored. Data about spending was based on the GAM funding matrix tool submitted by the Government to UNAIDS every year. Per the official data, the commitment to increase the share of public spending out of the total HIV spending in 2019-2020 was overachieved (fulfillment score of 102%).

The commitment to ensure sustainable funding of IBBS and PSE studies among key populations was not realised (fulfillment score of 0%) and no such studies have taken place in the period 2019-2020.

As provided for in the national strategic plan, the government has committed to increase state funding for HIV prevention interventions targeting key populations, including low threshold harm reduction and community support services. Though data was found in the AIDS spending matrix, calculating the achievement scores was not possible as the national strategic plan has not set any targets for the given years.

The last commitment under the Financing Domain was completely fulfilled as documented in the Ministry of Health (MoH) letter to the Global Fund[37]. The letter states that the Government of Georgia has met the two core co-financing requirements for the new implementation phase (2020-2022) – increasing government expenditures for disease programmes and health systems, and progressive absorption of key programme components using domestic financing, as well as co-financing incentive requirements including the allocation of a minimum 50% of additional investments for interventions targeting key and vulnerable populations.

[36] IBBS among MSM in Tbilisi and Batumi. Tbilisi; Curatio International Foundation; Tanadgoma, 2019.

[37] Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs in Georgia. Letter submitted to TGF Country Portfolio Manager. No:01/6413, of 12 December 2019, Signed by the Acting Minister.

The average score for fulfilling the commitments under ***Domain 1- Financing*** was 67%, which implies that average progress has been achieved by the government. This calculation did not take into account two commitments, for which data was absent – we have observed that the government has made progress on those commitments but were not able to measure those due to lack of data. However, we question the reliability of financial data sources, particularly those reported within GAM.

The annual achievement scores for each commitment in both years 2019 and 2020, as well as 2-year average achievement scores by every commitment under the ***Domain 1- Financing*** are presented in Table 9, below.

Table 9. Assessment of the fulfillment of State commitments: Domain 1 - Financing

No.	Commitment	Indicator	2019	2020	Commitment average	Average performance by domain
1	Domain: Financing					
1.1	Ensure adequacy of state budget allocations for HIV prevention and treatment	The share of public spending out of the total HIV spending	113%	92%	102%	
1.2	Increase state funding of HIV prevention interventions targeting KAPs	% share of public funding on HIV targeting KAPs	Na	NA	NA	
1.3	State provides funding and contracts non-state actors to deliver HIV prevention services/ low threshold HR (excluding OST) services and community support services	Total funding allocated by the state to CSOs/CBOs to deliver HIV prevention/harm reduction services (excluding OST)	Na	NA	NA	67%
1.4	Ensure sustainable state funding of IBBS and PSE among KAPs	The number of IBBS/PSEs among KAPs conducted through state funding	NA	0%	0%	
1.5	Meeting co-financing incentive requirement - for allocating defined share of additional investments for prevention targeting KPs.	Co-financing incentive requirement for allocating defined share of additional investments for targeting KPs is met	100%	100%	100%	

Discussion: These results are based on the AIDS Spending Matrix[20] submitted by the country to UNAIDS within the Global AIDS Monitoring platform. Traditionally, the spending data is collected by the Ministry of Health through surveying all potential donors and implementing partners. While we do not underestimate the credibility of the sources, reviewing data disaggregated by various spending categories shows that there might be some inaccuracies that need to be clarified. Otherwise, the results concerning increasing state financing of the HIV response may not be reliable.

The results showed that average progress has been achieved by the government in terms of increasing investments in the HIV national response expressed as the percentage share of public funding out of total HIV spending. Obviously, due to decreasing spending by the Global Fund in the HIV response, the percentage share of public spending is increasing despite the fact that public investments were not increasing annually. This trend will continue as the Global Fund spending continues to drop in the years to come. Thus, we can assume that the measurement method should be revised to capture factual changes in the level of state investment and to avoid misinterpretation of results.

Table 10. HIV/AIDS spending in 2018-2020

	2018		2019		2020	
	Public	Total	Public	Total	Public	Total
Total HIV/AIDS Spending (USD)	$12,937,655	$19,761,124	$14,159,868	$15,897,791	$12,449,435	$15,892,206
Total HIV Prevention spending (USD)	$7,636,736	$12,181,995	$7,361,540	$8,191,422	$5,881,531	$7,685,482

Accuracy of AIDS spending data should be double-checked: Spending data for HIV prevention was analysed for 2019 and 2020 and its breakdown by financing source was reviewed.

State funding accounted for 63% of all HIV prevention spending in 2018, which increased to 90% in 2019 and decreased to 77% in 2020. Of HIV prevention spending, the largest share was allocated to cover the cost of OAT services (USD3.9 million in 2019 and USD3.6 million in 2020). Under *Section 3 – HIV prevention*, there is a spending category named *synergies with health sector (Prevention 3.15)* that accounts for the large share of all prevention spending: 34,2% in 2020 and 45,8% in 2019. However, it is not clear as to what types of interventions are included under this spending category. Presumably, the government reported the total expenditures for the Safe Blood programme and integrated screening to support the Hepatitis C elimination state programme within this spending category. Nevertheless, if combined, only two spending categories – 'OST among PWID', and 'Synergies with Health sector' - account for 95.3% and 98.5% of all HIV prevention spending in 2020 and 2019, respectively. Less than 5% of public spending in 2020 was allocated to support low-threshold HIV prevention services (excluding OST)[38].

Under no circumstances does this report intend to dispute the high volume of spending for 'Synergies with Health Sector', nor to conclude that reported numbers have been misclassified as expenditures for HIV prevention, particularly without understanding what components are included in this category. Moreover, the Global Fund co-financing requirement allows a broad interpretation of 'Resilient and Sustainable Systems for Health' (RSSH), which may give the Government a high degree of flexibility to include interventions not directly linked with HIV under the RSSH. This finding highlights that additional analysis is needed to better reflect the reality of public financing.

[38] The National Strategic Plan Indicator: Financing: Fin.57.

Table 11. HIV spending data: Prevention

HIV prevention	2020		2019	
	N in USD	% share	N in USD	% share
	5 881 531 USD	**100%**	**7 361 540 USD**	**100%**
Out of total HIV prevention spending:				
Synergies with health sector	2 011 944 USD	34,2%	3 371 230 USD	45,8%
Substitution Therapy	3 595 225 USD	61,1%	3 877 889 USD	52,7%
Condoms	110 926 USD	1,9%	0 USD	0,0%
PrEP	18 768 USD	0,3%	6 038 USD	0,1%
HIV prevention for **PWID** (Needle and syringe program)	103 922 USD	1,8%	0 USD	0,0%
Prevention, promotion of testing... **for young women and adolescent girl**s (high-prevalence countries)	40 197 USD	0,7%	0 USD	0,0%
Prevention, promotion of testing.. for **MSM**	0 USD	0,0%	0 USD	0,0%
Prevention, promotion of testing...for **sex workers and their clients**	0 USD	0,0%	0 USD	0,0%
Prevention, promotion of testing...for **transgender persons**	0 USD	0,0%	106 383 USD	1,4%
Post -exposure (PEP)	549 USD	0,0%	0 USD	0,0%

The data presented in Table 12, below, also raises other concerns. In 2019, the State reported spending of USD106,383 for HIV prevention work targeting transgender persons. The procurement of condoms by public funds (USD110,926) was also reported in 2019; and the State also reported spending some USD40,000 for prevention, promotion of testing and linkage to care services for young women and adolescent girls in 2020. However, most members of the Reference Group interviewed are not aware of these interventions. Due to the limited timeframe, more in-depth analysis of AIDS spending data was not possible within this TMT mission.

The State also reported spending some USD40,000 for prevention, promotion of testing and linkage to care services for young women and adolescent girls in 2020 even though HIV service providers are not aware of interventions targeting vulnerable women and girls in the context of HIV prevention and testing. Due to the limited timeframe, more in-depth analysis of AIDS spending data was not possible within this TMT mission.

Level of replacement funding: As Global Fund support for Georgia is declining and the State is taking over the key HIV programme components, it is important to understand whether the State intends to provide a comparable level of replacement funding for low threshold/harm reduction services targeting key populations that are currently implemented by CSOs/CBOs.

In 2020, GHRN was contracted by the Government to implement interventions among PWID. Moreover, starting from 2021, in addition to PWID, the State allocated funding for HIV prevention among SW through contracting the local NGO, Tanadgoma. However, State support at this stage covers only HIV testing provided at fixed services and during street outreach. Many components that have been traditionally supported by the Global Fund still remain dependent on donor funding, such as programme management and administration, psycho-social support services, awareness raising activities and capacity building interventions, none of which are covered under the agreement between the NCDC and local NGOs in 2020-2021.

Additional analysis was carried out to examine the current level of replacement funding for HIV prevention services targeting PWID and SW as presented in Table 12 and Table 13, below.

Table 12. Public and Global Fund financing for HIV prevention among PWID and SW in 2020-2021 in GEL[39]

	2020		2021	
	Global Fund	**State Prograı**	**Global Fund**	**State Prograı**
HIV Prevention for PWIDs	2,103,068	335,000	1,791,099	712,000
HIV Prevention for SW	1,273,587		1,193,484	80,994
Total	**3,376,655**	**335,000**	**2,984,583**	**792,994**
Replacement funding				
Reduction of GF funding		-	392,072	
Increase of public funding			457,994	
Share replaced			117%	

The State invested around GEL335,000 to support HIV prevention among PWID in 2020 (June-Dec), while the Global Fund provided GEL2.1 million (6-times more) for the same programme at the same time period. In 2021, the Government investment to PWID services doubled, but accounted for only 28% of the total funds allocated for HIV prevention work among PWID. Similarly, State funding for HIV prevention among SW is trivial – GEL80,994 - which accounted for only 6% of the total programme budget.

