

HIV/AIDS in Georgia

Addressing the Crisis

*Tamar Gotsadze
Mukesh Chawla
Ketevan Chkatarashvili*



THE WORLD BANK

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THE WORLD BANK
Washington, D.C.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
API	AIDS Program Effort Index
ARV	Anti-retroviral
BBP	Basic Benefit Package
BD	Blood Donor
CDC	Center for Disease Control
CEE	Central and Eastern Europe
CSW	Commercial Sex Worker
DIF	Direct Immuno-fluorescence
ELISA	Enzyme-Linked Immunosorbant Assay
EU	European Union
FGD	Focus Group Discussion
FP	Family Planning
FCSW	Female Commercial Sex Worker
GORBI	Georgian Opinion Research Business International
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH
ICRC	International Committee of the Red Cross
IDP	Internally Displaced People
IDU	Injecting Drug User
IEC	Information, Education, Communication
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
KAP	Knowledge, Attitude, Practice
MDR	Multi-Drug Resistance
MoLHSA	Ministry of Labor Health and Social Affairs
MSF	Medicines Sans Frontiers
MSM	Men who have sex with Men
NGO	Non-governmental Organization
NIS	Newly Independent States
OSGF	Open Society Georgian Foundation
PHD	Public Health Department
PSI	Population Service International
PY	Person Year
RH	Reproductive Health
SO	Strategic Objective
STD	Sexually Transmitted Diseases
TB	Tuberculosis
TG	Theme Group
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

HIV/AIDS is increasingly being recognized as a major impediment to development. As a result many developing countries have attempted to “mainstream” HIV/AIDS into instruments of development. In a country like Georgia, where PREGP serves as the country’s agenda for poverty reduction and economic growth, it is crucial to make credible proposals for the inclusion of HIV/AIDS in the poverty reduction effort.

The World Bank is well positioned to advocate and assist Georgia in seizing more fully the current and future opportunities to bring HIV/AIDS to the forefront of the national priorities to alleviate poverty. The report is intended primarily for the use of World Bank staff; it can also provide guidance to governments, other international agencies, and non-governmental agencies in the design and implementation of HIV prevention and mitigation programs in Georgia.

The paper attempts to give an insight into the complex mechanics of the epidemic and to provide an overview of the challenges and opportunities in addressing the problem of HIV/AIDS in Georgia, besides identifying the assistance needed to build capacity to improve the design of national response program. It presents information concerning selected HIV/AIDS topics relevant to Georgia, and attempts to project the status of the epidemic in the country for the years 2005–2010. This is done by offering examples of ways in which the country has responded to the epidemic, discussing alternative actions for addressing the emerging crises, and highlighting a range of strategies for donor coordination and cooperation, including the World Bank.

The Problem

Georgia is experiencing fast growing HIV/AIDS epidemic, although the prevalence remains at low level. The primary mode of transmission are injecting drug users representing 71 percent of cases, followed by 22 percent heterosexual contacts, 3.6 percent homo-bisexual contacts, 1.4 percent blood recipients, 1 percent of vertical transmission.

From 1989 to 1998 the epidemic progressed slowly with sporadic occurrences. However, even at this low level of transmission, the infection had reached all administrative regions of the country. Since 1996 the situation has changed dramatically. The number of HIV cases increased nearly

three fold in 1997 compared with the previous year and accounted for 21 cases. In 2001 alone, this number reached 93. From 1998 through 2001 more than half of newly-registered HIV infection cases have been attributed to IDUs. The reports indicate that the percentage of new cases attributed to heterosexual contacts have also increased, although the absolute numbers remain small. More people (mostly women) appear to be contracting HIV through sexual transmission, suggesting a shift of the epidemic into the general population.

HIV/AIDS is predominantly present in the age group of 21–35 years, while children between the ages of 5 and 15 provide a special opportunity and window of hope. In 2001, over 87 percent of all new AIDS cases are detected in the individuals of 26–35 years age group. As this is the most economically productive segment of the population, deaths in this age group cause great economic hardship to the families. Many productive years and investment in education and training is thus lost. These deaths also have significant family consequences, since most people in this age are raising young children.

During the last three years three cases of HIV infection have been detected among pregnant women, and two cases of vertical transmission have been reported, thus sexual mode of transmission becomes apparent. The situation is further complicated with the transfusion of non-screened blood in case of emergencies becoming a common practice due to the failure of adequate public financing on the one hand, while the number of infected blood donors is increasing on the other.

Risks and Contributing Factors

There is a sharp increase in the number of intravenous drug users (IDUs) as well as drug addicts, especially in the adult population. Incidental recreation drug use, high risk drug and injection practices paired with high sexual activity of the latter are becoming common.

Similar to the other developing countries in the region, a marked increase of STDs is observed in Georgia, mainly being prevalent in young people and in male population, predominantly present in in-employed economically active population and in the group of people working on streets (CSW and MSM) and transport sector.

Commercial sex work (CSW) is considered to be one of the most significant tribulations. About 50 percent of women engaged in the commercial sex industry belong to the 16–25 age group. Majority of CSW are single or divorced, and 49 percent of those married have children. About half are unemployed, while the rest consider themselves self-employed. Main reason for being involved in this sector appears to be poverty and lack of financial means and adopting this profession appears to be the only way to earn money and support families.

MSM are highly stigmatized in Georgia. Although the level of HIV/STD awareness in this group appears to be slightly higher than in other risk groups, risky behavior is quite common. Majority of MSM are involved in sex industry, however not because of poverty but lack of partners characterized with higher level of occasional contacts.

The harsh social and economic conditions of the country during past years are reflected in deteriorating health and education of children and adolescents. The role of the family in education has declined, the role of school in formation of future generation psychology has been attenuated, and the system of extra-school activities of alternative education and leisure time organization has been disrupted. As a result the adolescents have become exposed to the strong influence of street life manifesting itself in the anti-social activities of minors and adolescents like smoking, alcoholism, drug-abuse, prostitution, etc. At the same time, it has also stimulated migration.

A cumulative number of registered TB cases declined by 9.6 percent and morbidity by 5.5 percent, which points to the moderate effectiveness of National TB Program, but leaving MDR cases stable. TB is predominant in 24–45 years old individuals, although the incidence in young population is also on the rise, especially in males, and TB morbidity in AIDS patients has been increasing during the past years.

TB is particularly worrisome in the prisons. The prisons are the recipients of a multiple pronged and uncontrolled TB epidemic. These dual prison epidemics are driven by: (i) an inadequate infra-

structure and insufficient resources; (ii) a unique combination of overlapping risk factors, such as severe overcrowding, poor ventilation, prolonged exposure to under-treated/active TB cases, and general under-nutrition associated with the stress of confinement; and, (iii) low government priority status compared to unmet civilian needs.

Apart from TB, the HIV infection is also prevalent in Georgian prisons. Two main conditions influence the prevalence of HIV among prisoners: (i) the prevalence of HIV among IDUs in prison community, and (ii) the criminal sentencing policy for drug related crimes.

Increased migration further aggravates the threat of the epidemic. Since 1990 the scale of external migration has significantly increased. Males make up to 57.1 percent of the arrived and departed migrants, and the females represent 42.9 percent. External migration is more common towards Russia (50 percent), Turkey (13 percent), and Ukraine (7 percent). The contributing role of migration on spreading of HIV/AIDS is evident from available epidemiological data. Forty-five percent of HIV positive cases registered in Georgia and 78 percent of injecting drug-users were infected in Ukraine and Russia.

Occupational risks to HIV infection in health care sector are quite wide and represent: (i) outdated sterilization equipment; (ii) poor sterilization due to electricity shortages; (iii) lack of single use consumables, like gloves, syringes, etc. (iv) frequent use of non-tested blood in emergency cases; (v) no follow-up mechanisms for the needle stick accidents; and, (vi) poor medical waste management.

National Response Analysis

Georgia was one of the countries in the NIS that immediately reacted to the epidemic. However, there is considerable room for improvement. Best efforts have occurred in the establishment of organizational structure, legal, and policy areas. Even in these areas notable improvements are needed primarily to ensure that policy is implemented in a conducive legal environment that protects human rights of people regardless of their affiliation either to risk groups and/or to HIV/AIDS patient groups.

The political commitment of national leaders to confront HIV/AIDS has been a major concern to many. Commitment has been weak and this has affected programs in a variety of ways. One of the weakest areas being availability of resources to support an effective response. Although financial resources increased in past two years mainly due to donor contributions, the increase was small compared to other components and political commitment has not yet led to a similar increase in resources.

The analysis show quite clearly that the effort that is currently being made to care for people living with HIV/AIDS is the weakest component of the program. Care and availability of adequate services are the lowest rated components. Service availability is a major problem as the most of population does not have access to the services. The response is relatively positive in supporting safe blood, condoms and STDs services, while other services reached less than half of the population.

United Nation agencies and other international donors are making a significant contribution to the program effort. It is apparent that international assistance is a positive factor and international contribution is greatest for policy, planning and prevention and weak for care.

Policy Implications

Government's comprehensive and multi-sectoral national strategy should aim to generate greater political commitment, to mobilize more resources from, within and outside of the country, and to replicate on a national scale a more comprehensive program that includes an increased number of interventions targeted at virtually all groups in the society. The response should emphasize prevention as well as treatment, policies and programs to mitigate the impact of AIDS, and policies that will change the societal factors that influence vulnerability to HIV in the long term.

Priority Areas and Strategic Actions for Strengthening National Response Capabilities are:

Objectives:	Priority Areas of Intervention	Strategic Actions
Mitigating the impact of the epidemic on social and economic development	Strengthening country's capacity to develop and implement policies aimed at reducing the incidence of HIV/AIDS: Policy Development	Target leadership in critical sectors; Strengthen policy analysis through enhanced research on effectiveness of intervention, social and economic impact assessment, behavior assessment, define best practices etc; Development of mechanism and procedures for the involvement of stakeholders from different sectors and civil society in the process of policy development; Strengthen HIV/AIDS surveillance.
	Development of enabling legal environment for policy implementation	Promote human rights and non-discrimination through careful analysis of existing legislation and enhance and/or modify areas where necessary.
	Priority Setting and resource allocation	Develop coordinated approaches for resource mobilization; Base resource allocation on the investment justification and efficiency.
	Establishment of capacity in both public and private sectors to address the HIV/AIDS epidemic	Support capacity building in key agencies; Strengthen monitoring and evaluation capacity; Network with regional/district agencies and NGOs.

Strategic Options for the World Bank Involvement

In response to the ever-changing nature of the epidemic, the World Bank can play a key role in intensifying action against AIDS and in strengthening country's response. This could be achieved by adopting country/sub-regional specific strategy, which may encompass the following:

Advocacy

The World Bank is well positioned to advocate and lead policy dialogue with the government to ensure that HIV/AIDS is placed at the top of the development agenda. To be instrumental and convincing, the institution has to enhance its knowledge on the best practice stories, country experiences available, as well as other country and sub-regional studies undertaken by others institutions and authors. Another area, where the Bank can play an important role is to advocate the government on strengthening and extensive involvement of the civil society in development and implementation of HIV/AIDS strategy.

Research

The Bank, as well as government, has to extend knowledge base through the support of operational research, increase resources and technical support to mainstream HIV/AIDS into all sectors. This is an area where the Bank could play an active role by supporting the technical expertise as well as providing funding to the committed governments.

Coordination

HIV/AIDS response needs to be stretched well beyond the health sector domain, and there is a need and opportunity for the World Bank to further enhance its active participation in the UN

Theme Group on HIV/AIDS. Moreover, it needs to strengthen and expand partnership with UNAIDS, other co-sponsors and interested by-lateral agencies with a view toward implementation of the National HIV/AIDS strategy in the country.

Apart from coordination with the outside world, the World Bank may focus on introducing innovative coordination mechanisms between different sector teams working in the country. Moreover, coordination with the International Finance Corporation (IFC) to promote private sector involvement could be explored. Building upon IFC-supported private/public partnerships, efforts could be made to enlist the participation of private firms interested to invest in Georgia to support HIV/AIDS prevention and to control efforts as part of risk-minimization strategies.

Technical Assistance

The World Bank can consider providing technical assistance to Georgia on issues such as:

(i) economic impact of HIV on fragile economy of the country; (ii) the process of governmental planning for HIV/AIDS within the context of evolving economic and social conditions; and (iii) support efforts of the HIV/AIDS State Commission to mobilize Georgian leaders, civil society organizations, religious groups and private sector to intensify action against HIV/AIDS.

Lending

The World Bank's presence in the health sector is fairly small. Nevertheless, as the challenges posed by HIV/AIDS stretch well beyond the health sector, there is a need to incorporate HIV/AIDS prevention and control activities into its country assistance program and lending portfolio. While funding of the stand alone operation seems to be long-term objective, the short term comparative advantage of the organization would be to use ongoing projects as an entry point of channeling and promoting HIV/AIDS related activities. Particularly in the health sector, the World Bank could assist in strengthening country's response to HIV/AIDS epidemic as part of the broader health reform efforts. The details of possible interventions are outlined in the table.

World Bank support may help promote active involvement of civil society organizations in HIV/AIDS prevention and control. To this end, a promising approach to stimulate innovative multi-sectoral activities might be:

- Creation of a demand-driven fund managed by an inter-sectoral group headed by the Ministry of Health officials and financed by public and private sources that could channel resources to public and private organizations, including community groups. Activities that could be financed by such a fund would include pilot interventions or their replication at the community level, media campaigns, and applied research on risk factor prevalence and effectiveness of interventions;
- Using World Bank's Small Grants Program to mobilize civil organizations from different HIV/AIDS related sectors to design and proliferate preventive measures in certain geographical locations focusing on priority risk groups and/or risk factors.

INTRODUCTION

HIV/AIDS is increasingly being recognized as a major impediment to development. As a result many developing countries have attempted to “mainstream” HIV/AIDS into instruments of development. In a country like Georgia, where PREGP serves as the country’s agenda for poverty reduction and economic growth, it is crucial to make credible proposals for the inclusion of HIV/AIDS in the poverty reduction effort.

The World Bank is well positioned to advocate and assist Georgia in seizing more fully the current and future opportunities to bring HIV/AIDS to the forefront of the national priorities to alleviate poverty. The efforts to mainstream HIV/AIDS in the development agenda, therefore, need to be well articulated to ensure buy-in from multiple sectors and the highest levels of the government.

To make it a national priority, the World Bank needs to demonstrate that an effective national HIV/AIDS program will contribute in the fight against poverty. Country teams are more likely to be credible and effective advocates in combating the AIDS epidemic, if proposals incorporate effective strategies that have worked against HIV/AIDS, drawing clear outline of the approach to be adopted as part of a national response to the epidemic and the expected outcomes.

The report is intended primarily for the use of World Bank staff; it can also provide guidance to governments, other international agencies, and non-governmental agencies in the design and implementation of HIV prevention and mitigation programs in Georgia.

The paper intends to give an insight into the complex mechanics of the epidemic and to provide an overview of the challenges and opportunities in addressing the problem of HIV/AIDS in Georgia, besides identifying the assistance needed to build capacity to improve the design of national response program. It presents information concerning selected HIV/AIDS topics relevant to Georgia, and attempts to project the status of the epidemic in the country for the years 2005–2010. This is done by offering examples of ways in which the country has responded to the epidemic, discussing alternative actions for addressing the emerging crises, and highlighting a range of strategies for donor coordination and cooperation, including the World Bank.