Table 13. Share of State funding for HIV prevention among PWID and SW by year

	2020	2021
Share of state funding out of total spending for HIV prevention among PWIDs	14%	28%
Share of state funding out of total spending for HIV prevention among FSWs	NA	6%

Currently, the perception of civil society is that State funding has been symbolic, covering only a small portion of interventions under the comprehensive package for each key population as outlined in the approved guidelines. As shown, the share of public funding for HIV prevention services targeting PWID (excluding OST) and SW in 2021 does not exceed 21% (for PWID – 28%; and for SW – 6%). There is a hope that state funding will increase incrementally to take over all the components of HIV prevention among key populations.

Nevertheless, it is obvious that the total cumulative budget (combined from both sources – the Global Fund and public) for programme components have been sustained: A total budget for the HIV prevention programme for PWID was GEL2,438,068 in 2020 and it remained stable (slightly more) in 2021 at GEL2,503,099. The same result was found for the FSW programme: in 2020, when the programme was fully financed through the Global Fund, the annual budget was GEL1,273,588; in 2021, the government absorbed (albeit) a small portion of the programme components, but the total budget from both sources remained almost identical at GEL1,274,478. **Thus, we can assume that the level of replacement funding provided by the government to PWID and SW programmes was optimal.** However, CSOs have still complained that annual targets for service coverage were on the rise while the allocated budget remained the same.

[39] Programme budget figures were provided by GHRN and Tanadgoma.

Sustainable funding of IBBS and PSE among KAPs: Availability of up-to-date data about HIV vulnerability of key populations, as well as population size estimation (PSE), is critical for evidence-based strategic planning, the forecasting of needs and monitoring of progress achieved. It has been almost 2 decades since the first ever IBBS in Georgia, conducted through USAID-funded projects among PWID, SW and MSM. After several rounds of surveillance studies were completed with financial and technical support from USAID in 2002-2009, the Global Fund started investing in HIV research, and after 2009 it has become the only financing source to ensure continuity of IBSS/PSE studies in Georgia. Per the Transition Plan, as well as the latest national strategic plan for 2019-2022, the Government was expected to cover a certain share of research-related costs starting from 2018. However, the latest IBBS/PSE conducted in 2017 (among PWID and SW) and in 2018 (among MSM) were financed by the Global Fund. Per the national strategic plan, the State should have carried out the next round of IBBS/PSE among PWID and SW no later than 2020 and among MSM no later than 2021. However, as of May 2021, none of them has been completed. Failing to realise this objective is explained by the COVID-19 pandemic that, on the one hand, has placed a substantial burden on the healthcare system in 2020, and on the other hand, restricted physical contacts and the gathering of people. According to civil society, the NCDC is currently in the process of planning an IBBS/PSE survey among PWID.

CONCLUSION

The TMT findings show that average progress (67%) has been achieved in terms of fulfilling government commitments in the domain of Financing. Official data states that the Government of Georgia has met the two core co-financing requirements: increasing the share of government spending for disease programmes and the progressive absorption of key programme components with domestic financing. It has also met the co-financing incentive requirements, including the allocation of a minimum of 50% of additional investments for interventions targeting key and vulnerable populations. However, a consistent increase in the amount of public investments for HIV services was not documented by AIDS spending data. The TMT analysis has demonstrated that monitoring the percentage share of public spending out of all total spending may be misleading and that the level of State investment expressed in absolute numbers should also be monitored.

The Government has started financing HIV testing and counseling services for PWID (from 2020) and FSW (from 2021) through the contracting of civil society organisations, but the amount of funding remains insignificant and constitutes only one-fifth of the budget needs of HIV prevention programmes among the two target groups. Thus, a substantial portion of funding continues to be provided by the Global Fund. Some programme components have never been funded by the Government, such as procurement of prevention commodities (condoms and lubricants); needle-syringe programmes; HIV prevention among MSM (excluding PrEP); psycho-social, legal and material support for key populations, including PLHIV, etc. Thus, despite the progress made, there has not been enough evidence to believe that the Government intends to sustain all essential service components under public funding in the near future.

The Government has not realised its commitment to gradually absorb the cost of IBBS/PSE studies among key affected populations.

AIDS spending data, which is the major source for monitoring funding data, may not accurately capture progress towards fulfilling financial commitments. At this point, the TMT results under Domain 1 - *Financing* should be interpreted with caution before the validity of AIDS spending data is proved. Based on the above, we strongly encourage civil society organisations to have a closer look at the spending data submitted on an annual basis by the Ministry of Health. The cross checking and triangulation of available data sources on HIV financing is warranted.

Health Domain 2: Drugs, Supplies and Equipment

Average performance score for this domain: 85% - significant progress has been achieved.

The RG proposed adding 4 new commitments to **Health Domain 2: Drugs, Supplies and Equipment** (see Annex 1 for more details):

1. **Ensure the uninterrupted supply of ARV drugs for PLHIV;**
2. **Ensure the uninterrupted supply of OAT medications for opioid dependent PWID;**
3. **Ensure the uninterrupted supply of prevention commodities (condoms, lubricants, naloxone, syringes and other safe injection paraphernalia) for key population groups; and,**
4. **Achieve lower prices for the purchase of ARV drugs to ensure the sustainable and reliable supply of a full range of ARVs needed.**

It should be noted that no standard definition and measurement methods for monitoring stock-outs were found in published literature. Therefore, the RG has defined the operational definition for each commitment as well as corresponding indicators. The operational definition of stock-outs, and the threshold for reporting stock-outs, was defined as: a stock-out of a product to be monitored for more than 3 consecutive days for ARV and OAT medication; and for more than 7 consecutive days for prevention commodities.

The following method for scoring was piloted during the first TMT exercise:

- If only **one episode** of documented stock-out is observed during one year – the highest level of achievement score is to be downgraded by 20% (achievement score will be set at **80%**);
- If **two episodes** of documented stock-out are observed during one year – the score is to be downgraded by 40% (achievement score will be set at **60%**);
- If **three episodes** of documented stock-out are observed during one year – the score is to be downgraded by 60% (achievement score will be set at **40%**); and,
- If **more than three episodes** are observed during a year – this is to be considered as a failure and the score will be set at **0%**.

- We acknowledge that the proposed scoring system is arbitrary, and the RG welcomes any feedback and suggestions. In order to not overload the TMT tool with complicated formulas, we offer to enable the manual entry of assessment scores for the stock-out commitments.

No ARV Stock-outs: Georgia has achieved universal access to ARV drugs for all PLHIV through the joint efforts of the Government of Georgia and the Global Fund since 2003. Furthermore, Georgia was one of the first countries in the EECA region to adopt the 'test and treat' strategy. Since then, no stock-outs of ARV drugs have been documented. Therefore, the Achievement Score for this commitment is set at 100%.

No stock-outs of OAT medications were observed during 2019-2020, and, therefore, the achievement score was 100% for each year.

Stock-outs of HIV prevention commodities: In 2020, stock-outs of prevention commodities were observed, namely condoms, naloxone and certain types of syringes were not accessible to beneficiaries for a few weeks. According to programme managers, this was due to the COVID-19 pandemic and resultant delayed transportation of procured goods. The Achievement Score for this commitment (2.2) was 100% in 2019 (no stock-outs) which was downgraded to 60% in 2020.

The cost of ARVs for Georgia is higher than the reference prices: It needs to be acknowledged that Georgia represents small and commercially may be not attractive market for pharmaceutical industry. Small volumes of required procurement of ARVs leads to a low purchase power to negotiate most affordable prices at the local market. In addition, the country would need to pay extra for quality check of procured medicines which is also difficult to the lack of adequate infrastructure and services. Thus, a Pooled Procurement Mechanism established by the Global Fund was a good opportunity for Georgia to benefit from the lower ARV prices resulted from the large volume of procurement.[40] Georgia is procuring ARVs with the domestic funds through the PPM since 2015 and is benefiting from continuous price reduction for the most of ARV medicines, but an analysis of data from 2020 shows that the actual prices paid for ARVs in Georgia substantially exceeded the reference pricing. For instance, despite the fact that ARV procurement in Georgia is done through the PPM by IPLUS SOLUTIONS Limited, WAMBO, the price paid for lopinavir/ritonavir was 2-times higher; darunavir at 5-times higher; and abacavir at 6 times higher[41] than the reference price[42]. Thus, the score was set at 60% in 2020. Data for 2019 was not available.

Annual achievement scores for each commitment in both years – 2019 and 2020 - as well as a 2-year average achievement score for every commitment under *Domain 2- Drugs, Supplies and Equipment* are presented in Table 16 Table 14, below. Thus, despite some challenges related to these commitments, overall the Government has fulfilled its commitment under this domain.

[40] ARV Reference Pricing. Last updated April 2021. https://www.theglobalfund.org/media/5813/ppm_arvreferencepricing_table_en.pdf

[41] Giorgi Soselia. Analytical Report: Procurement of HIV/AIDS Antiretroviral Medicines in Georgia. 2020

[42] Prevention Task Force: Position Paper, 2020. Prepared through financial support from MDM France.

Table 14. Assessment of the fulfillment of State commitments: Domain 2 - Drugs, Supplies and Equipment

No.	Commitment	Indicator	2019	2020	Commitment average	Average performance by domain
2	Domain 2: Drugs, supplies and equipment					85%
2.1	Ensure uninterrupted supply of ARV drugs	Number of episodes in a year when stock out of ARV drugs for more than 3 consecutive days was observed	100%	100%	100%	
2.2	Ensure uninterrupted supply of HIV prevention commodities	Number of episodes in a year when stock out of at least one prevention product (naloxone, syringes, condoms, lubricants) for more than 7 consecutive days was observed	100%	60%	80%	
2.3	Ensure uninterrupted supply of substitution medication	Number of episodes in a year when stock out of substitution medication for more than 3 consecutive days was observed	100%	100%	100%	
2.4	Achieve lower prices for ARV to ensure the sustainable and reliable supply of the full range of needed ARVs	Ratio of actual ARV prices in Georgia over the reference pricing	NA	60%	60%	

Discussion: Sustainability of an uninterrupted supply of life-saving, high-quality ARVs has become one of the top priorities of the Government of Georgia. The share of government expenditure on ARVs has been on the rise. While civil society acknowledges that the government has already proved its commitment to ensure an uninterrupted supply of ARVs and universal access to AIDS treatment, they are concerned about the large share of ARVs procurement in the national HIV programme budget. Taking into account the budgetary limitations for the healthcare system in Georgia, it can be recommended to achieve further price reduction on ARVs and, thus, increase the fiscal space available for other HIV interventions.

The national currency fluctuation is another significant challenge that negatively affects the ARV cost as the Georgian Lari has substantially devalued against the US Dollar over the last two years, which, ultimately, has increased the financial burden on the State budget.

Therefore, during the transition phase, greater emphasis should be placed to mitigate the challenges linked to transition from Global Fund support to national procurement. Some of the strategies recommended in the report[44] include the following: Maintain and ensure sustainable access to Pooled Procurement Mechanism after full phasing out of Global Fund, through backing it up with legislation; continue the national efforts for lower price negotiations for ARVs with PPM revise national legislation to allow using of waivers for import of non-registered pharmaceutical products not only within emergency situation, but as a routine strategy for certain lifesaving products; utilize TRIPS flexibilities and revise national Intellectual Property Legislation to improve access of generics to the market; elaborate respective bylaws providing detailed mechanism on technical execution and implementation of compulsory licensing and parallel import.

[44] Ibid

Uninterrupted supply of OAT medications has been ensured: No stock-outs of OAT medications were reported; however, PWID community members are sometimes complaining about the quality of OAT medications. This issue was discussed during the 97th CCM[45] meeting and it should be noted that the Government pledged to consider the community complaints and, indeed, has changed the supplier for the subsequent tender. Unfortunately, the TMT is less capable of capturing the challenges related to the quality of services and/or supplies.

CONCLUSION

The Government has achieved significant progress (with an achievement score of 85%) to ensure the uninterrupted supply of ARVs, OAT medications as well as HIV prevention commodities. The ARV prices procured in Georgia remain much higher than the reference pricing. Taking into account the budgetary limitations for the healthcare system in Georgia, it can be assumed that overspending on ARVs may limit the fiscal space available for the HIV response. Thus, it seems to be critical to optimise the procurement of ARV drugs to avoid overspending and to ensure that limited resources available for the HIV response in the country are spent most efficiently.

A few episodes of stock-outs of HIV prevention commodities in 2020 were observed that may be caused by external factors, namely the COVID-19 pandemic and restrictions in transportation and international shipping.

Health Domain 3: Service Provision

Average performance score for the domain: 98% - significant progress has been achieved

The national HIV response in Georgia has been successful in providing HIV prevention services to key populations. The coverage of PWID, MSM and SW was on the rise over the last few years, until 2020. During the past year, the government-imposed restrictions to control the COVID-19 epidemic in the country has created service barriers and resulted in downsizing the scope and scale of prevention work. The share of PWID, MSM and SW receiving a combined set of HIV prevention services stayed below the targets set for 2020 even though the two-year average score showed significant progress in attracting key populations into HIV services. Annual achievement scores for each commitment in both years – 2019 and 2020 - as well as the 2-year average achievement scores for every commitment under the *Domain 3 - Service Provision* are presented in Table 15, below.

[45] Minutes of the 97th CCM meeting, March 5, 2021. Tbilisi, Georgia; CCM Secretariat.

Table 15. Assessment of the fulfillment of State commitments: Domain 3 - Service Provision

No.	Commitment	Indicator	2019	2020	Commitment average	Average performance by domain
3	Domain 3: Service Provision					98%
3.1	Care cascade: Improve HIV case detection	Percentage of PLHIV who know their HIV status	107%	84%	96%	
3.2	Ensure uninterrupted delivery of high-quality treatment and care	Percentage of PLHIV diagnosed with HIV receiving ARV at the end of the reporting year	96%	96%	96%	
3.3	Ensure uninterrupted delivery of high-quality treatment and care	Percentage of people on ARV who are virally suppressed (VL<=1000 copies /ml)	101%	104%	103%	
3.4	Increase coverage of PWID with HIV services	Percentage of PWIDs reporting having received a combined set of HIV prevention packages (last year) (program data)	105%	88%	96%	
3.5	Increase coverage of PWID with HIV services	Number of syringes distributed to one PWID during one year (# of syringes /per person/per year)	69%	58%	64%	
3.6	Increase coverage of PWID with HIV services	Number of PWIDs receiving OST	118%	130%	124%	
3.7	Increase coverage of MSM with HIV services	Percentage of MSM reporting having received a combined set of HIV prevention packages (last year) (program data)	119%	84%	101%	
3.8	Increase coverage of MSM with HIV services	# MSM receiving PrEP at least once during the year	103%	97%	100%	
3.9	Increase coverage of SWs with HIV services	Percentage of SWs reporting having received a combined set of HIV prevention packages (last year) (program data)	128%	70%	99%	
3.10	Increase coverage of transgender people with HIV services	Number of transgender people receiving HIV prevention services (program data)	NA	NA	NA	

Discussion: The declared commitment of the government to prioritise the HIV response has been translated into mobilising state funds, although the level of state funding remains low, particularly for provision of HIV prevention services. Therefore, the achievements under this domain cannot be attributed solely to the Government's efforts as the Global Fund continues to allocate substantial resources to strengthen the national response and to ensure service provision for PWID, SW and MSM, respectively.

HIV case detection: Historically, Georgia has been struggling with low HIV case detection. While the country has had substantial achievements in the 2nd and 3rd indicator of the HIV care continuum, a significant proportion of PLHIV in Georgia have remained undiagnosed. For instance, in 2017, the share of PLHIV who knew their HIV positive status was as low as 48%. The latest results reported for 2019 and 2020 show that 75% and 76% of the estimated number of PLHIV were aware of their status, making the achievement score for HIV case detection high: 107% and 84% in 2019 and 2020, respectively. However, the scores can be misleading and could be the result of recent adjustments in the Spectrum estimates for PLHIV in the country. According to data provided by the AIDS Centre, the estimated number of PLHIV per year was as follows:

- in 2016, the number was set at 12,000;
- in 2017, 11,000;
- in 2018, 9,400;
- in 2019, 9,100; and,
- in 2020, the estimated number of PLHIV reached its lowest value over the five years at 8,300.

Thus, the denominator for the 1st indicator of the 90 X 90 X 90 target has reduced significantly since 2017 (by 25%) which, most likely, is the major reason for the overachievement. Ideally, when new population estimates are determined, it is highly desirable to readjust rates from past years to be comparable to new population estimates. Despite high achievement rates, HIV case detection clearly needs to be further improved as in 2020 one person out of four infected with HIV did not know his/her HIV status; and, therefore, such people were not accessing the care and treatment they need to stay healthy and to prevent transmission of the virus to others.

ARV treatment coverage and outcome: Georgia has maintained significant progress in reaching the 2nd and 3rd indicators of the HIV care cascade: 86% of those diagnosed are on ARV and 94% of those on treatment have achieved viral suppression.

HIV service provision for PWID: The targets set for improved coverage of PWID with a combined set of HIV prevention services were overachieved in 2019 (105%) but reduced to 88% in 2020. These results should be interpreted cautiously as the programme data on coverage of PWID may be somewhat inflated. HIV services are anonymous, and beneficiaries are registered using unique codes. There is a possibility that some beneficiaries are registered in different service centres with different unique codes that does not rule out the double-reporting of beneficiaries. Ideally, the programme data should be cross tabulated with IBBS data that traditionally shows a much lower result for the coverage of PWID with services than the programme data. For instance, in 2017, harm reduction programme data reported reaching 52% of PWID with services while IBBS data of the same year showed that only 23% of respondents reported receiving HIV services during the past 12 months. This example once again proves how critical it is to have research-based data available at least every 2-3 years. Given that the last IBBS among PWID was conducted four years ago, we had to rely only on programme data.

Access to injection paraphernalia by PWID: In 2020, the number of syringes distributed to each beneficiary during one year has remained far below the target: 70 syringes versus 120 syringes per beneficiary/per year. According to service providers, this underachievement is largely caused by COVID-19 restrictions and the downsizing of outreach work during the pandemic. Another reason might be the observed stock-outs of certain types of syringes in 2020.

Coverage of PWID with OAT: Significant achievement was observed in terms of expanding OAT which is fully financed through state funding. The national strategic plan target for 2020 aimed at maintaining the number of PWID receiving OAT at 11,000. However, the actual result for 2020 exceeded the target by 30%.

HIV service provision for MSM: Coverage of MSM with HIV services remains comparable with the targets set in the national strategic plan. However, the result is far beyond optimal: less than half of the MSM population have been reached with prevention services. Reducing the coverage in 2020 was due to COVID-19 related factors: mobility restrictions; curfews; shutting down public transportation, which resulted in the cessation of outreach work. During this period, greater

focus was placed on promoting HIV self-tests. This strategy was introduced in 2020 and has gradually become popular among both MSM and transgender populations. Beneficiaries have the opportunity to order self-tests online (at http://selftest.ge/) for home-delivery by courier services. Starting from 2021, PWID were also given access to the ordering of HIV self-tests. Currently, work is in progress to expand this service to the SW community as well. The HIV self-test component has been fully supported by the Global Fund and, at this point, there is no evidence that the Government intends to sustain the existing model (especially a home-delivery via courier services) after the Global Fund support ends.