It is expected that this analysis will serve as an important tool for the Bank in its advocacy efforts to place HIV/AIDS at the center of the development and aid agenda, and to prepare the analytical rationale for identifying the most appropriate and cost-effective interventions in the context of poverty reduction. The study will also help in discerning the relative impact of the development strategy proposed by the country and the Bank on the incidence of the epidemic, focusing particularly on the premise whether the presence of the epidemic is hampering the achievement of the development objectives.

The basic analysis of the epidemic includes an assessment of the current situation, its seriousness as well as the threat it poses in the future. The first chapter of this document draws together a range of existing data in a way that is of interest to the Bank, government policy-makers and donors. It focuses on presenting the synthesis of currently available data supported by an explanatory text. The second chapter presents analyses of the national response that has been launched. It assesses the institutional arrangements, political commitment, enabling legal environment, government's program and resource availability, and donor's and civil society engagement. At the end it attempts to answer the question "what has been the effect of the HIV/AIDS national response?" by conducting a thorough analysis using AIDS Program Effort Index (API) diagnostic tool developed by UNAIDS, USAID and POLICY Project. The chapter summarizes the result of analyses identifying the strong and weak areas of the program and suggesting corrective measures.

The third chapter describes the HIV/AIDS projections and potential implications on population demography, outlining possible development of the epidemic and prevalence rates for the years 2000–2015. It examines the social impact of the epidemic, namely on households and orphans. The chapter also attempts to estimate the impact of the epidemic on agriculture and transport sectors, labor markets, health care and social security, as well as on deepening the poverty.

Based on the findings of previous chapters, chapter four outlines the main barriers that need to be countered during the development of comprehensive multisectoral national action plan. This chapter highlights areas such as leadership and implementation capacity, priority setting and resource allocation, social barriers, poverty and gender inequality, the sexual "code of silence," misperception, access to drug treatment and sterile injection equipment, comprehensive sex education, and HIV and TB prevention and treatment in penitentiary system. In short, it outlines areas and strategic actions for strengthening national response capabilities.

Finally, the fifth chapter defines strategic options for the Bank's involvement. In particular, it lists areas of involvement, possible methods and tools, proposing the guiding principles for the Bank's country focused strategy.

HIV/AIDS EPIDEMIC

Country Brief

Georgia, a country in the Southern Caucasus mountains, is located between the Black sea and the Caspian Sea, bordering Turkey, Armenia, Azerbaijan, and Russia. The Russian border is near Chechnia, and the Pankisi valley, which is one of the main routes of drug transit and import in the country.

The country has an area of 69,700 square km. According to the last census (1989), the population of Georgia is 5.4 million. The conflicts of recent years coupled with increased migration in 1999, have led to a decline in the population, which has come down to 4.6 million. Fifty-six percent of the people live in the urban areas, and 1.5 million are in the capital city of Tbilisi alone. Due to ethnic conflicts 288,000 people were forced to leave their houses in the Samachablo and Abkhazia territories and now live under IDP status. Besides, there are 188,000 registered refugees living in the Russian Federation.

Georgia is divided into 12 administrative units and 63 regions, which include Abkhazia and Samachablo. Georgian is the state language, which is derived from 14 functioning and/or defunct languages. It is a multi-ethnic country with 94 different nationalities: 70 percent are indigenous Georgians, 8 percent are Armenians, 6 percent are Russians, 6 percent are Azeris, 3 percent are Ossetians, and 2 percent are Abkhazs. The religion of the majority is Greek Orthodox. The minorities include Muslims (Shiites and Sunnis), Gregorians, Catholics, Jews, and others.

The 1990s heralded the advent of massive emigration from Georgia. This can be gauged by the fact that the migration rate doubled from the annual figure of 300,000 in the 1980s to 600,000 after 1991. Owing to poor economic conditions, a considerable part of the population is studying or working abroad. The highest numbers of emigrants live in Russia and Ukraine, two countries that had a severe outbreak of HIV/AIDS epidemics in recent years. Therefore, migration has significantly increased the risk of HIV infection distribution. According to epidemiological studies, 45 percent of registered HIV positive persons in Georgia were infected in Ukraine and/or Russia, of which 78 percent are injecting drug-users.

Georgia is a presidential republic. Its executive, legislative, and judicial structures are based on the model of classical democracy and a constitution that was adopted in 1995. The country regained its political independence in 1991. The initial years of independence degenerated into a civil war and armed conflicts in Abkhazia and South Ossetia, with a devastating impact on the economy. Nevertheless, after the democratic elections of 1995, there is an increasing trend toward economic and political stabilization, and active integration into international society.

Georgia has low levels of economic growth and the fiscal situation continues to be of a cause for concern in 2001, when GDP grew by 4.5 percent and GDP per capita amounted to US\$588. Low levels of tax revenue and inefficient management of government finances also forced budget cuts during the year.

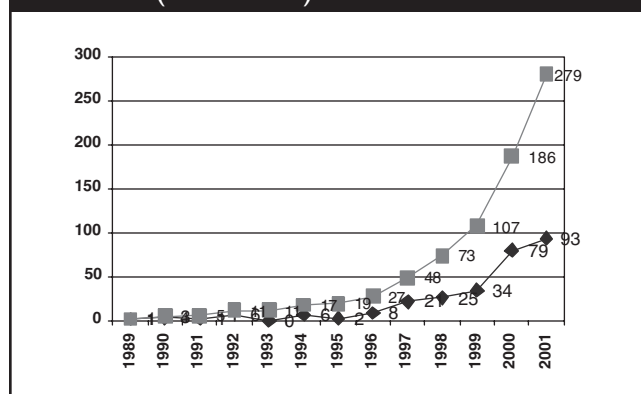
The 2001–2 Human Development report shows a decline in Human Development Index (HDI). In 1998, Georgia ranked 108 out of 174 countries, advancing in 1999 to the 85th position and in 2000 to the 70th position. However, this advance was mainly caused by refined methodology to discount income while the difference in 15 positions between 1999 and 2000 originated in an updated estimation of Georgian GDP per capita.

In 2001, the HDI for Georgia fell to the 76th position. There are several reasons for this decline. First, though the adult literacy rate increased from 99 percent to 99.6 percent, the combined gross primary, secondary, and tertiary enrollment ratio fell from 72 percent to 70 percent. As a result, the education index fell from 0.90 to 0.89. Second, the GDP index fell from 0.59 to 0.53 reflecting a decrease in per capita income. Third, though life expectancy at birth increased from 72.9 to 73.0, this difference is too small to affect the Life Expectancy Index, which remains at 0.80. The combined effect of the changes in the indexes for GDP, life expectancy, and education resulted in a fall of HDI from 0.762 to 0.742.

HIV/AIDS Epidemic

The first evidence of HIV infection in Georgia was reported in 1989. Official estimates—which are undoubtedly low—indicate that 305 people are living with HIV/AIDS in the country. As of May 2002, 67 out of 305 HIV-infected persons have developed AIDS, of which 44 died (as registered by the AIDS and Clinical Immunology Research Center).

FIGURE 1: REGISTERED HIV CASES IN GEORGIA (1989-2001)



Source: National HIV/AIDS Center.

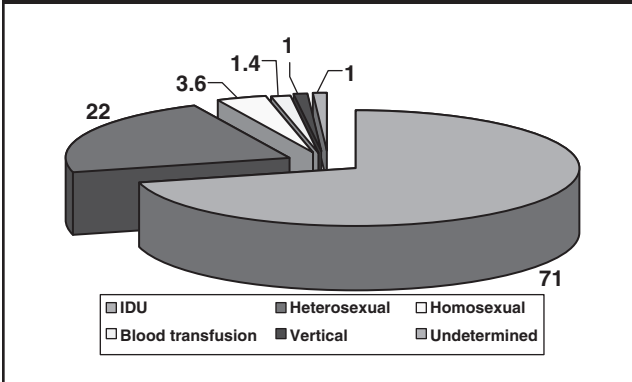
cases are registered in Tbilisi, the capital of the country with a population of 1.5 million. Eighteen percent of cases are reported in Samegrelo, the region bordering Abkhazia,¹ which has the highest

However, given the widespread underreporting, WHO and local experts estimate that more than 1500 individuals are infected with HIV. Currently, the primary mode of transmission of HIV/AIDS is injecting drug users who represent 71 percent of cases, followed by 22 percent of heterosexual contacts, 3.6 percent homo-bisexual contacts, 1.4 percent blood recipients, 1 percent of vertical transmission and 1 percent are undetermined (Figure 2).

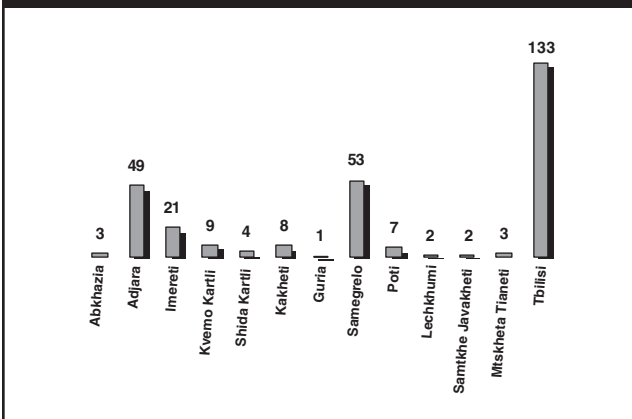
HIV/AIDS is widespread in all regions of Georgia (Figure 3), however the distribution of cases varies significantly throughout the country.

Over 46 per cent of all HIV infection

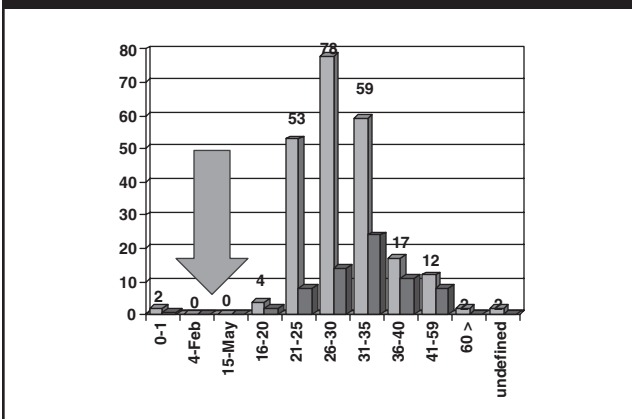
1. Abkhazia used to be an autonomous region of Georgia. In 1993 as a result of ethnic conflict and war, approximately 750,000 ethnic Georgians have been forcefully displaced from Abkhazia to other parts of the country.

FIGURE 2: STRUCTURE OF HIV BY MODES OF TRANSMISSION

Source: National HIV/AIDS Center.

FIGURE 3: DISTRIBUTION OF HIV/AIDS BY REGIONS, 2002

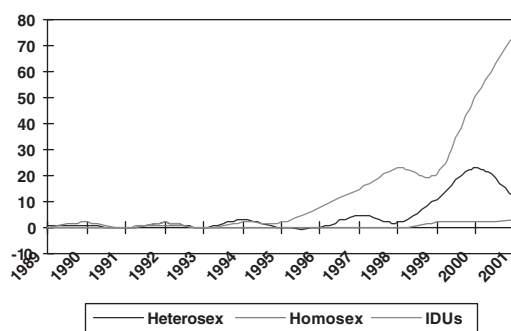
Source: National HIV/AIDS Center.

FIGURE 4: AGE STRUCTURE OF HIV & AIDS CASES

density of Internally Displaced People. Given that the region serves as a refuge for hundreds of thousands people displaced during the war, such a large number of cases is of serious concern. Sixteen percent of cases occur in Ajara, the region bordering Turkey, which is also the major sea-port. From the above discussion, it follows that the HIV is more prevalent in urban areas and bordering regions, where the density of population is high, and where cross border migration and trade is active.

The epidemic is scaling up (Figure 1). From 1989 to 1998, the epidemic progressed slowly with sporadic occurrences. However, even at this low level of transmission, the infection had reached all administrative regions of the country (Figure 3). Since 1996, the situation has changed dramatically. The number of HIV cases increased nearly threefold in 1997 compared with the previous year and accounted for 21 cases. In 2001 alone, this number reached 93. From 1998 through 2001, more than a half of newly-registered HIV infection cases have been attributed to IDUs. The reports indicate that the percentage of new cases attributed to heterosexual contacts have also increased, although the absolute numbers remain small. More people (mostly women) appear to be contracting HIV through sexual transmission, suggesting a shift of the epidemic into the general population (Figure 5).

HIV/AIDS is predominantly present in the age group of 21–35 years (Figure 4). In 2001, over 87 percent of all new AIDS cases are detected in the individuals of 26–35 years age group. As this is the most economically productive segment of the population, deaths in this age group cause great economic hardship to the families. Many productive years and investment in education and training is thus lost.

FIGURE 5: DYNAMICS OF SEXUAL & IDU TRANSFUSION

These deaths also have significant family consequences, since most people in this age are raising young children.

Children between the ages of 5 and 15 provide a special opportunity and window of hope. These children can be taught to protect themselves from HIV infection before they become sexually active, which may protect them from HIV for their entire lives. Both HIV and AIDS are predominantly prevalent in the male population. The male/female affliction ratio, in 2001, was 3.1, being almost the same for HIV infection and AIDS.

Antenatal screening on HIV is not a routine procedure and expenses

are not covered by public sources. However, during the last three years three cases of HIV infection have been detected among pregnant women, and two cases of vertical transmission have been reported so far.

Since the initiation of reforms, the government has prioritized blood donor routine screening. Due to irregular and deficient public financing, blood safety could not be assured, as the supply of test kits is intermittent and inadequate to meet national requirements. Therefore, transfusion of non-screened blood in case of emergencies appears to be common, on the one hand, while the number of infected blood donors is increasing on the other (Table 1).

TABLE 1: NUMBER OF BLOOD DONORS TESTED ON HIV

Years	Tested for HIV	Number of HIV + cases
1997	NA	1
1998	21,500	3
1999	18,210	4
2000	15,855	5
2001	22,100	7

All HIV infections to date have been caused by HIV-1. The isolates are the same A/B recombinant virus found elsewhere in Russia and Ukraine. The reported HIV/AIDS cases are felt to be a substantial underestimate due to weak passive surveillance systems.

TABLE 2: CROSS SECTIONAL HIV SERO-PREVALENCE IN HIGH-RISK GROUPS AT 0 AND 12 MONTHS AND HIV INCIDENCE PER 100 PERSON-YEARS (PY) (1997–1999) AND BASELINE HEPATITIS B AND HEPATITIS C SEROLOGY

	Baseline HIV Prevalence	HIV Prevalence after 12 Months	HIV Incidence Per 100 PY	Baseline HBV	Baseline HCV
IDU	0.54	1.62	1.48	40.9	53.3
STD	0.36	0.90	0.68	16.0	17.6
CSW	1.40	1.40	—	15.5	15.5
BD	0.36	0.54	0.21	7.1	8.1
TB	0.67	0.57	—	9.0	13.0

Source: Georgian AIDS and Clinical Immunology Research Center.