PrEP services *have been expanded and state funding is used to cover related costs*. Significant progress has been achieved to increase the number of MSM receiving PrEP: in 2019, a total of 258 MSM received PrEP at least once during a year; the number almost doubled in 2020, reaching 487 (versus a target of 500). It can be assumed that the Government has demonstrated its commitment to sustain the service and has met the targets in the national strategic plan.

MSM community members mentioned that access to PrEP services for migrant MSM is still associated with procedural difficulties. Nevertheless, the RG members agree that PrEP among MSM remains a key priority and the Government has been fulfilling its obligations in this regard. Public spending on PrEP was modest in 2019 at USD6,038, with a three-fold increase to USD18,768 in 2020. Despite this progress, special emphasis should be given to the fact that some support services that are important for reaching out to MSM and attracting them to PrEP still remain to be supported by the Global Fund.

HIV service provision for FSW: The coverage indicator for female SW (FSW) in 2019 and 2020 was fluctuating in comparison with the indicators in the national strategic plan, with overachievement in coverage observed in 2019 (128%) that sharply declined to 70% in 2020 largely due to the negative impact of the COVID-19 pandemic on the sex business as well as on HIV service provision. In general, less than half of the estimated number of SW (42%) accessed HIV prevention services in 2020.

CONCLUSION

A high degree of progress in fulfilling the commitments to increase access to HIV services for key populations was documented, with an overall achievement score of 98%. However, this assessment does not provide evidence that no risk to sustainability of services can be expected. The Global Fund still plays a critical role in expanding or maintaining the scope and scale of HIV essential services provided to key populations, including PLHIV, MSM, PWID and SW. There is a well-established opinion among stakeholders that long-term sustainability of ARV treatment and OAT programmes has been already secured by substantial engagement of the State; however, little evidence (if any) is available so far to believe that low-threshold services run by CSOs, specifically needle and syringe programmes, community outreach, care and support services - including material support services for key populations - will be sustained beyond the existing Global Fund

cycle. There is a declared political commitment from the government about sustainability of all programme components of HIV prevention, though this declaration has not yet been substantiated with commensurate funding for certain programmatic areas.

Health Domain 4: Governance

Average performance score for the domain: 27% - a fairly low degree of progress has been achieved

Based on the indicators prioritised by the RG under Domain 4 - Governance, a fairly low degree of progress was documented in 2019-2020.

A total of 6 commitments were prioritised by the RG under the Domain – Governance: one commitment about revising existing, punishment-based drug legislation which criminalises drug use; and a further 5 commitments about the development and approval of HIV prevention national standards (service guidelines, protocols and costing) for each key vulnerable population: PWID, MSM, SW, transgender persons and at-risk youth. The Government did not fulfill its commitment to amend existing drug legislation to remove service barriers for PWID.

Even though HIV prevention service guidelines and service protocols were developed in 2017-2018, the approval process was delayed. Only in 2020 were service guidelines for PWID, MSM, SW and at-risk youth approved by the Ministry of Health. Thus, the transition progress score was set as 33% for each.

The annual achievement scores for each commitment in both years – 2019 and 2020 - as well as the 2-year average achievement scores for every commitment under *Domain 4 - Governance* are presented in Table 16, below.

Table 16. Assessment of the fulfillment of State commitments: Domain 4 - Governance

No.	Commitment	Indicator	2019	2020	Commitment average	Average performance by domain
4	Domain 4: Governance					27%
4.1	Create conducive legal environment for HIV response to remove barriers to services	Revised legislation reduced (removed) legal barriers to service	0%	0%	0%	
4.2	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among MSM	National Standard on HIV prevention among MSM approved	NA	33%	33%	
4.3	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention SWs	National Standard on HIV prevention among SWs approved	NA	33%	33%	
4.4	Development and approval of the National Standard (guideline, protocol and costing) on harm reduction for PWIDs	National Standard on HIV prevention among PWIDs approved	NA	33%	33%	
4.5	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among Youth	National Standard on HIV prevention among youth approved	NA	33%	33%	
4.6	Development and approval of the National Standard (guideline, protocol and costing) of HIV prevention among transgender people	National Standard on HIV prevention among transgender people approved	NA	NA	NA	

Discussion: Punishment-based harsh drug legislation continues to create service barriers for PWID. Changing drug legislation has been prioritised in every national strategic plan developed in the country over the past decade. The revision of drug legislation and adopting an amended package of relevant laws and regulations, should have been completed by 2017 (as per the Transition Plan); and this indicator was carried over into the latest national strategic plan, 2019-2022, with the target set by 2019. However, no tangible results have been achieved towards decriminalisation/depenalisation of drug use as of June 2021.

The purpose of HIV prevention service standards is to ensure that service providers offer all fundamental components of HIV services that are tailored to the specific needs of each target population across the country. Service standards define a comprehensive package of HIV prevention, care and support services that should be offered by the State after the Global Fund support ends. While the approval of the prevention service guidelines in 2020 has been considered a step forward, the RG members agree that national standards should be seen as a combined set of all major components: guidelines, service protocols and costings. To facilitate the transition process, it is essential to define the costs of standard prevention packages to be able to set policy priorities and make adequate budgetary allocations. In addition, the costing tool, if approved, will be an important instrument to identify in which interventions the Government should invest to produce optimal health outcomes with consideration of the economic perspective.

Some members of the RG doubt that approval of guidelines may lull the government into complacency, and the process of development and approval of service protocols and costings may be further postponed.

Conclusion: A fairly low degree of progress has been achieved by the Government in terms of good governance with a transition progress achievement score of 27%. Every Government that has been in power in Georgia over the last 15 years gives false promises about amending punitive drug legislation and in making drug policy more humanised; none of the Governments have kept this promise. Failing to create a conducive legal environment may jeopardise the sustainability of harm reduction services that currently operate without any legal basis.

Adoption and approval of HIV prevention service standards for key populations has not been fully realised: only service guidelines have been approved in 2020; approval of service protocols has been delayed; and the costing of HIV prevention services has not yet been developed. Given the importance of having approved HIV prevention standards for key populations in the transition phase, more advocacy from civil society and community groups will be needed to encourage the Government to foster this process.

Health Domain 5: Data and information

Average performance score for the domain: 0% - no progress has been achieved

All the commitments under this domain were related to conducting IBBS and PSE among key populations. As per the current national strategic plan, the IBBS and PSE among PWID and SW should have been completed in 2020. However, as of June 2021, no studies had been carried out. The delay in implementation of surveys may be due to COVID-19 related restrictions.

The annual achievement scores for each commitment in both years – 2019 and 2020 - as well as the 2-year average achievement scores for every commitment under *Domain 5 - Data and Information* are presented in Table 17, below.

Table 17. Assessment of the fulfillment of State commitments: Domain 5 - Data and Information

No.	Commitment	Indicator	2019	2020	Commitment average	Average performance by domain
5	Domain 5: Data and Information					0%
5.1	Up-to-date data from IBBS and PSE among PWIDs is accessible	IBBS & PSE among PWIDs conducted	NA	0%	0%	
5.2	Up-to-date data from IBBS and PSE among SWs is accessible	IBBS & PSE among SWs conducted	NA	0%	0%	
5.3	Up-to-date data from IBBS and PSE among MSM is accessible	IBBS & PSE among MSM conducted	NA	NA	NA	
5.4	Up-to-date data from IBBS and PSE among transgender people is accessible	Study among TG persons completed	NA	NA	NA	

Conclusion: There is a declared political commitment from the Government about ensuring the sustainability of second-generation surveillance studies among key affected populations; however, no investments have been made by the Government until now to progressively absorb the cost of IBBS/PSE studies. According to the Transition and Sustainability Plan developed in 2016, the State should have started financing IBBS from 2017. However, this commitment has not yet been realised and completing surveys relies on Global Fund support. Perhaps the Government has been slow to invest in research because there has been constant support from the Global Fund to cover the cost of IBBS and PSE among key population groups.

Health Domain 6: Human Resources

Average performance score for the domain: 0% - no progress has been achieved

As mentioned above, only one commitment was prioritised by the RG under Domain 6: Human Resources. The commitment was stated in the Transition and Sustainability Plan[46].

[46] Georgia Transition Plan 2017-2021. Tbilisi; Curatio International Foundation, 2017.

Implementation of this commitment should have started in 2018 and be completed by 2021. It aimed at integrating the Global Fund-supported training modules into the formal education system, as well as development of an e-learning platform that would facilitate access to capacity-building opportunities for medical and non-medical staff employed in the HIV field, including those from civil society organisations. Unfortunately, no progress to realise this objective has been evidenced in 2018-2020.

Table 18. Assessment of the fulfillment of State commitments: Domain 6 - Human Resources

No.	Commitment	Indicator	2019	2020	Commitment average	Average performance by domain
6	Health Domain 6: Human resources					0%
6.1	Integrate HIV training modules in the undergraduate and postgraduate education system to improve access to training opportunities (including for) CSOs	Number of training modules integrated into formal education system	0%	0%	0%	

Discussion: During Transition Monitoring, it was found that civil society organisations do not expect the Government to be committed to strengthen human resources in HIV, specifically referring to non-medical staff employed by CSOs. Thus, only one commitment from the Transition Plan[47] was prioritised with some hesitancy: no members of the RG regarded this commitment as 'very important'. There was an impression that it was picked up just to have at least one commitment under Domain 6. Nevertheless, no progress has been achieved until 2021 in terms of the institutionalisation and integration of the Global Fund-supported training modules into the formal and informal education system, or within e-learning platforms.

Conclusion: It seems that addressing the challenges related to human resources in health, including in the HIV field, has not been perceived as a priority issue by the Government. There were few interventions proposed in the Transition Plan[47] , such as: adopting a HR policy for continuous professional development of human resources for HIV/AIDS; defining professional competencies and qualification frameworks for various specialists; as well as accreditation/re-certification procedures, etc. It should be noted that none of these objectives has been realised until now.

Overall status of transition by programmatic area

This analysis is focused only on one programmatic area – HIV prevention. Commitments for different key population groups have been grouped together for the analysis, given their small number.

The majority of transition-related commitments are common and not specific to key population groups. In several domains, commitments are not disaggregated by key populations and the scores are identical for all three major groups. Therefore, assessing transition progress of programmatic areas of prevention for each key population has been challenging as data lacks robustness and representativeness. Nevertheless, below we present the transition progress for MSM, PWID and SW.

[47] Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs in Georgia, Ibid.

Domain: Financing - an average degree of progress has been achieved (with an overall combined score of 67%) for each key population group in terms of fulfilling the Government commitment. These commitments include ensuring an increased percentage share of State funding for HIV prevention services and to meet the co-financing requirements (both scored 100%), although the Government has failed to ensure State funding for IBBS and PSE for each target group (score of 0%).

Domain: Governance – an identical commitment specific to each target group was measured – development and approval of national HIV prevention standards (guidelines, protocol and costing) for each population group, with progress scored for each group being identical at 33%. However, one additional commitment under the domain – creating a conducive legal environment through amending drug legislation – was specific to PWID. Given that no progress was achieved to fulfill the latter commitment (progress score of 0%), the average score for transition progress for PWID was reduced to 16.5% - low progress.

Domain: Service provision – Government commitments in this domain were specific to each key population group.

- PWID: the calculation comprised three commitments: increased coverage of PWID with a HIV prevention package; increased number of syringes distributed to PWID per year; and increased access to OAT. The average score for all three commitments (96%, 64% and 124%, respectively) was calculated and the transition progress score was 95%. The result shows that significant progress was achieved towards transitioning HIV service provision for PWID.
- MSM: two MSM-specific commitments were identified: increased coverage of MSM with a HIV prevention package (progress score of 101%); and increased access to PrEP (progress score of 100%). An average score for the domain was 100%, showing that significant progress has been achieved in fulfilling the Government's commitment to HIV service provision for the MSM population.
- SW: only one SW-specific commitment – increased coverage of SW with HIV prevention services - was included in the domain with a progress score of 99%.

Domain: Drugs, Supplies and Equipment - one commitment – to ensure the uninterrupted supply of HIV prevention commodities, which is common for all three groups - was scored at 80%; specific to PWID was the additional commitment of uninterrupted supply of OAT medications) , with an overall score for PWID of 90%.

Domain: Human Resources – only one common commitment was included in the domain – integrating HIV related training programmes into the formal education system. No progress has been achieved in terms of fulfilling this commitment.

Domain: Data and Information – the Government has not fulfilled its commitment to ensure up-to-date data about PWID and SW from IBBS and PSE, resulting in 0% for these two population groups. This commitment was not applicable to MSM as the next round of IBBS among this group was not planned for 2019-2020.

Summary results

Table 19 and Figure 3, below, present summary data about the extent to which the Government has realised its declared commitments in all 6 health domains. Scores are presented in a pre-defined colour-coded system for better visualisation.

Table 19. Assessment of the fulfillment of State commitments: summary results for all domains

Health Domains	Progress	
Financing	67%	Average progress
Drugs, Supplies and Equipment	85%	Significant progress
Service Provision	98%	Significant progress
Governance	27%	Fairly low progress
Data and Information	0%	Low (no) progress
Human Resources	0%	Low (no) progress

Figure 3: Visualisation of summary results for all 6 health domains

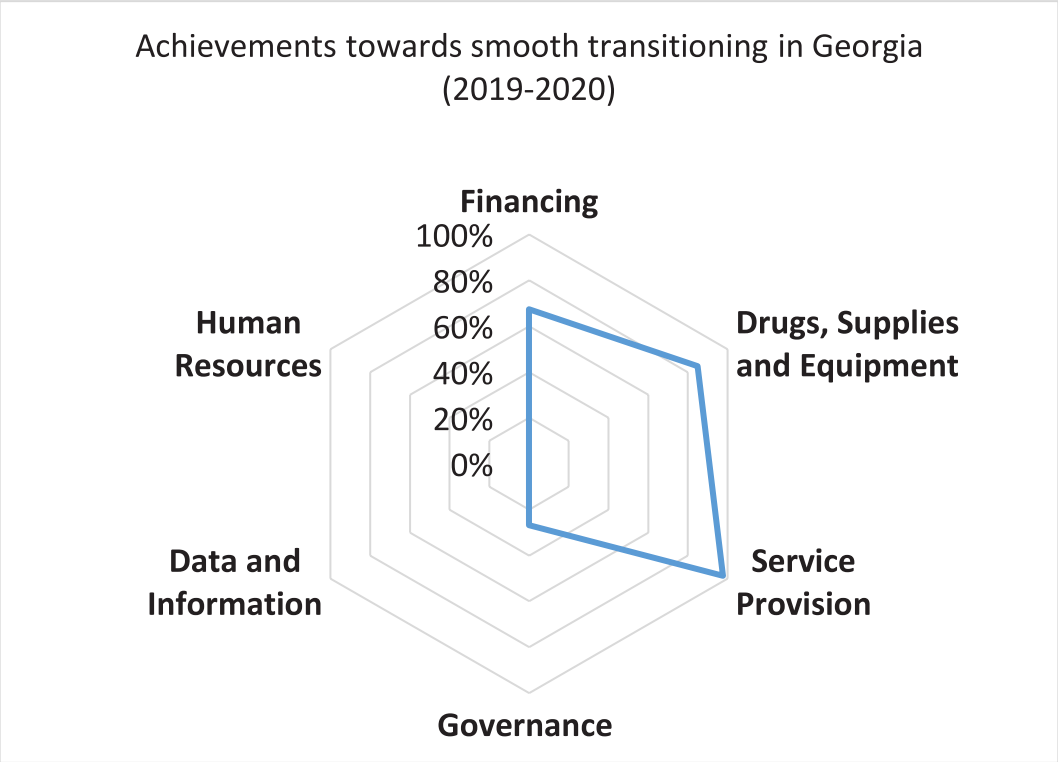


Table 20. Transition progress by health system domains within the programmatic area of HIV prevention

Health System Domain	Financing	Governance	Service Provision	Drugs, Supplies and Equipment	Human Resources	Data and Information
HIV_Prev:_MSM	67%	33%	100.5%	80%	0%	N/A
HIV_Prev:_SW	67%	33%	99%	80%	0%	0%
HIV_Prev:_PWID	67%	16.5%	95%	90%	0%	0%

Transition progress in HIV prevention by health system domains for each key population group is presented below:

Figure 4: Transition progress in HIV prevention among PWID by health system domain

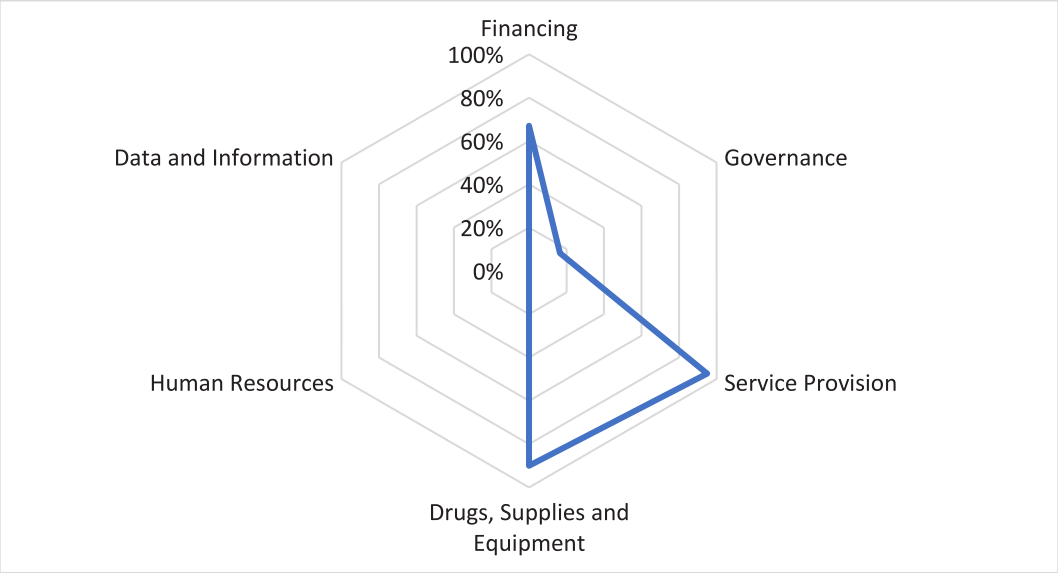


Figure 5: Transition progress in HIV prevention among MSM by health system domain