The prevalence and incidence data for HIV infection was obtained by the Georgian AIDS and Clinical Immunology Research Center, for a cohort study of 2,406 adults in the following population groups, recruited from the cities of Tbilisi, Poti, and Batumi: (i) present or past history of IDU (n=926), (ii) men with STDs attending treatment centers (n=556); (iii) female commercial sex workers (FCSW) (n=71); (iv) professional blood donors (BD) (n=553); and (v) Tuberculosis (TB) patients (n=300). The study reported the highest prevalence and incidence of HIV in the IDU population.

BOX 1: SUMMARY OF SIGNS OF HIV/AIDS EPIDEMIC

SIGNS OF EPIDEMIC

- Epidemic is on the rise, although prevalence remains at low level.
- Spread out across the country, particularly prevalent in urban areas and bordering regions.
- Predominantly present in 20–36 year old, economically active population, mostly in males.
- Primary mode of transmission is IDUs.
- Pregnant women are being affected and cases of vertical transmission have been observed, thus sexual mode of transmission is apparent.
- Increasing number of infected Blood Donors.
- Children 5–15 may be a special window of hope.

Risk Groups and Factors Affecting the Spread of HIV Infection

Intravenous Drug Users

Drug abuse has become one of the most serious problems in Georgia. Since independence, marked escalation of drug abuse and drug dependence has been observed in the country. A number of factors may be identified for this trend like: the disruption of existing anti-drug-abuse system, ongoing political instability, civil war, unprotected borders, escalated criminal activities, socioeconomic downturn, widespread unemployment, and disruption of the system of common values.

The official statistical data provided in Figure 6, shows a sharp increase in the number of drug users as well as addicts. This phenomenon is easily explained by the increased drug inflow into the country for the last couple of years. This significant increase of drug inflow is a result

of multiple factors including the increased production of drugs in Afghanistan, unprotected borders due to the Abkhaz, Ossetian, and Chechen ethnic conflicts, and transformation of the Southern Caucasus into a connecting corridor between Central Asia and Europe.

Beside the increasing number of drug abusers and users, age range of such users has also broadened in recent years (Figure 7). The official statistics show that there are about 9,000 drug users of whom 60–70 per cent inject drugs. In contrast to the age distribution of drug users in the past years, the present day scenario

FIGURE 6: DISTRIBUTION OF DRUG USERS AND DRUG ADDICTS

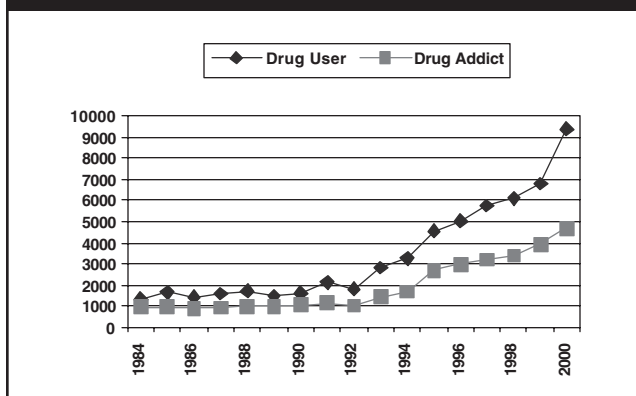
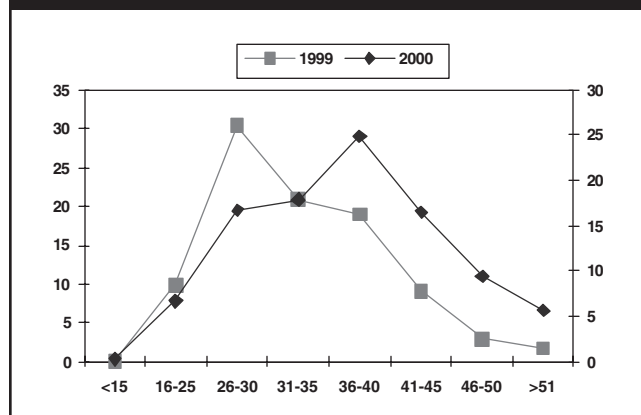


FIGURE 7: AGE DISTRIBUTION OF DRUG USERS AND DRUG ADDICTS

Source: Institute of Narcology.

ried out by HealthNet International in January 1998 found that 69 percent of 63 Georgians arbitrary chosen on the streets of Batumi reported keeping syringes and needles at home and accepted that 46 percent of their household members had received injections in the previous six-month period. This phenomenon was confirmed by the assessment team where pharmacies in Kutaisi, Poti, and Tbilisi reported selling each between 100 and 200 syringes per day, mainly the 2 cc syringes.

As has been mentioned, there appears to be a general acceptance of recreational drug injecting which prompted frank discussions at one level. However, on an individual basis IDUs and addicts are highly stigmatized. The country does not have visible street-based drug activity. The families report shame and fear of police if a family member is an IDU. IDUs however, usually remain within families and the recreational drug use appears to occur in the company of friends and acquaintances.

The Institute of Narcology officials report from their experience that heroin is the most common narcotic injected, accounting for 70 to 80 percent of the patients that they have evaluated. The current price of heroin is 100 Lari for a one gram compared to 25 Lari for 0.25 gram of poppy straw. These data differ from those found by Georgian AIDS and Clinical Immunology Research Center where the most commonly injected drugs among the 926 participants from Tbilisi, Poti, and Batumi were: opium (41.1 percent), various psychoactive substances from medical facilities (28.3 percent), poppy straw (18 percent), and heroin (12.6 percent). These differences may reflect changes in drug availability over time or the socioeconomic level of the patients seen by each group.

Drug sharing is reported to be a symbolic expression of friendship. Needle and syringe sharing (72.9 percent) is common. The majority (83.5 percent) borrow from friends, 3.2 percent borrow from sexual partners, 1.4 percent from dealers and the rest borrow from casual acquaintances at the time of drug sharing. Rinsing the needles and syringes in hot or cold water accounted for 87.9 percent of the cleaning practices. Other high-risk needle/syringe use practices common in Georgia are “frontloading” (sharing of drugs by using a single syringe to load others), as well as sharing drugs from a common bowl.

Poppy straw is the raw ingredient from which Koknar is extracted. This is the same drug that is injected by the majority of users in Ukraine and Belarus, and it is the preparation procedure used in these countries that is felt to have contributed to the explosive epidemic there. The drug is prepared by the consumer and used directly after preparation. Preparation involves thinner, calcygluconate, soda, water, anhydride, cotton, and syringes. Reportedly human blood may also be used in

shows a notable change being characterized by a proliferation of drug users in the age bracket of 25–35 years. The officials from the Institute of Narcology are of the view that the official numbers of drug users underestimate the problem by about 12- to 15-fold.

Incidental recreational drug use, perhaps as a result of the economic situation, is reported to be common. Self-injection of drugs due to both medical and recreational purposes is a commonly accepted phenomenon among the general population of Georgia. The reason for this is the belief that injected drugs are more effective than oral ones. A survey car-

this preparation when certain ingredients are not available. It is not clear that in Georgia how common is the practice of using human blood in the preparation of poppy straw.

Majority of surveyed IDUs treated at the National Institute of Narcology are familiar with AIDS, and transmission risks associated with intravenous drug use. However, about 55.5 percent practiced sharing of injecting equipment, 27.2 percent used drugs prepared with the blood of other individuals, and 41.3 percent used drugs from the bowl containing other user's bloody needle. Out of those individuals who shared injecting equipment with peers, 15 percent never cleaned equipment, while others at least tried different and improper methods of disinfections.

Most IDUs (87.1 percent) reported never or rarely using a condom. Also, 16.5 percent of male STD patients reported giving money or drugs for sex of which 97 percent never or rarely used condoms. Drug use among students is quite common. In one interview with a patient, he indicated that he started drugs in college with his friends. His major concerns while injecting drugs were the fear of overdose and the police. Hepatitis and HIV/AIDS were not important to him.

These data provide glimpses of a potential high-risk behavioral pattern of youth vis-à-vis HIV and STDs. There appears to be poor awareness and knowledge of these infections, the means of transmission and the personal risk involved. The above discussion shows that there is a high probability of AIDS transmission among IDUs, as well as penetration of infection into the general population.

BOX 2: IDUs: SUMMARY OF RISKS AND CONTRIBUTING FACTORS

Risk Factors	Contributing Factors
Sharp increase in the number of drug users as well as addicts, especially adults	<p>Macro-Environment</p> <p>Increased drug inflow into the country for the last couple of years.</p> <p>Increased production of drugs in Afghanistan coupled with unprotected Georgian borders due to the Abkhaz, Ossetian, and Chechen ethnic conflicts.</p> <p>Transformation of Southern Caucasus into a connecting corridor between Central Asia and Europe.</p>
Incidental recreational drug use is common	<p>General acceptance of this activity on the one hand, and the paradoxically, high stigmatization on the other.</p> <p>Belief that injected drugs are more effective than oral.</p> <p>Access: It is cheaper to shop around at pharmacies, rather than paying doctors for medications.</p> <p>Availability: Injecting equipment available without prescriptions.</p> <p>Stigmatization: Fear of police, as IDUs are considered criminals rather than patients.</p>
High-risk drug and injection equipment use practices	<p>Beliefs: Symbolic expression of friendship.</p> <p>Knowledge/Practice: Although majority is familiar with AIDS and transmission risks associated with IDU, practice is different: a) hot or clod water rinsing—appears a common cleaning practice; b) sharing of drugs by using a single syringe and loading others; c) sharing dugs from a common bowl; d) using drugs prepared by other individual's blood.</p> <p>Availability/Practice: Poppy straw is commonly used with the same preparation procedures as in Ukraine and Belarus, felt to have contributed to the explosive epidemic in these countries.</p>
High sexual activity of IDUs	<p>Knowledge/practice: a) Poor awareness and knowledge of STDs and HIV infection, means of transmission and personal risks; b) rare use of condoms.</p>

Sexually Transmitted Diseases

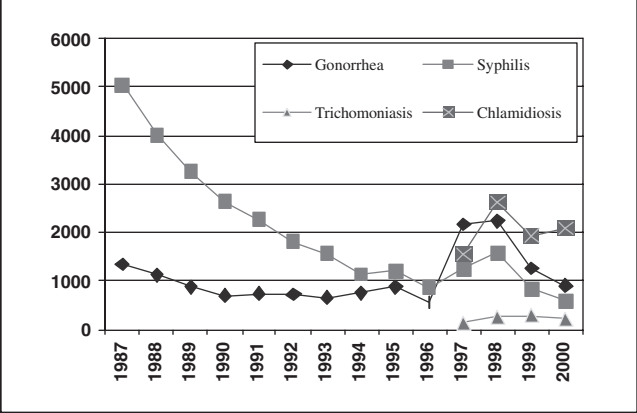
The global experience confirms that STDs significantly increase the risk of HIV infection transmission. Similar to the other developing countries in the region, a marked increase of STDs is observed in Georgia. The reported STD data presented in the Figure 8, are unlikely to reflect the true magnitude of the problem. The increase in the incidence of disease after 1996 is the result of overall deterioration of political and economic stability in the country, disruption of health care system and poor STD reporting. Experts estimate that STD morbidity has increased, at least, by 4–5 fold in comparison to the levels in late 1980s.

The rate of reported syphilis cases was rising until 1998, followed by a decreasing trend. However, one may want to question the validity of the STD surveillance data in the country. A study has recently revealed that the reporting of syphilis and gonorrhea varied across the country and only 50 percent of such cases diagnosed by public STD services were reported to the national surveillance institution. In addition, many patients with primary symptoms may not have been treated at public STD clinics and thus not reported. Therefore true STD morbidity is likely to be much higher than the surveillance data suggests.

STDs are mainly prevalent in young people (Figure 9). Individuals of the 20–40 years age bracket have the highest rate of disease prevalence. The reported number of syphilis cases among adolescents has increased dramatically. At the same time, the teenage pregnancies are also on rise, and about 50 percent of them are not registered by the ANC clinics.

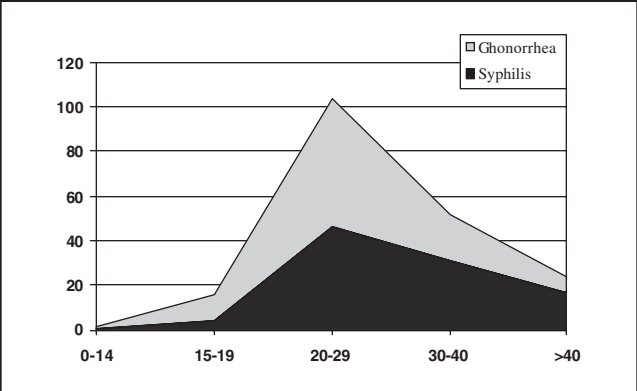
Gender distribution of STDs shows a male predominance, except for trichomoniasis, which is more common in women (Figure 10). This again proves the higher sexual activity of the male population. STDs are

FIGURE 8: REGISTERED STD CASES BY YEARS



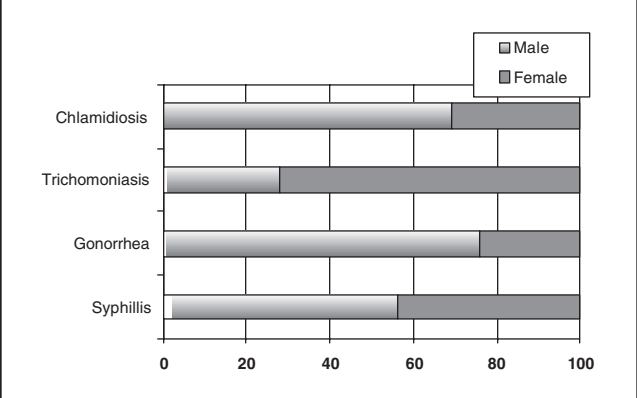
Source: MoLHSA.

FIGURE 9: AGE DISTRIBUTION OF STDs



Source: MoLHSA.

FIGURE 10: DISTRIBUTION OF STD CASES BY GENDER



Source: MoLHSA.

mostly present in the unemployed and economically active group, which reflects the influence of social and political situation of the country. The other most affected groups are those working on streets and transport sector, as these groups are most exposed to accidental sexual contacts.

The prevalent trend of STD among sex workers is unknown due to the following reasons: (i) a draft law on “STD prevention” aiming to regulate the behavioral standards of HIV/AIDS high-risk commercial sex workers, is awaiting the Parliament’s approval, and (ii) non-existence of mandatory STD checkups of CSWs.

In short, although reported syphilis rates might well have constituted the best indicator of the spread of STDs during the early and mid-1990s, the observed stabilization of reported syphilis incidence since 1997 is unlikely to reflect the real development of the epidemic.

BOX 3: STDs: SUMMARY OF HIV/AIDS RISKS AND CONTRIBUTING FACTORS

STDs: Signs of HIV/AIDS Risk

- Marked increase of STDs
- Mainly prevalent in young people and in male population
- Predominantly present in un-employed economically active population
- People working on streets and transport sector

Contributing Factors

Macro-environment:

- Overall deterioration of political and economic stability in the country.
- Disruption of health care system and limited access to services.
- Poor surveillance and reporting systems.

Social:

- High sexual activity of male population.
- People working on streets and trade are more exposed to accidental sexual contacts, especially in the CSW industry.