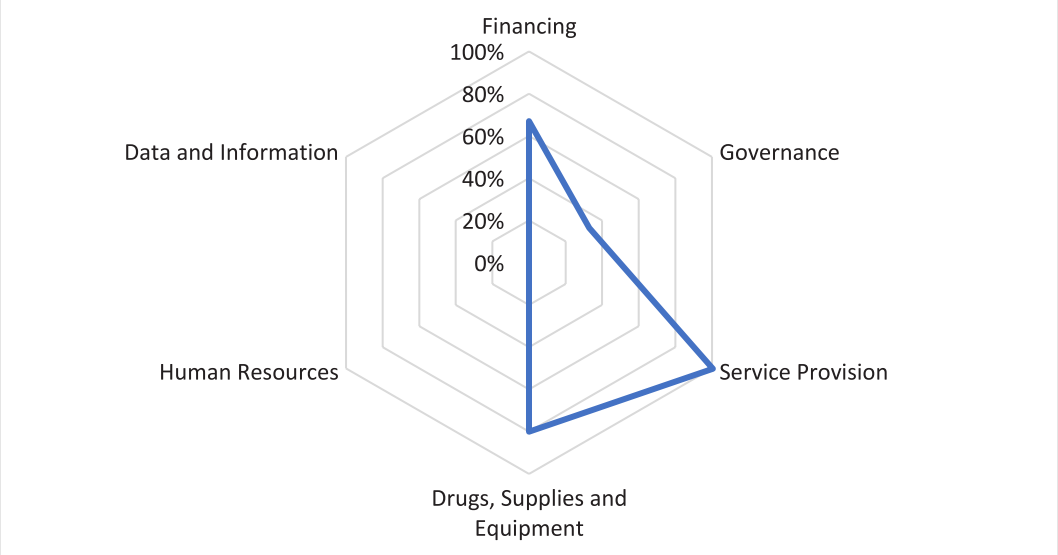
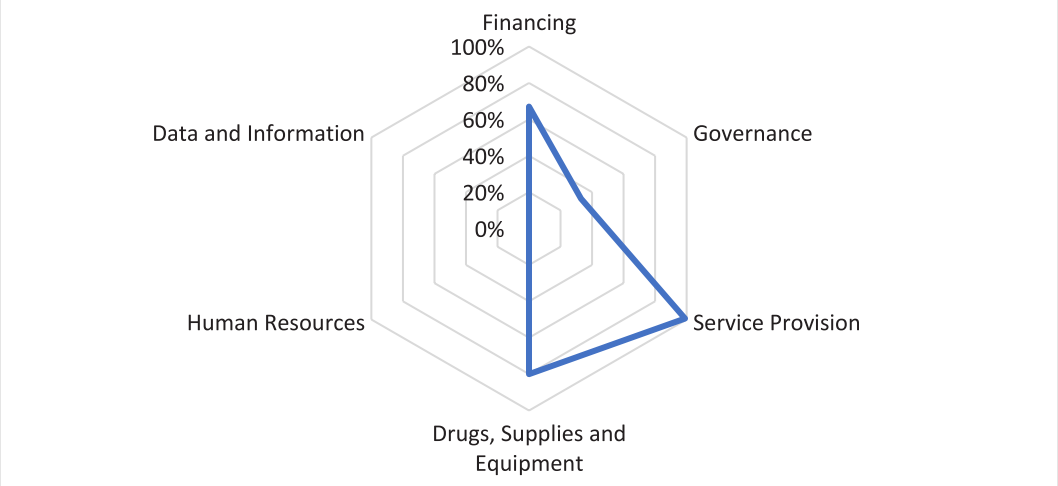


Figure 6: Transition Progress in HIV prevention among SW by health system domain



Recommendations and lessons learnt

To monitor Government commitments, they should be formally endorsed and legally binding: The Government commitments that are monitored through the TMT should be legally endorsed by the Government itself. For instance, the HIV national strategic plan of Georgia for 2016-2018 was approved by a Government resolution signed by the Prime Minister[48]; however, the latest HIV/AIDS Strategic Plan for 2019-2022, as well as the Georgia Transition Plan 2017-2021 have been approved only by the Policy and Advocacy Advisory Council (PAAC) and the CCM. Despite advocacy efforts, these two national-level strategic documents were not formally approved by the Ministry of Health, nor by the Government. While we do not underestimate the reputation and credibility of the CCM and the PAAC, we acknowledge that they lack legitimate decision-making power.

The National Strategic Plan for 2019-2022, and the Transition Plan for 2017-2021 are the two major sources from where the Government commitments were populated and then prioritised by the RG. We believe that the approval of the costed National Strategic Plan at the highest Government level will make the Government's commitments more legally binding. Thus, it seems to be important that civil society includes an additional indicator to report on whether the respective National Strategic Plan and budget have been approved by the Government or not. If the approval of a National Strategic Plan is procrastinated/avoided by the State, it should be seen as an alarming sign.

The national HIV strategic plan should be periodically reviewed and updated. Commitments should be well-formulated and targets for commitments should be set: The National Strategic Plan for HIV is a living document which requires periodic review and evaluation of performance. During the TMT exercise, it was found that most commitments were general rather that specific to key population groups. Tracking on national indicators is not routinely practiced and mid-term evaluation/revision of targets is done only when donor support becomes available, or when a review is requested (e.g. as a precondition for accessing a Global Fund allocation). In the latest National Strategic Plan, which was developed in 2018, there were some commitments that lacked annual targets or that were supposed to be defined after the signing of the new HIV grant agreement with the Global Fund. However, the revision has not taken place.

This challenge was most common for the commitments in the Domain – Financing. For instance, there were two commitments: *(1) increase State funding for HIV prevention interventions targeting KAPs;* and, *(2) provide State funding and contracts to non-state actors to deliver HIV prevention services/low threshold harm reduction services and community support services.* Neither of these two commitments have targets set and this prevented us from monitoring the fulfillment of these critical commitments.

[48] Government Resolution N326; 11 July 2016. Signed by the Prime Minister. http://www.georgia-ccm.ge/wp-content/uploads/HIV-strategy-2016-2018-GEO1.pdf

AIDS spending data should be reviewed and data discrepancies identified and addressed: The *Global AIDS Monitoring* (previously GARPR) (GAM) *Funding Matrix* has been the major source for obtaining data about State and donor expenditures disaggregated by programmatic areas and key population. While analysing finance data for the TMT, some inaccuracies or ambiguities were found that have never become a topic for debate among civil society organisations.

The TMT helped us realise that service provider CSOs, who are actively engaged in development of the GAM narrative report and producing quantitative indicators, are less involved in analysing the summary data about HIV expenditures to see the bigger HIV financing picture. Even though the Funding Matrix is accessible from the Ministry of Health upon request, so far CSOs/community groups have shown little interest to undertake a critical review of the data and initiate dialogue for clarification. Ideally, the spending tool (submitted in a form of protected excel worksheet) should be accompanied with an explanatory note spelling out what interventions are included in each spending category and the data sources. However, it does not seem feasible to request the Ministry of Health to add explanatory notes to the AIDS Spending Matrix unless it becomes a requirement of UNAIDS.

Some indicators measuring the Government's commitment should be modified to allow the capturing of genuine information: Through the TMT exercise, we realised that some indicators measuring the progress of commitments, which may seem commonly used and well-accepted measurements, in reality fail to capture genuine results. For instance, under the Domain - Financing, the commitment regarding increasing public financing of the HIV response is measured by the percentage share of public funding out of the total HIV spending. AIDS Spending data analysis for Georgia shows that while this indicator was consistently on the rise over the last three years, Government spending expressed in absolute numbers (USD) has declined over those three years. It is obvious that as the Global Fund support continues to drop, the share of public spending will automatically increase even if the Government cuts the budget for HIV in subsequent years. Civil society is encouraged to advocate for changing this measurement to avoid the misinterpretation of results in the future.

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Annex 1. The Transition Monitoring National Reference Group

	Name	Organization	Legal status
1	Medea Khmelidze	Real People Real Vision	CBO
2	Lasha Tvaliashvili	Real People Real Vision	CBO
3	Tamar gakhokidze	Real People Real Vision	CBO
4	David Subeliani	PWID Community	Community activist
5	Beka Gabadadze	LGBTQ+	CBO
6	Tamar Zurasvhili	PAAC; P&A specialist	Legally non-registered
7	Ketevan Bidzinashvili	Step to the Future, Gori	NGO
8	Koka Labartkava	New Vektor, Tbilisi	CBO
9	Lasha Abesadze	New Vektor, Rustavi	CBO
10	Nika Mirzashvili	Patients Union	CBO
11	Keti Kobiashvili	Patients Union	CBO
12	Nino Tsereteli	Tanadgoma	NGO
13	Bart Nikolo	Equality Movement	CBO
14	Maka Gogia	GHRN	CSOs
15	Zaza Karchkhadze	New Way, Kutaisi	NGO
16	Giorgi Soselia	MDM	NGO
17	Ina Inaridze	MDM	NGO
18	Makuna Uchaneishvili	Curatio International Foundation	NGO
19	Nikoloz Chkhartishvili	AIDS Center	AIDS clinic
20	Ketevan Stvilia	NCDC	LEPL
21	Irina Javakhadze	MoF; Budget department; Budget Formulation Division, Chief Specialist, PAAC/CCM member	LEPL
22	Eliso Bichashvili	MoJ; Medical Department of Special Penitentiary Service/Coordinator of Primary Healthcare Services Unit	LEPL

Annex 2. Process and results of commitment prioritisation

As a part of the study, the national review and the reference group assured prioritisation of the commitment; in accordance with the methodology and in exceptional cases, the group has also made modifications in the existing commitments and established new ones.

Commitments removed

Out of the initially reviewed 47 commitments, 19 were considered either irrelevant or less critical to monitor the transition process and were removed from the TMT. For instance:

- ***Ensuring OAT for prisoners:*** Since 2017, the Government has already assumed full responsibility to finance OAT for PWID in both the civil sector and correctional settings; therefore, the RG opted to keep only one indicator about OAT in the civil sector and removed the 2nd indicator about OAT in prisons;

- ***Develop 4-pillar Drug Policy, anti-drug strategy and 3-year action plan to create a conducive legal environment for the HIV response and remove barriers to services:*** This commitment has already been fulfilled. A Strategy and Action Plan 2021-2022 was developed and approved by the State Interagency Council on Drug Prevention on 5 February 2020[49];

- ***Revise State Procurement Law and regulations to improve access to public funds for CSOs working in the field of HIV prevention and care:*** This commitment was considered no longer relevant. CSOs have already started participating in State tenders. In 2020-2021, the NCDC contracted CSOs under the State Procurement Law to deliver HIV prevention services;

- ***Conduct four surveys among various populations:*** IBBS among prisoners (1); HIV vulnerability and size estimation study among children living and working on the streets (2); HIV vulnerability study among migrants (3); and an IBBS among youth (4). The RG considered these commitments important, though less critical taking into account the current context and budgetary limitations of the Government;and,

- ***Several commitments in the Service Provision domain:*** increased number of MSM, PWID and SW who were tested and know the results – these were also removed as the RG believed that coverage of key populations with the HIV prevention package would be sufficient to monitor the transition process.