Knowledge/practice:

- Poor awareness and knowledge of STDs and HIV infection, means of transmission and personal risks.
- Rare use of condoms.

Commercial Sex Workers

The social, political, and economic upheavals of the last decade in Georgia led to many critical problems. Among these, the commercial sex work is considered to be one of the most significant tribulations. This profession had always existed in Georgia, but in recent years has become very widespread. Unfortunately, there is no statistical data that is available regarding this problem, due to the lack of enabling legal environment to regulate the profession. The characteristics of the commercial sex business and the exact number and age distribution of individuals involved or employed in this sector are not known. Likewise, the client group characteristics and prevalence of HIV/AIDS and STD in CSWs community is also not known.

Diametrically opposite views and attitudes regarding commercial sex and CSWs are observed among the different layers of society. The most commonly encountered expression of such an attitude is aggression and unacceptability, thus making the sector difficult to regulate. The authors of this paper have obtained information from key players by organizing Focus Group Discussions (FGD) to be able to analyze the situation in the sector and its potential impact on the spread of HIV/AIDS epidemic in the country. The FGDs carried out for the CSW revealed that CSWs are categorized according to the location where sexual intercourse takes place as well as the styles of their activities.

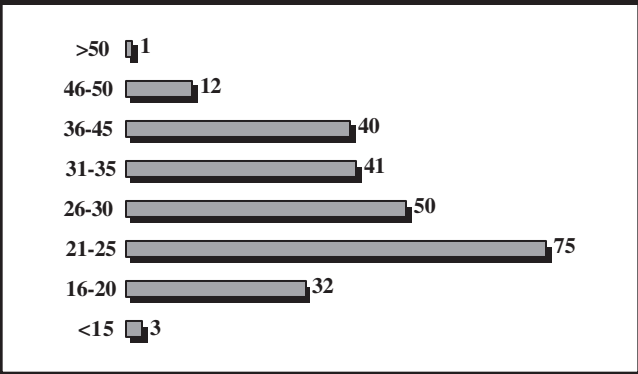
There are three main categories of sexual workers in Tbilisi: (i) the “lowest” category is the one that works mainly on streets and railway station, (ii) the “median” category is represented by prostitutes working in sauna baths and other illegal establishments, and (iii) the “highest” category so-called “mobile phone” prostitutes are those that work “on call.”

Figure 11 shows that 42 percent of CSWs fall in the age group of 16- 25 and 1.2 percent are younger than 15 years. The majority of CSW are single or divorced and only a small number are married, out of whom 49 percent have children. Sixty percent of CSWs are unemployed, while the rest consider themselves self-employed in commercial sex. Most of CSWs are not Tbilisi residents and live in the capital with relatives, or rent an apartment while having a family in the region. The sample design does not allow us to reveal the ethnic diversity of CSWs, though during the discussion participants mentioned few IDPs and some ethnic minorities who are more heavily represented in the commercial sex business.

The main reason cited by CSWs for practicing commercial sex was poverty and lack of financial means. Resorting to this profession appeared to be the only way to earn some money and support their large families. The majority of CSWs perceive themselves as professionals, while some see themselves as temporarily involved in this sector. Most of the women employed in this sector had incomplete high school education, which further compromises their chances in an already under-developed labor market.

The service fee varies according to the category of sex workers. It ranges from 5–10 Lari on streets and railway station to US\$100–200 for elite prostitutes. The fee also depends on the type of sexual intercourse. For example, oral sex is relatively cheaper compared to vaginal sex. The monthly income of prostitutes varies according to the category, but majority make US\$100–250 or more by serving an average of 2–7 clients per day. Their minimum monthly income is ten times higher than the official minimum salary, which in turn encourages them to stay on in the profession.

FIGURE 11: DISTRIBUTION OF CSWs BY AGE GROUP



Source: Center Tanadgoma.

BOX 4: POVERTY AND COMMERCIAL SEX WORK

- About 50 percent of women engaged in the commercial sex industry belong to the 16–25 age group.
- Majority of CWS are single or divorced, and 49 percent of those married have children.
- 49 percent of CWS are unemployed, while the rest consider themselves self-employed.
- Most of CWS have migrated from the place of their residence to the capital, leaving families behind.
- Main reason for being involved in this sector appears to be poverty and lack of financial means and adopting this profession appears to be the only way to earn money and support families.
- Women involved in this sector usually have incomplete education, thus having limited ability to occupy position in an already underdeveloped labor market.
- The minimum monthly earning of CWS is 10-times higher than official minimum salary in the country, which in turn encourages them to stay on in the sector.

More than half of the interviewed women regularly used condoms with clients, whereas the rest never use them or only rarely. The main reason for not practicing safe sex is the adverse implication of condom use on the earnings. Half of FGD participants reported that reluctant clients react violently on the suggestion or simply move on to those who are willing to forego the con-

doms. The clients offer almost double the fee for sex without a condom, which in turn represents a significant disincentive against practicing of safe sex. In order to institute effective interventions among sex workers, it is crucial that this fact be taken into consideration.

In addition to everyday clients, an absolute majority of sexual workers have a regular partner. As a result, CSWs appear to be the main source of infection because as a rule they do not use condoms with regular partners. Explanations of this type of behavior are: “I am sure my partner is healthy,” “I am sure my partner is faithful,” “If I propose to use a condom, he may think that I have other partners as well,” “Can not use a condom with a regular partner.” Even those women who regularly use condoms with clients never use it with a regular partner.

The risky behavior of sexual workers as well as their partners is often dominated by beliefs such as: elite sex workers are clean and when the client pays, he has to enjoy the intercourse in the way he likes. The clients of the street sex workers often use condoms, as they believe they may be more exposed to the infection. Another prevalent myth is that once a week injection of antibiotics secures absolute protection. A dangerous widespread belief is that the oral sex is the safest way in the sense of infection transmission, whereas, in reality, oral sex represents a grave risk for the spread of STDs and HIV. Some sex workers also use alcohol regularly. As sex with a client who is drunk or under the influence of drugs, is quite common, it increases the risk of infection transmission.

Men who have Sex with Men

MSM practitioners are a highly-stigmatized group in Georgia. Social workers and consultants of the local NGO “Tanadgoma” consulted with 55 MSM, between May 2000 and January 2001, throwing some light on the peculiarities of this risk group. There are places in Tbilisi where MSM meet each

BOX 5: MSM: SUMMARY OF RISKS AFFECTING THE SPREAD OF HIV INFECTION

- MSM are highly stigmatized.
- Level of HIV/STD awareness slightly higher than in other risk groups, however risky behavior is quite common.
- Majority of MSM are involved in sex industry, however not because of poverty but lack of partners.
- Higher level of occasional contacts.

other and look for the partner. MSM are also divided into the following categories: (i) those who do not hide their orientation and often demonstrate it in public; (ii) underground MSM, hiding their orientation; (iii) bisexuals, that are married as a rule, but have a lot of other occasional partners of the same sex; (iv) transsexuals; and (v) MSM, working in commercial sex.

The level of HIV/AIDS awareness is slightly higher in this group

compared to CSWs. However, despite that, risky behavior is frequently observed as very few of them use condoms on a regular basis during chance contacts. Like women sex workers, almost no MSM use condoms with regular partners. MSM mainly have anal and oral intercourse. The same myth of oral sex safety prevails among them as was observed among CSWs.

The majority of MSM are involved in commercial sex, but unlike CSWs, the motivation is not poverty but lack of partners. There are cases when a man pays the client himself, which is a common practice among soldiers. MSM also have a higher rate of occasional contacts. This was substantiated by “Tanadgoma” data, which shows that more than half have between 2–5 partners per day. Often they indulge in intercourse under intoxication, which increases the risk of HIV and other STD transmission.

Youth

The harsh social and economic conditions of the country during past years are reflected in deteriorating health and education of children and adolescents. The role of the family in education has declined, the role of school in formation of future generation psychology has been attenuated, and the system of extra-school activities of alternative education and leisure time organization has been

disrupted. As a result the adolescents have become exposed to the strong influence of street life manifesting itself in the antisocial activities of minors and adolescents like smoking, alcoholism, drug-abuse, and prostitution. At the same time, it has also stimulated migration.

The available limited data suggests that the young generation in Georgia is engaged in potentially high-risk behavior in the context of STD and HIV/AIDS. Alcoholism has assumed serious proportions in recent years as shown by marked increase of alcoholism and alcohol psychosis among young people. A survey (carried out on adolescents practicing unprotected sex) showed that in males 54 percent do it because of the influence of alcohol and 14 percent because of drug use. In the females, the comparative figures are 21 percent and 14 percent respectively. Alcohol use is more prevalent in boys, while other reasons for unsafe sex practices appear to be more frequent in girls.

About one-fifth of 14–16 year olds in the capital city consider sexual relationships before marriage acceptable. The data collected by non-governmental organizations working in the field shows that majority of adolescents begin their sexual life with street sex workers due to the inability to have a permanent partner. Such types of contacts are mostly unprotected and therefore put them at risk of STDs and HIV infection. The situation is aggravated by low awareness of young people regarding safe sex principles. The majority of the surveyed do not use condom at all during sexual intercourse or only on rare occasions.

Drug abuse and use is another important problem in adolescents. According to the data given by the State Department of Georgia on youth issues, 45.7 percent of adolescents have tried or used drugs and 69 percent of them are aware of the fact that by sharing injecting equipment, HIV/AIDS can be transmitted. But still, majority of drug users reported using shared instruments. About 21 percent of surveyed young individuals reported using drugs in between the ages of 12–16 years, followed by 12.9 percent who are in the age bracket of 17–19. The fact that many in the 12–16 years age group attempt drugs, and that girls and boys are equally eager to try, portrays a very gloomy picture of the future. According to adolescents (42.3 percent), the best way of fight with drug addiction is the legalization of drugs, although 52 percent do not agree with this statement.

BOX 6: YOUTH: SUMMARY OF RISKS AFFECTING THE SPREAD OF HIV INFECTION

- Alcoholism among youth is a severe problem.
- Drug abuse is emerging.
- Low level of sex education and high sexual activity.
- Poor access to the health services.

The committee on health and social issues of the Georgian Children and Youth Parliament conducted a survey of 14–24 years age group. The goal was the evaluation of Georgian youth’s awareness on HIV/AIDS. The survey revealed that the general awareness and knowledge of youth is poor; and the main sources of information about HIV/AIDS are TV, press, and specialists, although an

absolute majority stated that provided information is not sufficient. The majority of surveyed individuals consider that education centers are the most effective sites for raising awareness, followed by TV educational programs that promote wide-scale informative and preventive activities. The youth also are of the view that the mass media can and must play a key role in solving this problem. They suggest that a great deal depends on parents; who should educate their children. Unfortunately, in many cases parents themselves do not have an adequate knowledge in this field. This is why a special program of parent education should be started.

To conclude, alcoholism, drug abuse, and low level of sex education (including HIV prevention) are important pre-existing factors for the spread of HIV/AIDS among youth.

TB in the General Population

The WHO has declared tuberculosis a “Global Emergency.” It represents one of the most important public health problems in Georgia. To intensify efforts against TB, in 1995, MoLHSA and TB Institute established the National TB Program for control and prevention of TB, with the support

of WHO. Since the second half of 1995, based on the WHO recommendations, the new classification of TB based on disease category have also been introduced.

During 1980s, the number of TB patients was gradually decreasing, but since 1992, the number has picked up. Again in 2000, the number of registered new cases decreased. A cumulative number of registered cases declined by 9.6 percent and morbidity by 5.5 percent, which points to the moderate effectiveness of National TB Program (see Figure 12). However, MDR cases still remain stable.

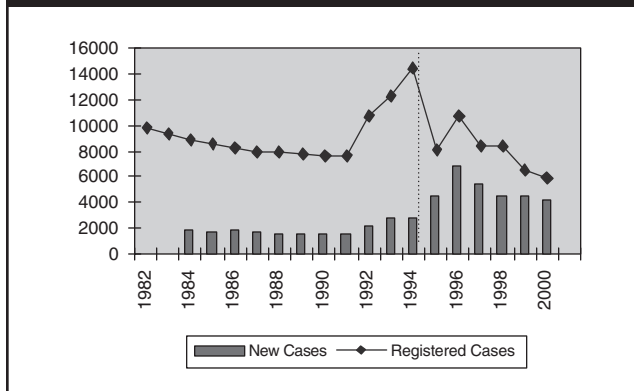
Distribution of TB cases across the regions of the country is not homogeneous. The most affected age group is 25–45 year individuals, although the incidence in younger population is also on the rise. TB is mainly prevalent in the male population.

TB morbidity in AIDS patients has been increasing during the past years. 26.5 percent of individuals from this group had developed TB. In 2000 alone, 7 cases of TB were reported in the 10 new AIDS cases. Under the framework of epidemiological research, 250 TB patients were screened for HIV infection and three were HIV positive.²

TB in Prisons

TB situation is particularly worrisome in the prisons. Because the disease is airborne, overcrowded prisons provide ideal conditions for transmission between prisoners, staff, and visitors. It is estimated, that out of a total 7,500 detainees in Georgia proper, 600 are ill with TB. The ICRC identified TB as the major cause of mortality in prisons in 1997. Prison deaths from all causes dropped from 74 to 53 from 1997 to 2000. The MDR TB rate, one of the major indicators of TB program performance, has decreased drastically and remains low for a prison setting which had very high initial levels of MDR-TB. In 2000, 70 percent of patients completed the standard DOTS regimen in prisons. Finally, the number of new cases treated under the program, compared with those who had previous history of TB is increasing, indicating an earlier detection.

FIGURE 12: DISTRIBUTION OF TB CASES BY YEARS



Source: Center Tanadgoma.

BOX 7: TB IN GENERAL POPULATION: SUMMARY OF RISKS AFFECTING THE SPREAD OF HIV INFECTION

- TB is on decline.
- Predominant in 24–45 years old population.
- Prevalent mostly in male population
- 26.5 percent of AIDS patients developed TB.
- MDR cases.

BOX 8: TB IN PRISONS: SUMMARY OF RISKS AFFECTING THE SPREAD OF HIV INFECTION

- Severe overcrowding
- Poor ventilation
- Prolonged exposure to under-treated TB cases
- Undernutrition
- Inadequate infrastructure and lack of adequate resources
- Low government priority

2. The study was conducted in collaboration with the Emory University School of Public Health, USA

The prisons are the recipients of a multiple pronged and uncontrolled TB epidemic. These dual prison epidemics are driven by: (i) an inadequate infrastructure and insufficient resources; (ii) a unique combination of overlapping risk factors, such as severe overcrowding, poor ventilation, prolonged exposure to under-treated/active TB cases, and general under-nutrition associated with the stress of confinement; and, (iii) low government priority status compared to unmet civilian needs.

HIV/AIDS in Prisons

HIV infection is prevalent in many prisons in the ECA region. The exact number of HIV positive prisoners is difficult to estimate, due to the fact that testing procedures vary from place to place (for example, voluntary testing, screening of all new arrivals, screening on occasion of outbreaks of infectious diseases). Two main conditions probably influence the prevalence of HIV among prisoners: (i) the prevalence of HIV among IDUs in community, and (ii) the criminal sentencing policy for drug related crimes.

Prisons are not only a reservoir for TB, but also a potential market of various injecting products for drug users. The population of inmates is considered a high-risk group for HIV/AIDS. Surveys conducted in 1998, 1999, and 2002 in the prisons in Georgia, revealed a very low prevalence of HIV (five, three, and six cases respectively). All 14 AIDS prisoners were IDUs, out of whom eight were repatriated from Russia, where they tested HIV positive.

Intravenous drug use is widespread in prisons. Although the officials concede, they are reluctant to make official statements or to provide relevant information. Despite the best efforts of prison authorities to prevent entry of drugs into penal institutions, the reality is that drugs can and do enter prisons. Many prisoners come to penal institutions with established drug habits. People who have used drugs outside often find a way to continue using them inside. Often prisoners start using drugs to release tensions and to cope with being in an overcrowded and violent environment. In some cases drug gangs within the penal institutions force prisoners to take drugs.

Sharing of needles and syringes is more common in prisons due to the difficulty in smuggling them as compared to the drugs. Most often, only a handful of needles circulate among large IDU population of prisoners leading to 15–20 people using the same equipment. Sometimes, equipment is even homemade, and needle substitutes are fashioned out of hardened plastic and ballpoint pens, causing damage to veins, scarring, and severe infections.

The high rates of injecting drug use, coupled with the lack of access to sterile injection equipment which leads to increased levels of equipment sharing, can result in a frighteningly quick spread of HIV in penal institutions in Georgia, as has been demonstrated by a number of studies in different countries.

The sexual activity in prisons is generally considered to be a less significant risk factor for HIV transmission, than sharing injection equipment. Nevertheless, it does occur and puts prisoners at risk of contracting HIV infection.

Some prisons in Georgia allow conjugal visits during which prisoners may engage in sexual activity with their partners.

Most sexual activity that takes place in penal institutions involves sex between men. This may also be a consequence of sexual orientation, but most men who have sex in penal institutions do not identify themselves as homosexuals, nor do they accept the label even if they are penetrating a partner. Sometimes they are reluctant

BOX 9: HIV/AIDS IN PRISONS: SUMMARY OF RISKS AFFECTING THE SPREAD OF HIV INFECTION

- Prevalence of HIV in IDUs in community
- Criminal sentencing policy for drug-related crimes
- Prisons being reservoirs of TB, STDs and IDUs
- Risky behavior induced by lack of sterile injecting equipment
- Lack of knowledge
- Limited or no access to health services after discharge from penitentiary system

to acknowledge any such practice. This results in underreporting of sexual activity in penal institutions. Generally speaking, Georgian prison authorities have great difficulty accepting the reality of men having sex with men, as such activities are officially prohibited.

Sexual activity between prisoners varies in frequency and kind. It includes consensual sex and various kinds of non-consensual activity, including so called quasi-consensual sexual activity (for example, submission based on intimidation, or submission in return for protection or other favors).

In fact, the two infections have a symbolic relationship: HIV is fueling the TB epidemic and TB is escalating the HIV mortality rates.

Migrants

Increased migration further aggravates the threat of the epidemic. Since 1990, the scale of external migration has significantly increased. Males make up to 57.1 percent of the arrived and departed migrants, and the females represent 42.9 percent. Almost 80 percent of all migrants are aged under 50, and slightly over half are under 40. The majority of migrants (70 percent) are married, while widows/widowers and singles make up an insignificant share. The highest share among both arrived and departed migrants is Georgians, followed by Russians, Armenians, and Azeris. The great majority of arrived migrants (above 90 percent) are living in the cities.

Harsh economic conditions, unemployment are cited as reasons for leaving the country. The great majority migrated alone from the country and spouses and/or family members have accompanied only about 6 percent. Migrants mainly have only one accompanied person and in most cases it is either a daughter or a son.

External migration is more common towards Russia (50 percent), Turkey (13 percent), and Ukraine (7 percent). The share of men departing for Russia, Ukraine, Azerbaijan, and Armenia are significantly more than women departing for Turkey. Mostly the migrants who arrive in Georgia from Russia are under 40. The reverse flow from Ukraine to Georgia exceeds departures. The migrants coming from Russia mainly cite the purpose as homecoming or home visit, whereas migrants going to Turkey name employment and commerce as their main motivation.

The contributing role of migration on spreading of HIV/AIDS is evident from available epidemiological data. 45 percent of HIV positive cases registered in Georgia and 78 percent of injecting drug-users were infected in Ukraine and Russia.

Occupational Risks to HIV Infection in Health Care

This is an area where there has not been any research nor any interventions applied. To have an understanding of the potential occupational risks in the health care system as well as the risk of acquiring HIV, the authors conducted key informational interviews, as well as site visits. The exercise revealed the following risk in medical facilities: (i) outdated sterilization equipment; (ii) poor sterilization due to electricity shortages; (iii) lack of single use consumables, like gloves, syringes; (iv) frequent use of non-tested blood in emergency cases; (v) no followup mechanisms for the needle stick accidents; and (vi) poor medical waste management.

The reasons why these risks are not mitigated in the sector are many, starting from the lack of public financing, which does not allow the facility managers to maintain proper sanitary conditions, or to periodically update necessary equipment, and the lack of managerial skills preventing timely purchases of regular recurrent items.

ANALYSIS OF THE NATIONAL RESPONSE

To be able to analyze the National Response, the authors have studied the institutional arrangements, political commitment, enabling legal environment, government's program and resource availability, donors and civil society engagement as described below.

Main Stakeholders

HIV/AIDS immediately attracted attention of Georgian politicians since its first detection in late 1995. It led to the formation of State Commission on HIV/AIDS and Socially Dangerous Diseases in 1996. The commission is the highest governing body responsible for the development of the national policy to fight HIV/AIDS and other socially dangerous diseases. The Minister of Labor, Health and Social Affairs chairs it with representations by the high officials from different ministries and state departments. The commission coordinates and closely monitors the implementation of the AIDS prevention program, as well as being in charge for mobilization, allocation and monitoring of financial resource utilization.

The country's political commitment is well demonstrated by the following steps that have been undertaken:

- Since 1994 the state program of HIV/AIDS prevention is operational.
- The National Health Policy Document approved in 1999, highlights strategies to fight HIV/AIDS and other dangerous infection diseases as one of the priority areas.
- HIV/AIDS is recognized as one of the important areas for interventions to reduce poverty in the country and is well articulated in the draft National Poverty Reduction and Economic Growth Document.
- Under the leadership of the state commission the development of the multi-sectoral National Action Plan³ for the prevention of AIDS and other socially dangerous diseases is underway.

3. National Action Plan for the prevention of AIDS and other socially vulnerable diseases is already developed in draft form and represents 5 year multi-sectoral plan (2003–2007)

The plan will be targeting the strengthening of multi-sectoral collaboration and will define the major strategies for HIV/AIDS prevention activities for the governmental sector.

At present, the Government of Georgia is well aware of the great economic importance of the AIDS epidemic, as well as of the necessity of adopting immediate urgent measures to prevent its further spread. Unfortunately, the difficult economic situation does not allow for wide scale initiatives.

The specialized HIV/AIDS control service is coordinated by the Georgian AIDS and Clinical Immunology Research Center and is composed of 12 main laboratories in different regions and cities of the country. Three of these centers, Tbilisi, Batumi, and Kutaisi, have Enzyme-Linked Immunosorbant Assay (ELISA) capabilities for testing. The other nine centers use simple rapid tests for screening. All confirmatory testing is carried out at the Center in Tbilisi and results are released within two weeks. The Center uses the WHO recommended testing protocols for low prevalence settings using two serial antibody tests of different formats, followed by a western blot on dual positive samples. All laboratory technicians are trained at the Center. At the HIV VCT centers, condoms are supplied through UNFPA, and informational material developed by the Center is distributed (quantities are limited due to the high printing costs). The Center has developed targeted material for IDUs and safe sex materials for all groups.

The Georgian AIDS Clinical and Immunology Research Center also provides services for AIDS patients in Georgia. It operates a nine-bed in-patient unit and outpatient services. The resources are available only for the management of opportunistic infections. Patients on anti-retroviral (ARV) treatment are monitored at the Center but expenses are covered through private donations. The Center has also developed a booklet on HIV/AIDS for medical professionals in Georgian and provides occasional training to medical personnel.

Enabling Legal Environment and Shortcomings

Georgia was one of the first countries in NIS that immediately reacted to the epidemic and adopted a law on "HIV/AIDS prevention." The law on HIV/AIDS recognizes: (i) the government's (central, regional and local levels) responsibility for the fight against AIDS; (ii) voluntary screening of citizens on HIV/AIDS; (iii) protection of HIV/AIDS patients' rights, ensuring individual freedom, respect, safety and equality principles; (iv) epidemiological surveillance and state-funded treatment of infected individuals; (v) anti-discrimination, confidentiality, individual autonomy, personal privacy, and free decision making of HIV/AIDS patients (screening is mandatory only for blood, organ and sperm donors); (vi) equal right protection of HIV/AIDS patients, their family members and contacts; (vii) rights, duties, and responsibilities of medical personnel working on HIV/AIDS and the protection of the medical staff.

The law drafting process revealed different points of view among the society and authorities in regard to policy on HIV/AIDS screening. The law adopted in 1995 envisioned mandatory HIV/AIDS screening of every individual coming from a foreign country, as well as Georgian citizens returning from long business trips. Or, they were required to submit an official certificate of the HIV/AIDS test result. Later this article was amended streamlining a right for voluntary screening (except for donors).

The revision of the law had a number of opponents, who demanded further enforcement of the mandatory screening mechanisms. Such attitude revealed that false myths still abound in the society, with the assumption that the country can "close the door" to AIDS patients and thereby reduce the risk of further spreading of HIV/AIDS epidemic. Authors of the Law amendments were able to convince the opponents that enforcement of voluntary screening is based on universal protection of human rights. Furthermore, the amendments increased responsibility of individuals on self-reliance and in general terms it is expected to have a great influence on the overall prevention of the epidemic.

In 1998, the President, and the government of Georgia recognizing the critical epidemiological situation and its possible detrimental effects on the country issued the Presidential Decree #587

on “Enforcement of the process of fight against AIDS and preventive activities.” This was issued to introduce several amendments to the law on HIV/AIDS prevention. Consequently the amended law was passed and adopted by the Parliament in January 2001. The amended law stipulates some mandatory articles necessitated by difficult economic and social conditions of the country namely:

- Infected individuals should inform the service provider about their HIV-status in view of the existing problems in healthcare facilities like inadequate supplies of disposable instruments, inadequate measures of sterilization and improper disposal of contaminated materials, etc.
- HIV-infected person is obliged to inform the sexual partner and/or future spouse about his/her HIV-status.
- The current legislation prohibits employment of HIV-infected individual on some of the positions determined by the law as the high-risk occupational fields (such as surgeons, gynecologists, dentists, surgical, and maternity hospital nurse).

The law ensures maximum possible financial assistance for HIV infected individual in an amount double the monthly salary in Georgia. Although this amount does not cover regular check-up expenses, even a symbolic financial assistance for patients demonstrates the Government of Georgia’s commitment.

The legislation still has important shortcomings that appear to be a main impediment to the achievement of the declared goals. There are two main areas that deserve special attention. As described in previous chapter the revealing mode of HIV transmission is IDUs, therefore to be able to prevent further growth of the epidemic special preventive measures are required for this risk group.

Although there is a general understanding and knowledge of what, when, where and how it has to be done, current legislation creates barriers for effective measures, as drug abuse is considered to be a criminal neglecting its social dimensions. Although the state program includes free HIV screening of IDUs, only small number of drug-users admit usage of drugs, being afraid to be imprisoned. This impedes timely detection of the HIV cases among the high-risk group. Unfortunately, due to inadequacy of the proper legislative base, Georgia is not able to implement the drug harm reduction projects, including needle and syringe exchange programs for IDUs that have been effective in a number of countries.

Another important area is legalization of commercial sex. So far Georgia has failed to establish enabling legal environment to be able to design and implement effective preventive measures targeting the high-risk groups. There are diametrically conflicting attitudes regarding this issue among different layers of the society. The most frequently observed attitude is that of aggression and unacceptability, thus making the sector difficult to regulate.

State HIV/AIDS Program

In 1995, in response to the economic crisis that brought public expenditures on health to a level of less than US\$1 per capita per annum, the Government launched an ambitious health sector reform program. The reforms began with a series of legislative acts and policy statements that laid out the basic principles of the new system. These were based on a vision of a social insurance model of health care financing, maintaining the principles of solidarity and equity. Good health would be maintained through a primary care based system, which emphasized health promotion and disease prevention. Financing was to remain semi-public through social insurance and out of pocket payments, provision of services was to be a public/private mix, with a few key facilities remaining in public hands in order to ensure access to remote areas and to specialized services. Competition between providers was introduced and reimbursement for services provided paid through new public financial intermediary agencies.

One of the principles of the health reform was to balance between the state’s responsibilities on health care and the state’s ability/resources to fulfill its responsibilities. The state limited its liabilities on health care focusing scarce resources mostly on public health and several curative health programs

through the design of package of services (Basic Benefit Package “BBP”). BBP defines the volume and types of medical services provided to population either free of charge or under different cost-sharing arrangements. The BBP has been split in two types of state programs: municipal and central state health programs financed by different sources and administered by different financial intermediaries. State healthcare programs are grouped into “public health,” “obligatory medical insurance,” “other healthcare,” and “local municipal programs.”

Since 1999 three independent programs have been implemented as part of the state health programs. These are prevention of HIV/AIDS, prevention of STDs, and safe blood program. Due to the inefficient public financing and necessity to efficiently use available scarce resources, the MoLHSA integrated all three programs into one. The program intends to provide: free of charge screening (screening and confirmatory tests) of high-risk groups; free of charge phone and clinical consultations to interested individuals; management and monitoring of epidemiological surveillance system; education and information of general population with particular emphasis on high-risk groups and youth regarding the prevention of HIV/AIDS and STDs; and finally the training of medical personnel and promoting a healthy lifestyle.

The state program also includes partial treatment programs for AIDS patients. However, due to inadequate public resources, this is limited to cover the cost of specific anti-retroviral treatment for all registered AIDS patients and only provides treatment for opportunistic diseases. This program was introduced in 1997, when only five patients required treatment, but now the number of patients has greatly swelled and is expected to grow even more. A pertinent question would be whether the required public funds could be made available to meet the new current and projected future demands. So far, the Government of Georgia has failed to allocate the resources needed and covers the treatment costs for only those patients who had already started the treatment (five patients).

Donor Assistance

Since 1997, a UNAIDS theme group (TG) has been established, which includes top-level managers of various UN organizations that are active in Georgia. The main purpose of the TG is to enhance collaboration between UN organizations and to work with the Government of Georgia in the field of HIV/AIDS prevention. A UNAIDS technical group headed by UNICEF was formed in 1999, to provide technical assistance to the TG.

UNICEF's contributions include: (i) supporting the establishment of a National Commission to review legislation related to HIV/AIDS and to recommend reforms, (ii) supporting the formation of an alliance of 130 multi-disciplinary NGOs to address HIV/AIDS; and (iii) supporting the need for life skills education in the Georgian curriculum. UNICEF-Georgia has also received a \$200,000 grant from UNAIDS/Geneva to establish a technical office on HIV/AIDS in Tbilisi to facilitate UNAIDS activities.