Commitments modified

The commitments by the Government to develop and approve national standards for HIV prevention among PWID, MSM, SW and youth have been slightly modified to better capture the progress, as well as the remaining gaps, within the context of transitioning.

[49] https://justice.gov.ge/Ministry/Index/308?fbclid=IwAR10CvxRt-KV45GWjBc8zf7GnSUWbkUsc8iDWj1Ct7pul6ksDJIIrqcnwAs

It should be noted that with the financial support of the Global Fund and UNFPA, and through collaborative efforts involving NCDC and civil society organisations, national guidelines and protocols for HIV prevention services for four groups - PWID, MSM, SW and youth - were developed as early as 2017-2018. However, procrastination in the approval process means that only in 2020, through the support of the Deputy Minister of Health, Dr. Tamar Gabunia, only the national guidelines were approved[50]. Civil society organisations have been concerned that approval of service protocols and costing may be overlooked or further delayed. Thus, the RG initially decided to remove the Government commitment on approval of national guidelines from the matrix and to add new commitments – 'approval of protocols and costings for key populations'. However, in this case, the TMT would omit the progress achieved by the Government in 2020 (the timeframe within which the TMT is being conducted) and would focus only on those commitments that have not yet been fulfilled. This, in turn, may not seem to be a fair judgement for some stakeholders.

Eventually, the RG proposed modifying the commitment to emphasise all three necessary components of service standards: service guidelines, service protocols and costing. Following this modification, the measurement method for the purpose of the TMT was also defined: development and approval of each of the three components was assigned an equal, one-third, score of 100%; approval of a guideline sets the value at 33.3%; approval of any additional component, at 66.7%; and completing the whole process will be assessed as fulfilling the commitment with a 100% achievement score.

Table 21: Modified Commitments

Domain 4: Governance		
Ind. Ref.	Previous formulation	Proposed new formulation
NSP. Service Delivery. SD.72	Development and approval of the National Standard on HIV prevention among MSM.	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among MSM.
NSP. Service Delivery. SD.73	Development and approval of the National Standard on HIV prevention among SW.	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among SW.
NSP. Service Delivery. SD.74	Development and approval of the National Standard on harm reduction for PWID.	Development and approval of the National Standard (guideline, protocol and costing) on harm reduction for PWID.
NSP. Service Delivery. SD.75	Development and approval of the National Standard on HIV prevention among Youth.	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among Youth.

[50] Ministerial Order No 01-16/ო January 24, 2020

New commitments added

The RG identified gaps in commitments and, in total, 9 new commitments were added based on the consensus reached. For some newly added indicators, no targets were set and they were not analysed for this monitoring cycle. For some indicators, operational definitions were also agreed.

Identifying a new target group – transgender persons - has necessitated adding new commitments: In the national HIV/AIDS strategy, four major target groups have been defined for HIV prevention interventions: MSM, SW, PWID and prisoners. Over the last few years, increased vulnerability of the transgender population (TG) has emerged, and civil society has been advocating for adding this population as a separate group with specific needs to be covered within the HIV national response. The current National Strategic Plan mentions transgender population under the same section as the MSM population.

As a result of advocacy efforts, in 2021 the reference group working on the development of the country proposal for the next Global Fund period 2022-2025 made a clear statement that TG people will become a new priority group (proposal finalisation is in progress and will be ready for submission in August 2021). Following this change, specific commitments about TG people will be added to the Monitoring and Evaluation (M&E) of the National Strategic Plan. The RG, members of which were also actively involved in the Global Fund proposal development and the National Strategic Plan mid-term review process, proposed to add relevant commitments to the TMT as well. These commitments have been distributed across various health domains, as follows:

- **Impact: Control HIV spread among the transgender population:** In addition to having targets set to contain the HIV epidemic among PWID, SW and MSM, an indicator measuring HIV prevalence among transgender people has been added. No target was set as no baseline data exists for this group;

- **Domain 3: Service Provision: Ensure access to HIV prevention services by transgender people:** The Government should be committed to ensuring increased access to HIV prevention services targeting TG people; a corresponding indicator – *'share of transgender people covered with a combined set of HIV prevention services'* – has been added. Besides, the definition of a combined set of HIV services in future should be based on the types of services offered to TG people;

- **Domain 4:** ***Governance:*** Development and approval of HIV prevention national standards for TG people which should consist of a national guideline, service protocol and costing; and,

- **Domain 6:** ***Data and Information: Up-to-date data from IBBS and PSE for transgender people is accessible:*** Currently, no research targeting the transgender population has been carried out in Georgia. Therefore, conducting IBBS and a PSE study among transgender persons becomes a critical enabler for evidence-based programming. Ideally, surveillance surveys among TG persons should be completed no later than 2022.

Domain 1: Financing: Meet co-financing incentive requirement by allocating a defined share of additional investments for HIV prevention targeting key populations. The RG proposed to include a new commitment into the TMT to monitor the realisation of transition and co-financing requirements. The Global Fund Sustainability, Transition, and Co-financing policy sets out two

core co-financing requirements to access a national Global Fund allocation. As Georgia is classified as an upper lower-middle-income country, at least 50% of allocation funding should be for disease-specific interventions for key and vulnerable populations. In addition, to further encourage domestic investment, at least 15% of a country's allocation is a co-financing incentive made available if a country realises additional domestic commitments over the implementation period (relative to expenditure over the previous implementation period)[51]. In the next funding cycle – 2022-2025 - the Government should invest an additional USD2.6 million to meet its co-financing requirement; out of this amount, at least 75% should be spent on services targeting key populations. Data can be verified by the formal report submitted by the Government to the Global Fund as well as by analysing AIDS spending data submitted to UNAIDS within the GAM reporting cycle.

Domain 2: Drugs, Supplies and Equipment: 3 new commitments were added to the TMT that would encourage the Government to: **a**) **ensure the uninterrupted supply of ARV drugs for PLHIV; b**) **ensure the uninterrupted supply of OAT medications for PWID; and, c**) **ensure the uninterrupted supply of prevention commodities** (**condoms, lubricants, naloxone, syringes and other safe injection paraphernalia**) **for key population groups.**

Until 2020, civil society organisations have not reported substantial stock-outs of key products in Georgia. However, in 2020, (and also continues into 2021) there were noticeable stock-outs of harm reduction supplies including condoms and naloxone within the GHRN organisations that lasted for a few weeks. This fact has encouraged civil society to add additional commitments to the TMT and to agree on a formulation and measurement method (for more details see , above).

Domain 2: Drugs, Supplies and Equipment: Achieve lower prices for ARVs to ensure the sustainable and reliable supply of the full range of needed ARVs: Procuring ARV drugs at optimal prices is of critical importance during the transition period. The commitment will be monitored by measuring the ratio of actual ARV prices over reference pricing[52] established.

Table 22: Summary of New Commitments added

Areas	New commitment/indicator	Comment
Impact	Prevent HIV spread among transgender persons/ Percentage of TG living with HIV.	Starting from 2022, TG people will be added as a separate target group in the National HIV strategy.
Financing	Meeting co-financing incentive requirement - for allocating defined share of additional investments for prevention targeting key populations.	Per the Global Fund allocation letter, at least 50% of allocation should be spent on services targeting key populations.

[51] https://www.theglobalfund.org/media/4755/fundingmodel_applicanthandbook_guide_en.pdf

[52] Programme budget figures, Ibid.

Areas	New commitment/indicator	Comment
Drugs, Supplies and Equipment	Ensure the uninterrupted supply of ARV drugs/ Number of episodes in a year when stock-out of ARV drugs for more than 3 consecutive days was observed.	Operational definition was defined. Targets were agreed with the RG.
	Ensure the uninterrupted supply of HIV prevention commodities/ Number of episodes in a year when stock-out of at least one prevention product (naloxone, syringes, condoms, lubricants) for more than 7 consecutive days was observed.	Operational definition was defined. Targets were agreed with the RG.
	Ensure uninterrupted supply of substitution medication / Number of episodes in a year when stock-out of substitution medication for more than 3 consecutive days was observed.	Operational definition was defined. Targets were agreed with the RG.
	Achieve lower prices for ARVs to ensure the sustainable and reliable supply of the full range of needed ARVs/ Ratio of actual ARV prices in Georgia over reference pricing.	Operational definition was defined. Target was set at 1 – the costs of ARVs procured in Georgia do not exceed reference pricing levels.
Service Coverage	Increase coverage of HIV services for transgender people / Share of transgender persons receiving a combined set of HIV prevention services.	New commitment targeting TG persons. No baseline exists; no targets were set.
Governance	Ensure quality and a comprehensive set of prevention services for transgender people; development and approval of National Standards (guideline, protocol and costing) of HIV prevention among transgender persons.	New commitment targeting TG persons.
Data and Information	Up-to-date data from IBBS and PSE among transgender people is accessible.	With the introduction of this new target group, IBBS among TG should be conducted.

Annex 3. Commitment Matrix

No.	Results, impact and outcomes	Source document	Action	Indicator	Baseline (year)	Final Target (year)	Target / Data collected		Overall achievement
							2019	2020	
I.1	Reduce HIV prevalence rate per 100,000 population	NSP. Impact Indicator: Imp.1	NA	HIV diagnosed person per 100,000 (target less than:)	400 (2017)	500 (2022)	500 / 500	500 / 500	100%
I.2	Reduce AIDS-related mortality	NSP. Impact indicator: Imp.2	NA	The number of AIDS related deaths per 100,000 population (target - less:)	1.90 (2017)	2 (2022)	2 / 2	2 / 1.8	106%
I.3	Contain HIV epidemic among MSM	NSP. Impact indicator: Imp.3	NA	Percentage of MSM who are living with HIV (target - be contained under <X%)	21% (2015)	25% (2022)	25% / NA	25% / NA	NA
I.4	Contain HIV epidemic among SW	NSP. Impact indicator: Imp.4	NA	Percentage of SW who are living with HIV (target - be contained under <X%)	2% (2017)	2% (2022)	2% / NA	2% / NA	NA
I.5	Contain HIV epidemic among PWID	NSP. Impact indicator: Imp.5	NA	Percentage of PWID who are living with HIV (target - be contained under <X%)	2.3% (2017)	3% (2022)	3% / NA	3% / NA	NA

I.6	Prevent the spread of HIV among the general population	NSP. Impact indicator: Imp.6	NA	HIV Incidence rate per 1,000 population (target - to be contained under <X)	0.22 (2017)	0.10 (2022)	0.19 / 0.17	0.16 / 0.17	103%
I.7	Prevent the spread of HIV among transgender persons	New commitment/ No source	NA	Percentage of TG living with HIV	NA	NA	NA	NA	NA
No.	**Commitment**	**Source document**	**Action**	**Indicator**	**Baseline**	**Final Target**	**2019**	**2020**	**Means of verification**
1	**Financing**								
1.1	Ensure adequacy State budget allocations for HIV prevention and treatment	NSP. Financing: Fin.55	Allocate budget	The share of public spending out of the total HIV spending	76% (2018)	86% (2021)	79% / 89%	85% / 78%	102%
1.2	Increase State funding of HIV prevention interventions targeting KAPs	NSP. Financing: Fin.56	Allocate budget	% share of public funding on HIV targeting KAPs	NA (2018)	10% (2021)	NA	NA	NA
1.3	State provides funding and contracts to non-state actors to deliver HIV prevention services/ low threshold harm reduction (excluding OST) services and community support services	NSP. Financing: Fin.57	Allocate budget	Total funding allocated by the State to CSOs/CBOs to deliver HIV prevention/harm reduction services (excluding OST)	NA	NA	TBD / NA	TBD / NA	NA
1.4	Ensure sustainable State funding of IBBS and PSE among KAPs	NSP. Financing: Fin.58	Allocate budget	The number of IBBS/PSE among KAPs conducted through State funding	0 (2017)	2 (2020)	NA	2 / 0	0%

1.5	Meet co-financing incentive requirement for allocating defined share of additional investments for prevention targeting KPs.	New commitment/No source	Allocate budget	Co-financing incentive requirement for allocating defined share of additional investments for targeting KPs is met	NA		Yes / Yes	Yes / Yes	100%
2	**Drugs, supplies and equipment**								
2.1	Ensure uninterrupted supply of ARV drugs	New commitment/ No source	Allocate budget; Plan procurement effectively	Number of episodes in a year when stock out of ARV drugs for more than 3 consecutive days was observed	NA	0	0 / 0	0 / 0	100%
2.2	Ensure uninterrupted supply of HIV prevention commodities	New commitment/ No source	Allocate budget; Plan procurement effectively	Number of episodes in a year when stock out of at least one prevention product (naloxone, syringes, condoms, lubricants) for more than 7 consecutive days was observed	NA	0	0 / 0	0 / 2	80%
2.3	Ensure uninterrupted supply of substitution medication	New commitment/ No source	Allocate budget; Plan procurement effectively	Number of episodes in a year when stock out of substitution medication for more than 3	NA	0	0 / 0	0 / 0	100%

				consecutive days was observed					
2.4	Achieve lower prices for ARV to ensure the sustainable and reliable supply of the full range of needed ARVs	New commitment/ No source	Negotiate prices of ARV drugs	Ratio of actual ARV prices in Georgia over reference pricing	NA	1	0 / NA	1 / 3	60%
3	**Service Provision**								
3.1	Care cascade: Improve HIV case detection	NSP. Outcome indicator: O.8	Improve case detection through intensified targeted testing	Percentage of PLHIV who know their HIV status	48% (2017)	90% (2022)	70% / 75%	90% /76%	96%
3.2	Ensure uninterrupted delivery of high-quality treatment and care	NSP. Coverage indicator: Cov.44	Ensure uninterrupted delivery of high-quality treatment and care	Percentage of PLHIV diagnosed with HIV receiving ARV at the end of the reporting year	81% (2017)	90% (2022)	90% / 86%	90% / 86%	96%
3.3	Ensure uninterrupted delivery of high-quality treatment and care	NSP. Coverage indicator: Cov.45	Ensure uninterrupted delivery of high-quality treatment and care	Percentage of people on ARV who are virally suppressed (VL<=1,000 copies /ml)	89% (2017)	90% (2022)	90% / 91%	90% / 94%	103%
3.4	Increase coverage of PWID with HIV services	NSP. Coverage indicator: Cov.16	Provide service	Percentage of PWID reporting having received a combined set of HIV prevention packages (last year) **(programme data)**	52% (2017)	75% (2022)	65% / 68%	70% / 62%	96%

3.5	Increase coverage of PWID with HIV services	NSP. Outcome indicator:).14	Provide service	Number of syringes distributed to one PWID during one year (# of syringes per person/per year)	73 (2017)	140 (2022)	110 / 76	120 / 70	64%
3.6	Increase coverage of PWID with HIV services	NSP. Coverage indicator: Cov.19	Provide service	Number of PWID receiving OST	8038 (2017)	11000 (2022)	9500 / 11206	11000 / 14300	124%
3.7	Increase coverage of MSM with HIV services	NSP. Coverage indicator: Cov.23	Provide service	Percentage of MSM reporting having received a combined set of HIV prevention packages (last year) (**programme data)**	22% (2017)	60% (2022)	40% / 48%	45% / 38%	101%
3.8	Increase coverage of MSM with HIV services	NSP. Coverage indicator: Cov.26	Provide service	# MSM receiving PrEP at least once during the year	50 (2017)	1000 (2022)	250 / 258	500 / 487	100%
3.9	Increase coverage of SW with HIV services	NSP. Coverage indicator: Cov.27	Provide service	Percentage of SW reporting having received a combined set of HIV prevention packages (last year) **(programme data)**	52% in Tbilisi, Kutaisi, Batumi, Zugdidi, Telavi (2017)	60% (2022)	55% / 71%	60% / 42%	99%

3.10	Increase coverage of transgender people with HIV services	New commitment/ No source	Provide service	Number of transgender people receiving HIV prevention services (programme data)	NA		0 / NA	0 / NA	NA
4	**Governance**								
4.1	Create conducive legal environment for HIV response to remove barriers to services	NSP. Governance and Policy: G&P.49	Revise drug legislation towards decriminalisation of drug use to reduce service barriers	Revised legislation reduced (removed) legal barriers to service	NA	Yes (2019)	Yes / 0	NA	0%
4.2	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among MSM	NSP. Service Delivery. SD.72	Development and approval of national standard	National Standard on HIV prevention among MSM approved	NA	Yes (2020)	NA	Yes / Yes. partially	33%
4.3	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among SW	NSP. Service Delivery. SD.73	Development and approval of national standard	National Standard on HIV prevention among SW approved	NA	Yes (2020)	NA	Yes / Yes. partially	33%
4.4	Development and approval of the National Standard (guideline, protocol and costing) on harm reduction for PWID	NSP. Service Delivery. SD.74	Development and approval of national standard	National Standard on HIV prevention among PWID approved	NA	Yes (2021)	NA	NA / Yes. partially	33%

4.5	Development and approval of the National Standard (guideline, protocol and costing) on HIV prevention among Youth	NSP. Service Delivery. SD.75	Development and approval of national standard	National Standard on HIV prevention among youth approved	NA	Yes (2021)	NA	NA / Yes. partially	33%
4.6	Development and approval of the National Standard (guideline, protocol and costing) of HIV prevention among transgender people	NA	Development and approval of national standard	National Standard on HIV prevention among transgender people approved	NA		NA	NA	
5	**Data and Information**								
5.1	Up-to-date data from IBBS and PSE among PWID is accessible	NSP. Health Information System: HIS.60	Conduct IBBS and PSE among PWID	IBBS & PSE among PWID conducted	NA	Yes (2020)	NA	Yes / 0	0%
5.2	Up-to-date data from IBBS and PSE among SW is accessible	NSP. Health Information System: HIS.61	Conduct IBBS and PSE among SW	IBBS & PSE among SW conducted	NA	Yes (2020)	Na	Yes / 0	0%
5.3	Up-to-date data from IBBS and PSE among MSM is accessible	NSP. Health Information System: HIS.63	Conduct IBBS and PSE among MSM	IBBS & PSE among MSM conducted	NA	Yes (2021)	NA	NA	
5.4	Up-to-date data from IBBS and PSE among transgender people is accessible	New commitment/ No source	Conduct IBBS/PSE among transgender people	Study among TG persons completed	NA		0 / NA	0	
6	**Human resources**								
6.1	Integrate HIV training modules into the undergraduate and postgraduate education system to improve access to training opportunities (including for CSOs)	TSP. Human Resources: HR.3	Training institutionalization	Number of training modules integrated into formal education system	NA	25 (cumulative) (2021)	5 / 0	5 / 0	0%