UNFPA has played a key role in Georgia in the promotion of reproductive health, including STI/HIV prevention. This includes supply of condoms for free distribution through public sector and NGOs, reproductive health programs; and design and development of IEC materials for adolescents, including brochures, pamphlets, and TV and radio materials.

Open Society Institute (OSI) focuses on public health issues including IDU interventions. A one-day seminar was held in March 2000 on methadone maintenance in Georgia. At present, OSI is awaiting the decision by authorities regarding whether regulations would be changed to allow this type of intervention. According to the OSI/Georgia office, OSI would support some of the implementation of methadone maintenance (this support would not include the cost of procurement of methadone) and introduction of the needle exchange focal points, as part of OSI's Global Harm Reduction strategy.

MSF/Greece, as a part of its outreach efforts to CSWs, has established an STD clinic within the STD Institute. The STD clinic tests for common reproductive tract infections including gonorrhea, chlamydeous, and syphilis. The Project operated a confidential hotline covering safer sex, contraceptives, STDs and HIV. The institute also produced 12 pamphlets concerning contraception

and family planning, all of which were inspired from foreign materials. The center had 1500 client contacts for counseling since the beginning of 2000. MSF/Greece was the only group actively working with sex workers. After their closeout, a local NGO “Tanadgoma” assumed these responsibilities. Funding for the project from MSF-Greece ended in December 2000.

USAID has been an important donor in the Caucasus region focusing on democracy building, social stabilization and economic privatization. However recently USAID has reoriented its strategy in Georgia to balance short-term humanitarian assistance and midterm transitional programs to assist communities in developing their capacity for delivery of basic health services. In the recently drafted USAID Georgia Health Action Plan, STI/HIV was viewed from a multidimensional primary care approach, encompassing both HIV and STIs and involving local, national and regional activities. Local projects will concentrate on prevention of STI/HIV among high-risk groups. A national approach has involved key Georgian leaders in STI/HIV prevention through study tours and informational training and workshops. The long term regional approach will involve those border countries contiguous to Georgia, including the countries that border the Black Sea, in an effort to implement mutual strategies for cooperation and intervention. These activities may become a collaborative effort between other partners and the successful applicant for this project.

Presently, USAID/Caucasus has a limited number of HIV activities underway. Population Services International (PSI) launched an 18-month condom social marketing (CSM) project in October 2000. The long-term goal of the project is to decrease the spread of HIV and to improve the reproductive health of young people in Georgia, including a reduction of unintended pregnancies. The project has developed and launched an affordable and accessible condom brand targeted at youth. In the fall of 2001, PSI held a conference for key stakeholders in HIV activities in Georgia, Armenia and Azerbaijan to share information and to discuss cross border issues.

The John Hopkins University/Population Communication Services (JHU/PCS) program is designed to support and strengthen Georgian families by providing public information services and education for married couples to assist them in making informed choices regarding healthy family planning. During 2001, promotion of the PSI condom, as a means of protection from HIV/STIs, was integrated into the *Care For Each Other* campaign. In addition, the program promotes STI prevention through reproductive health (RH) cabinets. JHU/PCS developed an STI counseling cue card for providers at RH cabinets. The RH hotline refers callers to appropriate service providers for STI diagnosis and treatment.

The Level of Civil Society Engagement

Although there are several local non-governmental organizations active in the sphere of HIV/AIDS and STDs prevention in Georgia, the response from the civil society still is somewhat limited. A brief description of areas and types of activities carried out by the NGOs follows.

HIV/AIDS Patients Support Foundation is the first Non-governmental organization founded in 1999, which became an official member of the international organization Global Event (Global Health Council). The members of the Foundation are doctors, psychologists and specialists, and also the HIV infected individuals. The major focus of the Foundation is on educating the people on the prevention principles, and providing psychological and social support to HIV infected individuals and their family members. Together with AIDS Center, the foundation actively participates in the anti-AIDS campaign in Georgia.

The NGO “Sasoeba” mainly works with drug addicts by providing treatment and psychological rehabilitation of IDUs. For this purpose the NGO offers a special consultation for drug users together with education on safe injection. It is demonstrated that the use of non-sterile (the so called friendship syringes) put IDUs in a real danger of HIV/AIDS. Unfortunately, due to lack of sufficient financial support, they work only with a limited number of IDUs.

The NGO “Tanadgoma” conducts the meetings and consultations with HIV/AIDS high-risk groups, mainly CSWs, MSM, and others. The NGO provides consultations on safe sex, AIDS and STDs prevention, unplanned pregnancy protection, and use of contraceptives. Consultations

are anonymous, confidential, and free of charge. The major interest is concentrated on the university and high school students. “Tanadgoma” also distributes contraceptives, including condoms that are provided to the organization by the Ministry of Health of Georgia. After the consultations, the organization sends citizens to the respective medical centers for professional consultations, diagnosis and treatment. In cases of suspicion of HIV/AIDS, consulted individuals are sent to AIDS center. The organization conducts field lectures and conversations on “Healthy life style” for the students of high schools and universities.

Bemoni is an NGO with a private detoxification clinic in Tbilisi. It has received funding from the European Union and GTZ to work with school youth, parents, teachers and school psychologists in an effort to prevent drug use among youth. The NGO currently has five staff members and has started a center for drug prevention and counseling which is open to drug users and anyone working with youth.

The Institute of Narcology provides both in-patient and outpatient detoxification services for drug addicts. It currently has no outreach services or long-term treatment services for the addicts.

The NGO Children and the Environment works with street children in Tbilisi. It recognizes that sex work is occurring in the street children population, but has not directly addressed the issue.

Summary of the National Response Analysis

The foregoing discussion and analyses covering the main elements of the national response still leaves behind important unanswered question, such as “what has been the effect of the HIV/AIDS national response?” To be able to conduct sorrow analyzes, authors used the AIDS Program Effort Index (API) diagnostic tool developed by UNAIDS, USAID, and POLICY Project. This tool helped the authors to indicate the weak and strong areas of the program and to suggest corrective measures. For this purpose a series of interviews and meetings were held with key informants and results were evaluated according on a scale from negative to positive. The key informants were not meant to be a representative sample but were carefully selected for their knowledge and viewpoint.

The summary of the diagnostics revealed the following results:

- a. The country has organized a reasonable effort, however there is considerable room for improvement.
- b. Respondents judged that the best efforts have occurred in the establishment of organizational structure, legal and policy areas. Even in these areas considerable improvements are needed primarily to ensure that policy is implemented in a conducive legal environment that protects human rights of people regardless of their affiliation either to risk groups and/or to HIV/AIDS patient groups.
- c. The political commitment of national leaders to confront HIV/AIDS has been a major concern to many. Commitment has been weak and this has affected programs in a variety of ways.
- d. One of the weakest areas is availability of resources. Respondents felt that resources devoted to HIV/AIDS programs are inadequate to support an effective response. Although financial resources increased in past two years mainly due to donor contributions, the increase was small compared to other components and political commitment has not yet led to a similar increase in resources.
- e. The diagnosis shows quite clearly that the effort that is currently being made to care for people living with HIV/AIDS is the weakest component of the program. Care and availability of adequate services are the lowest rated components.
- f. Service availability is a major problem as the majority of population does not have access to most of the services. The best scores were given to safe blood, condoms and STDs services. All other services reached less than half of the population.
- g. United Nation agencies and other international donors are making a significant contribution to the program effort. It is apparent that international assistance is a positive factor. The international contribution is greatest for policy, planning, and prevention, but weakest for care.

BOX 10: SUMMARY OF NATIONAL AND INTERNATIONAL RESPONSE TO HIV/AIDS

	Indicators	Status
Political Support	High-level government support exists for effective policies and programs	+
	Public opinion supports effective programs and policies	–
	Top government civil servants outside of the MoH recognize AIDS/STIs as a priority problem	+/–
	Major religious organization support effective policies and programs	–
	Private sector leaders support effective policies and programs	–
	There is awareness among policy makers that improving women's social and economic status is important to AIDS prevention	–
	International organizations have made a significant contribution to strengthening the political commitment of top leaders	–
	Summary of Political Support	–
Policy Formulation	A favorable national policy exists	+
	Formal program goals exist	+
	Special and realistic strategies to meet program goals exist	–
	A national coordination body exists and functions effectively	+/–
	Policy Dialogue and formulation involves NGOs, community leaders, special interest groups etc.,	+/–
	International organizations have facilitated policy formulation through provision of technical assistance and guidelines	+/–
	International organizations have facilitated planning through the provision of technical assistance and guidelines	+/–
	Summary of Policy Formulation	+/–
Organizational Structure	The AIDS Control Program or National AIDS Commission is placed high in the government structure	+
	The Director of the AIDS Control Program is full-time and reports to an influential superior officer	+
	The multi-sectoral approach has been implemented and functions well	–
	The private sector is formally included in the AIDS Control Program	–
	Efforts are made to ensure community participation	+
	There is good coordination between activities of the national government, local governments, NGOs, private sector and international donors	+/–
	Summary of Organizational Structure	+
Program Resources	Resources are allocated according to priorities	+
	Resource allocation decision are based on considerations of cost-effectiveness of interventions	+/–
	Adequate funding is available for public prevention programs	–
	Adequate funding is available for care of people living with HIV/AIDS	–
	Adequate funding is available for programs to mitigate the impact of AIDS	–
	The private sector plays a significant role in funding HIV/AIDS prevention and care programs	–
	International Donors have provided a significant portion of funding for prevention programs	+
	International Donors have provided a significant portion of funding for care programs	–
	Summary of Program Resources	–

(continued)

BOX 10: SUMMARY OF NATIONAL AND INTERNATIONAL RESPONSE TO HIV/AIDS (CONTINUED)

Indicators		Status
E/M & Research	Operational and financial plans are developed that correspond to objectives and targets	+/-
	Evaluation and research results are actively employed in policy formulation and program planning	+/-
	Mechanisms and structures for monitoring and evaluation, such as formal evaluation unit, exist within the programs	+/-
	Special studies are undertaken as needed to improve the program	+/-
	A sentinel surveillance system for HIV infection exists and functions regularly	+
	A behavioral surveillance system exists and functions regularly	-
	Summary of Evaluation, Monitoring and Research	+/-
Legal and Regulatory	Condom advertising is allowed	+
	There is no restriction on the import of condoms	+
	There are no restrictions on the condom distribution	+/-
	There are no restrictions on who may receive STI services	+
	There are no restrictions to the IDU treatment and prevention	-
	CSW is legalized and well regulated	-
	International conferences, documents, guidelines, covenants, conventions and treaties have been incorporated into national law or contributed to legal and regulatory reform	+/-
Summary Legal and Regulatory Environment		+/-
Prevention Programs	Guidelines to reduce the risk of HIV transmission to health workers	+
	An active program to promote accurate HIV/AIDS reporting by the media	-
	A functioning logistics system for drugs for the treatment of STDs and opportunistic infections	-
	A functioning logistical system for condoms	-
	A social marketing program of condoms	+
	Special prevention programs for high-risk groups	+/-
	Confidential counseling and testing services	+
	Family life education for Youth	+/-
	Programs to prevent mother-to child transmission by providing testing, counseling, antiretroviral treatment and infant feeding	-
	National IEC program	+/-
	A harm reduction program for IDUs	+/-
	People living with HIV/AIDS are formally included in the program	+/-
	International research has contributed significantly to the training of local staff working in prevention programs	+/-
	International research has contributed significantly to the design of program interventions	+/-
	International Organizations have helped program design and implementation through technical assistance and guidelines	+/-
Summary Prevention Programs		+/-

(continued)

BOX 10: SUMMARY OF NATIONAL AND INTERNATIONAL RESPONSE TO HIV/AIDS **(CONTINUED)**

	Indicators	Status
Care Programs	Up-to-date policies exist for the care and support of people living with HIV/AIDS	–
	An essential package of care and support is provided through the national health system (voluntary counseling and testing for HIV, psychosocial support, palliative care, treatment for pneumonia, oral and vaginal candidiasis, and pulmonary TB, and regulated delivery of care in particular of TB, STDs and advanced care options	–/+
	An intermediate package of care and support is provided through the national system (essential package plus enhanced TB management, cotrimoxazole prophylaxis, systemic antifungals, treatment of Kaposi's sarcoma with essential drugs and treatment of cervical cancer with surgery	–/+
	A comprehensive package of care support is provided through the national health system. (intermediate package plus antiretroviral therapy, diagnosis and treatment of MAC, CMV, MDR TB, toxoplasmosis and HIV-associated malignancies	–
	A comprehensive program exists to provide needed support to AIDS orphans	–
	International programs have contributed significantly to the training of local staff working in care programs	+/-
	International research has significantly contributed to the design of care programs	–
	International organizations have significantly helped program design and implementation through technical assistance and guidelines	–/+
	Summary Care Programs	–
Service Availability	Percent of sexually active adults in the capital city having reasonably convenient access to the following services (condoms, STDs treatment, voluntary counseling and testing, IEC programs for HIV prevention)	+/-
	Percent of blood transfusions using screened blood	+/-
	Percent of IDUs have reasonably convenient access to needle exchange program	–
	Percent of HIV+ people having reasonable convenient access to quality medical care of HIV related problems	–/+
	Percent of HIV+ people having reasonable convenient access to family and personal support to cope with affects of HIV	–
	Percent of youth having reasonably convenient access to the information about safe sexual practices	–/+
	Percent of pregnant women having reasonable convenient access to programs to prevent mother-to child transmission of HIV	–
	Summary Service Availability	–

+ positive; – negative; +/- moderate

HIV/AIDS PROJECTIONS AND POTENTIAL IMPLICATIONS

Projection Methodology

The low national prevalence rates of HIV/AIDS, at present, can be very misleading. They often disguise serious epidemics that are initially concentrated in certain localities and/or among specific population groups and that gradually threaten to spill over into the wider populations. All countries have, at some point, in their epidemic histories, been low-prevalence countries.

The evidence indicates that HIV prevalence is on the rise in Georgia. Experience in neighboring countries such as Russia and Ukraine suggests that HIV prevalence in Georgia could rise even higher than at present. However, the intensity of the rise cannot be predicted accurately. If it follows the patterns of some neighboring countries, a rise in incidence over the coming years is almost certain. However, if an expanded and effective program of interventions is put in place, the epidemic could remain relatively stable.

As part of the original research, projections were prepared to assess what the epidemic might look like in the years ahead. Projections presented here are not intended to be *forecasts* of what will happen, but should be seen as *possible ways* in which the epidemic might develop without intervention. It is very difficult to make accurate predictions as the type of data needed are simply not available and projection models so far developed are not applicable to ECA region.

For purposes of this analysis we will look at lower prevalence. To project the number of new infections in future, it is necessary to make an assumption about future levels of adult prevalence, or the percentage of adults aged 15–49 who are infected with HIV in the country. Due to the lack of official accurate data, the authors were limited to use any proposed projection models, therefore the country specific projections were based on the methodology developed by the authors themselves and is explained briefly below.

The model developed was based on following indicators and assumptions as given below:

1. *Projected birth* (PB): calculated by making an assumption that in 1000 population the birth rate in average would be 8.9 (as of 1999).
2. *Total mortality* (TM): equal to no AIDS mortality plus Aids mortality.

3. *No AIDS mortality* (NAM): calculated by making an assumption that per 1000 population the death rate would remain same as in 1999 and would be 8.8.
4. *AIDS mortality* (AM): assumption is made that AIDS patients die in Georgia within 3 (high) years after development of AIDS, therefore AIDS mortality cases equal to the cumulative number of AIDS cases for last 3–4 years.
5. *Projected population* (PP): $PP = PP(\text{previous year}) + PB - TM$.
6. *Population at risk* (PR): estimated that about 44 percent (as for 1999) of total population represents 15–49 age group.
7. *New entrants* (NE): assumed that represent 8.8 percent of total population (as in 1999) from the previous year.
8. *New entrants at risk*: it is assumed that about 30 percent of new entrants are exposed to the risk of acquiring HIV/AIDS.
9. *Total Population at Risk (15–49)*: $TPR = PP + NE$.
10. *Estimated new HIV cases*: based on 12 years HIV progression experience the factor of 1.8 was calculated and subsequently used for further projections.
11. *Estimated new HIV cases in the new entrants at risk*: assuming that only 30 percent of new entrants at risk may become infected.
12. *Cumulative HIV cases*: cumulative from previous years + total estimated HIV cases in a given year—new cases of AIDS in the given year.
13. *Incidence*: total new cases for the given year/total population at risk in the given year.
14. *Prevalence*: defined as the number of affected persons in the population at a specific time divided by the number of persons in the population at that time.
15. *Estimated AIDS cases*: Estimated cumulative HIV cases—estimated cumulative AIDS cases $\times 0.2$. The assumption made is that the health care system would be able to detect only 20 percent of cases.
16. *Estimated Cumulative AIDS cases*: estimated cumulative AIDS from previous year + estimated new AIDS cases for the given year—AIDS mortality for the given year.

Projections

Prevalence rates do not reflect the true impact of the epidemic. The 15–49 age group includes people who are not yet infected with HIV, but who may develop the infection subsequently. Prevalence also excludes men and women who were infected but have already died. If the probability that a person will become infected at any time in his or her life is summed up, the cumulative figures is higher than the snapshot provided by current and projected prevalence rates.

To have a better idea of the actual risk of dying of HIV associated diseases, researchers need to build models to follow up people throughout their lives, examining their exposure to risk of infection with HIV at each age. Developing of such models is not the objective of this task, therefore presented projections are not intended to be forecasts of what will happen, but should be seen as possible ways in which the epidemic might develop without interventions, as it is very difficult to make accurate predictions. Therefore, the following sections should be read with these caveats in mind.

Although the national prevalence in 1999 was estimated at about 0.012 percent it seems to be increasing and is likely to reach 3 percent (Figure 13). If HIV prevalence increases up to the indicated levels in 2015, then the number of estimated HIV positive population is estimated to increase as well, as is shown in Figure 14. The number of new AIDS cases each year resulting from these infections would increase to 600,000 by 2015.

AIDS will increase the death rate at all ages. However, the impact will be most severe among young adults and children under the age of five. Without AIDS, the annual number of deaths among young adults (ages 15 to 49) would decrease slowly (observed trend) or remain stable. However, AIDS will increase that number by 35 percent by the year 2015. This increase in young adult deaths would have serious consequences for economic and social development. Many of these impacts are examined in the next section of this report.

FIGURE 13: NUMBER OF PROJECTED NEW HIV POSITIVE

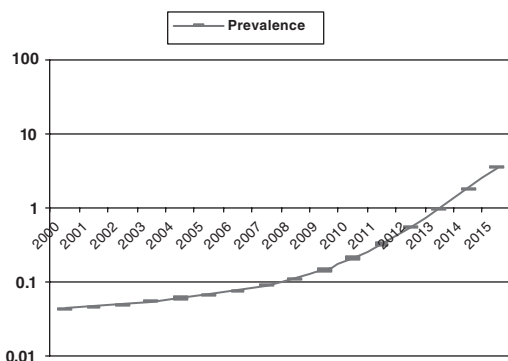


FIGURE 14: PROJECTED PREVALENCE AIDS CASES ('000)

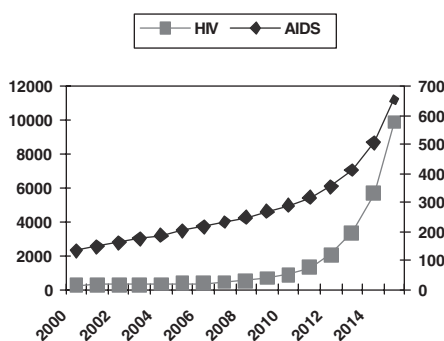
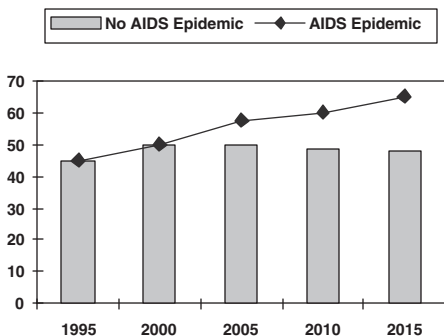


FIGURE 15: PROJECTED MORTALITY (15-49 YEARS OLD) '000



Social Impact of the Epidemic

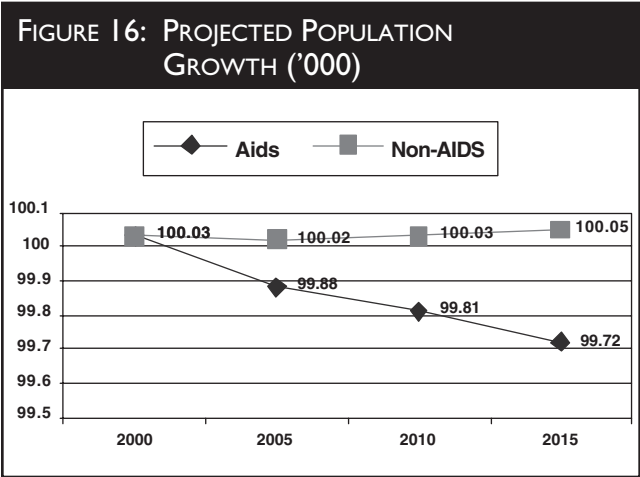
According to the projected level of the HIV/AIDS, the epidemic will affect the demography of the country, which will mean massive changes in the way societies organize themselves, make living and care for the family members.

The premature death of many adult population (Figure 16), typically at ages when they start forming their own families and have become economically active, can be expected to have a radical effect. Although it is difficult to measure precise social impact of HIV and no such studies have been carried out in Georgia, the worldwide experience suggests that the epidemic does affect everything from households to the public and private economy.

Households. A Significant decrease in the number of economically most active population, especially the bread earners, will have a devastating impact by dramatically decreasing the family income. Currently about 40 percent of Georgian families are below the poverty line. In case the epidemic affects the economically-active family members, it is estimated that this indicator will further deteriorate.

The number of people in formal sector employment has declined over the course of the last decade. Between 1998–1999, the number of employed decreased from 55.7 percent of economically active population to 56.9 percent. Hidden unemployment further compounded the picture with those recorded as “employed” being on unpaid or partially paid leave and those working a shortened working days. All these factors contribute to the reduction in living standards and create new challenges faced by the economically active part of the Georgian society.

The decline of living standards below subsistence levels is indicated

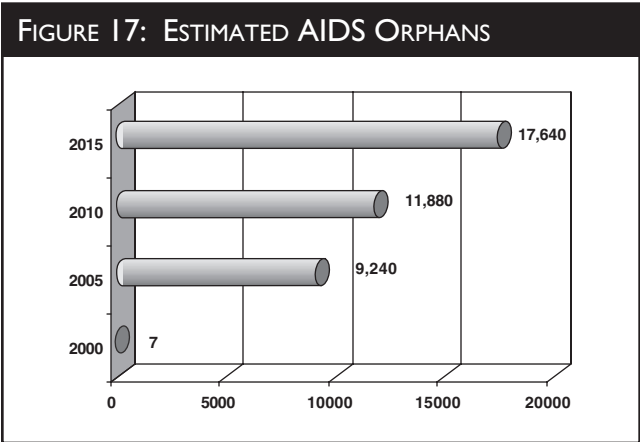


households health expenditures will increase by about 30 percent and will be used only for AIDS palliative treatment.⁴

Orphans. One of the worst impacts of AIDS deaths to young adults is an increase in the number of orphans. Some children will lose their father or mother to AIDS and many more will lose both parents. Typically, about half of adult people with HIV become infected before they turn 30, acquiring AIDS and dying by the time they turn 35, leaving behind a generation of children to be raised by their grand parents and extended family members or institutions.

The number of AIDS orphans could increase from 7 orphans⁵ in 2000 to 17,640 by 2015. These children may lack the proper care and supervision they need at the formative phases in their lives. There will be a tremendous strain on social systems to cope with such a large number of orphans.

At the family level, there will be an increased burden and stress for the extended family (for example, the grandparents that are saddled to care for these orphans). However, children will suffer in many ways, being taken out from school due to the reduced incomes and for help required at home. They will become more prone to malnutrition and illness.



At the community and national level there will be an increased burden on society, in future years, to provide services for these children, including orphanages, health care, and school fees.

There may also be an increase in the number of urban street children, as well as increase in child labor, applied by orphans as a coping mechanism.

4. HHs health expenditures include only palliative care costs for the AIDS patient.
5. National average number of children per family as of year 2000 is 1.2. For the projection of number of AIDS orphans, a factor of 1.2 has been used.

Women. AIDS can have very serious repercussions on the lives of women when it strikes a family member. In most cases women do not have a secure occupation that can provide a steady and adequate income. Thus, if the husband dies, the remaining wife and children can be particularly vulnerable. Some women may be exploited or may have to resort to selling sex to provide cash income.

A woman may also have reduced ability to be a provider for the family if she needs to spend a significant portion of her time caring for family members who are sick with AIDS. It may reduce the time she has for productive work, as well as affecting the amount of time she can spend caring for children. Because other tasks, such as food preparation, fetching water and fire wood, etc., must still be done, many women will have to work much harder than normal in order to cope with AIDS in the family.

Sectoral Impact

What makes AIDS so important to national development is the fact that it affects the development of virtually all sectors, as it is much more than a health problem. In the following section we will try to estimate the potential AIDS impact on selected sectors.

Agriculture

Agriculture is one of the most important sectors in Georgia, particularly when measured by the percentage of the people dependent on it for their living. The sector currently produces about 40 percent of the country's wealth (measured as percent of country's Gross Domestic Product) and may well provide subsistence to more than half of the total population. The impact of AIDS is devastating at the family level, as when an infected farmer becomes increasingly ill, he and family members looking after him spend less time working on the farm. The family begins to lose the limited income it possessed, has to buy food which it normally grows and may even have to sell household goods to survive. The vicious cycle is compounded by the increasing costs of health care. Apart from the households, this will also have a negative impact on the country's economic growth by decreasing production and sector output.

Labor

The loss of people in most productive years of their lives will certainly impact the overall economic output of the country. Some sectors, particularly those that require trained and skilled workers, will be harder struck than others. The productivity of an enterprise will be affected even before an employee dies, due to lost workdays because of illness. The number of workdays lost due to illness for a person with HIV/AIDS can range from as few as 30 days to as many as 240 days in a year.⁶ Even healthy workers may need more time off from work to attend funerals of relatives and co-workers and/or take care of ill family member.

AIDS has an adverse effect on the productivity of enterprises and firms. AIDS related illness and death to employees affect a firm both in increasing expenditures and reducing revenues. Expenditures are increased for training and recruitment of replacement employees. Revenue decreases as a result of absenteeism due to the illness or looking after ill family member. Labor turnover can lead to a less experienced labor force that is less productive. Thus HIV/AIDS presents a dual challenge in that it is both an extremely serious health problem and a major economic concern.

Transport

The transport sector is especially vulnerable to AIDS and also important to its prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, which increases the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families and are more susceptible to unprotected sex.

6. HIV/AIDS in Ghana, 2001, National AIDS/STI Control Program, Ministry of Health

Health Care

The major significance of HIV/AIDS epidemic is that it will put stress on the health care system in Georgia at a time when it is already under great pressure. The crucial determinants of the impact on the health care system will be: how many people will require such care from the state and how many are treated.

The treatment of the AIDS patients is expensive and will place considerable strains on the delivery of health services in the country. The demand on health services due to AIDS can be examined by looking at health care expenditures. A rapid analysis undertaken within the framework of this study sheds light on the costs to treat the opportunistic infections afflicting the AIDS patient in the country for one year and the resultant burden of the epidemic for the whole health care system. To be able to measure the impact the authors made the following assumptions: (i) that only half of those with AIDS will seek the state health care system; (ii) that allocation of resources for treatment of each patient will remain constant and would represent 1000 USD per patient per annum; and (iii) that each patient will seek care only for one year.

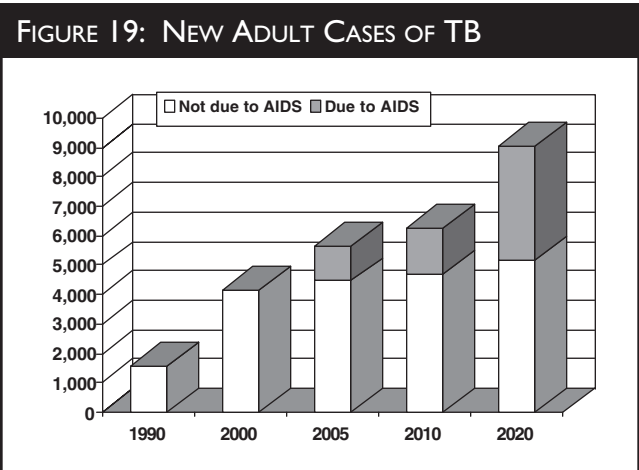
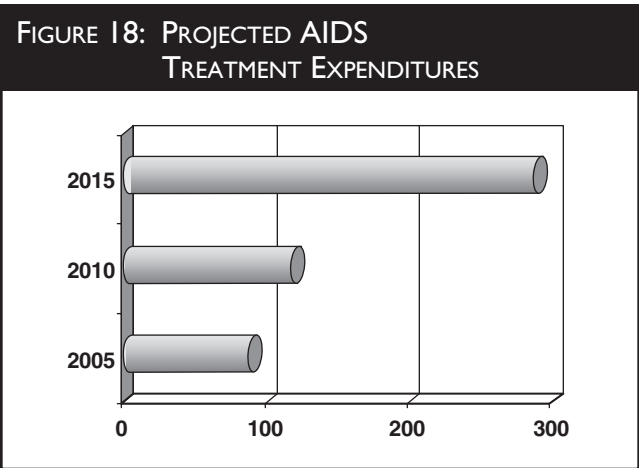
Figure 18 illustrates the total health expenditures required in Georgia to treat these opportunistic infections. The expenditures would increase from US\$80,000 in 2000 to US\$289,000 in 2015. The increasing need of additional financing for AIDS care threatens to divert spending from other important health care needs, or leave many AIDS patients without adequate care. In case fund-

ing is relocated from other health needs, then mortality and morbidity not related to AIDS is likely to increase as well, adding to the overall impact of the epidemic.

It is clear that the cost of AIDS care will have a major bearing on the allocation of health resources. Analysis of the cost of care will vary depending whether one is considering only the essential drugs for opportunistic infections or the full cost of anti-viral treatment.

The exploding tuberculosis in the country underscores the burden of the epidemic on the health sector. Efforts in the past to control TB have shown limited success, and the epidemic reached a plateau. However, the evidence shows that HIV infection weakens immune system of otherwise healthy adults and makes individuals far more vulnerable to develop active TB, thus causing increase in the incidence of TB again.

At present the frequency of HIV in TB patients is registered to be 0.67 percent. After 12-month control, HIV new cases were not detected in TB patients. To project how the TB epidemic will develop further with and without HIV/AIDS, assumptions had been made that the



frequency will remain constant and among people with both HIV and latent TB infections, 5 percent will develop TB each year. Under these assumptions, the additional number of TB cases due to HIV infection would be about 3,871 by 2015.

Even this is likely to be an under-estimate since TB is infectious through casual contact and will transmit the disease to others. Therefore the impact of HIV infection on tuberculosis is a serious problem because it threatens to vastly increase the risk of TB for the entire population. Also, drug-resistant strains of TB are making it much more difficult and expensive to treat tuberculosis making the control of TB expensive and puts considerable strain on the health budget.

The development of new therapies for HIV infected individuals and of vaccines will further raise health care costs in infrastructure, drugs, training and personnel expenditure. At the same time, HIV related illness and premature death among health care personnel, although not registered yet, will continue to create costs of another kind for the sector.

Social Security

Because AIDS threatens the future of the society, it must be an important concern to social security administrators. The death and sickness caused by AIDS will cause a persistent erosion of the social security base. The magnitude of the impact and the actual channels through which the erosion takes place will depend on the location of the infected individuals in the economy, and their role in the household and the community.⁷

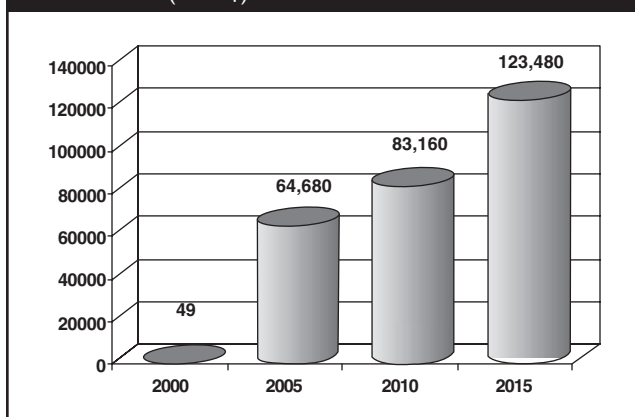
One obvious consequence of HIV/AIDS is further erosion of the tax/contribution base, by decreasing the number of employed individuals and by weakening the income generation system, thereby consequently declining inflows for the social security system. The AIDS epidemic has thus the potential of hitting the safety net from both sides, the benefit side on the one hand and the revenue side on the other.

For the purposes of estimating burden of the epidemic on the benefit side of the social security system we would limit ourselves only to the pension example.

As described in Figure 17, the number of AIDS orphans will increase from 7 in 2000 to 17,640 by year 2015. According to the present legislation all children would be eligible to the social pension in an amount of \$7 per month/per child due to the death of the breadwinner, (assuming that given amount will not be farther increased). Therefore the demand for this budget line item would increase by 18.5 percent from US\$49 in year 2000, to US\$123,480 by the year 2015 (Figure 20).

A simple calculation method has been used to projecting the potential impact of the epidemic on the social security system's contribution base. There is a general understanding of the authors that the method greatly underestimates the changes that would occur in the age structure of the Georgian population,⁸ as well as economic growth of the country and future employment opportunities, which

FIGURE 20: SOCIAL BENEFITS 2000-2015
(IN US\$)



7. Theodore K. et al; The Impact of HIV/AIDS on Social Safety Nets: What can the Caribbean Expect.

8. Due to the available data limitations the projection methodology used was not able to predict structural changes of the Georgian population by age.

in itself would change the future picture. For this purpose following assumptions have been made: (i) percent of economically active population would remain same as in 1999 and would represent 52.8 percent of the total labor force; and (ii) employment growths and employment opportunities will remain at the present level. The results are obvious (Figure 21). The trends of employment that decrease due to only HIV/AIDS (without taking into account non-AIDS death) would represent 11.5 percent decrease by year 2015.

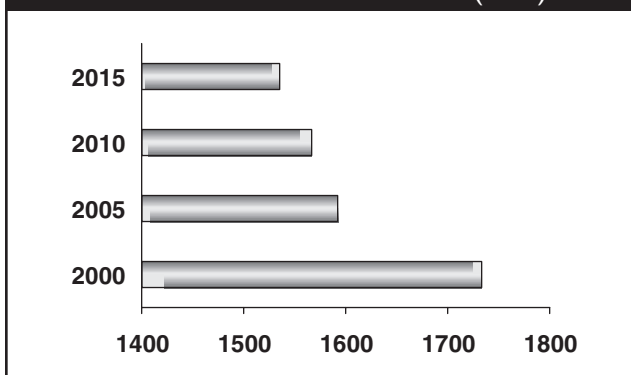
The fact is that with more contributors dying before retirement age, the social value of the security system will shift to the pre-retirement living conditions of the contributors and their dependants. Therefore there is a need for the system to reassess its role and policy. The sector may deepen its understanding of the HIV/AIDS epidemic, which would facilitate the involvement of the social security schemes in the prevention and care program. The sector should adopt a planning process that is truly strategic to ensure that appropriate projections of HIV/AIDS and the impact of the epidemic on the social security system are taken into consideration and factored into actuarial analyses. However, there is a critical need to ensure that projections of growth in HIV/AIDS are based on appropriate epidemiological models that generate rigorous estimates on the incidence of the disease.

Poverty Deepening

The effect of HIV/AIDS on households is profound. Lost income and diversion of assets to caring for affected family members, will impoverish families. AIDS causes labor losses or diversion from production to care. The falling production affects the country's economy, as a whole. AIDS will generate new poverty, as people will lose housing and employment. Household incomes will fall due to loss of wage earners and rising expenses, particularly on care, treatment and funerals. At the same time, AIDS will decrease public spending on health and welfare services.

Poverty resulting from AIDS will interact with other dimensions of poverty to generate a vicious downward cycle. The loss of income and assets, social marginalization and disruption of social support networks will undermine outreach of HIV interventions into affected communities. Social exclusion will make it difficult for the poor households to access HIV/AIDS programs, and will reduce incentives for behavior change. Risk reduction strategies need to effectively replace high-risk survival mechanisms, and be backed by supportive environment to be viable.

FIGURE 21: NUMBER OF ECONOMICALLY-ACTIVE POPULATION CONTRIBUTING TO THE SOCIAL SECURITY SYSTEM ('000)



POLICY IMPLICATIONS

As mentioned in Chapter 2, the Government of Georgia initiated a comprehensive and multi-sectoral National Plan of Action. This strategy should aim to generate greater political commitment by the government, to mobilize more resources from within and outside, and to replicate on a national scale a more comprehensive program that includes an increased number of interventions targeted at virtually all groups in the society.

The response should emphasize prevention as well as treatment, policies and programs to mitigate the impact of AIDS, and policies that will change the societal factors that influence vulnerability to HIV in the long term. Priorities should be defined from a technical point of view and not a ranking of interventions according to their costs and impacts.

In the next sections of this chapter we would briefly outline main barriers that need to be counted during the development of the comprehensive multi-sectoral national action plan.

Lack of Leadership and Implementation Capacity

Concerted efforts by Georgian politicians and national leaders to openly discuss HIV and engage the public in HIV prevention efforts can set the stage for a national-level mobilization against the epidemic. A high level political commitment is necessary for developing a coherent strategy for responding to the epidemic and for providing leadership and direction to public and private partners. While there have been some preventive activities undertaken by the state, these have generally occurred on a more localized scale and often in the absence of highest political leadership.

Because the implementation capacity of the government is so stretched already, expanded multi-sectoral responses are likely to dramatically increase the responsibilities of NGOs and the need for coordination. NGOs have a crucial role in the effective delivery of AIDS prevention and care, particularly to marginalized groups who may actually fear contact with the government. However, this does not absolve the government from its responsibilities to produce those public goods essential to disease control, to coordinate and monitor response, and to make available adequate financing and resources, which are used in a cost-effective manner. Therefore, to ensure

successful implementation of the national action plan the implementation capacity needs to be assessed critically and respective interventions need to be considered where the gaps are defined.

Priority Setting and Resource Allocation

To improve the performance of national program, policymakers need to build on a smaller core set of objectives, defined in terms of measurable outcomes and impact, and identify most cost-effective set of activities and actors to meet them on a national scale.

Given the limited financial resources of the country, the politicians are reluctant to act until many people are visibly affected, since there are many other conflicting urgent health problems. Even with more resources and with acknowledgement of the impact and potential role of different sectors in a response, there is still a need to prioritize. AIDS mortality may strike every sector of the economy, but this does not necessarily imply that adding AIDS prevention and mitigation to every ministry's program will be a cost effective way of reducing the epidemic.

Prevention resources should be allocated to prevent as many infections as possible. Such an allocation must take into account the cost of effectiveness of the programs. Evaluation should be a major component of resource allocation decision-making. With better evaluation data reflecting the cost, efficacy and targeting of programs, resources could be more profitably invested in interventions that work efficiently.

Overcoming Social Barriers

Policies regarding fair and humane treatment and care for those infected based on the good understanding of major social barriers, are key to strategies to cope with the epidemic and reinforce prevention.

Poverty and Gender Inequality

There is considerable evidence that social inequalities defined by income, ethnicity, and gender are key elements in the social context and environment that contribute to HIV infection risk. Moreover, the social inequalities create conditions that make it difficult for individuals and communities to even focus on the problem of HIV, since other problems may seem more immediate (for example, housing, food, employment). Better understanding of these societal forces is critical in achieving the objective of preventing new afflictions.

Inadequate access to health care and lack of supportive and culturally appropriate social services allow co-existing conditions—such as substance abuse, mental illness, tuberculosis, sexually transmitted diseases, and violence—to flourish, thus forming epidemiological clusters for a wide variety of current health and social problems. Moreover, the higher prevalence of drug trade in impoverished neighborhoods increases the likelihood of exposure to and use of drugs.

As has been mentioned social inequalities create the environment that contribute to HIV infection risk. Current economic conditions, widespread unemployment and poor social safety nets in the country, in many cases contribute to the social environment in which a woman is forced to seek employment in the street (become CSW) and/or is either unable or unwilling to negotiate consistent condom use to lower risk of sexual practices. In extreme cases, as reported by CSW, initiating discussions of condom use and risk reduction may lead to physical or sexual abuse. Gender inequality may be extreme for drug-addicted women and for those whose partners are drug users.

In addition, for some women, sexual risk behavior may be tied to practice (such as commercial sex work) that insure economic survival for themselves and their families. For these reasons, it is essential to acknowledge that gender inequality affects many women and must be taken into account when creating prevention messages for women.

The Sexual “Code of Silence”

Georgian Society's reluctance to openly confront issues regarding sexuality results in a number of untoward effects. This social inhibition impedes the development and implementation of effective

sexual health and HIV/STD education programs, and it stands in the way of communication between partners and children and between sex partners. It perpetuates misinterpretations about individual risk and ignorance about the consequences of sexual activities and may encourage high-risk sexual practices. It also impacts the level of counseling training given to health care personnel to assess sexual histories, as well as provider's comfort levels in conducting risk-behavior discussions with clients.

In addition the code of silence has resulted in missed opportunities to use the mass media. The media can be powerful allies in promoting knowledge about HIV and other STDs, and in fostering behavioral change that can reduce the chances of acquiring these diseases. For example, while both children and adolescents are constantly exposed to—and particularly vulnerable to—explicit and implicit sexual messages in various media, the presence of prevention messages in the media is practically nonexistent. Further, because many adolescents are not receiving accurate information from their parents, teachers, or other trusted adult sources, they often rely on the media as a primary source of information. Given the impact of media on young people's impressionable minds, messages that consistently promote risk reduction could facilitate much-needed changes in social norms regarding sexual behaviors and drug-use practices by helping in fashioning attitudes, as well as consumer behavior.

Misperceptions

In addition to the social conditions and attitudes that impede HIV prevention efforts, many people at risk of becoming infected have a variety of misperceptions about HIV/AIDS that hinder the effectiveness of preventive efforts. The number of KAP surveys carried out have shown that individuals often underestimate or misperceive the risk of acquiring HIV and STDs, which can lead to an increase in risk behaviors. This misperception is driven, in large part, by the complexity of exposure to HIV, the uncertainty of exposure, the low probability of infection per encounter, the time interval between infection and clinical manifestation of HIV, and the emotional reaction to the severity of AIDS. Even when the individuals are worried about contracting HIV, their perception of the likelihood of actually contracting HIV is often relatively low.

Individuals, who do not consider themselves to be in high-risk groups perceive themselves at low risk and thus engage in riskier behaviors. Moreover, some individuals believe that anyone who looks healthy must not have AIDS, which may lead these individuals to be falsely confident in selecting partners.

Access to Drug Treatment and Sterile Injection Equipment

IDU is a major factor in the spread of HIV in Georgia, accounting for 71 percent of reported cases. Although the primary route of transmission is through sharing of contaminated injection equipment, yet the sexual partners and children of IDUs have a higher risk of contracting infection. Two of the most effective strategies for preventing HIV infection among IDUs include: eliminating or reducing the frequency of drug use and associated risk behaviors through drug abuse treatment; and reducing the frequency of sharing injecting equipment. However legal, regulatory, and funding barriers prevent widespread implementation of these interventions.

The stigma associated with drug use isolates IDUs from medical and social services, such as education, prevention, or drug abuse treatment that can reduce the risk of HIV. In addition, stigma can limit support for drug use treatment. For instance, the "not in my backyard" syndrome can seriously hinder the development of conducive legal framework for drug treatment programs and limits the number of advocates for the drug addicted population.

The underlying misinterpretation and stigma associated with addiction, drug use, and treatment have shaped policy decisions and public support of efforts to address the twin epidemics of HIV and substance abuse. Current policy is largely focused on increasing funding for imprisonment of drug sellers as well as IDUs, with no allocations at all for drug abuse treatment. The national policy to incarcerate drug offenders, alongside with the poor internal control procedures

in the detention areas, has been a major contributor to the explosive growth of IDUs in the prison population.

The federal Agency which will be charged with improving and streamlining the availability of substance abuse and mental health prevention, treatment and rehabilitation services, needs to play a critical role in leading efforts to address the interrelated epidemics of substance abuse, mental illness and HIV.

Drug abuse treatment is not a panacea for the drug epidemic. Regardless of the availability of treatment opportunities, a certain portion of drug users will continue to inject drugs. For those who cannot or will not stop injecting drugs, the one-time use of sterile needles and syringes remains the safest and most effective method for preventing HIV transmission. The global evidence suggests that expanded provision of needle exchange programs have reduced the incidence of the epidemic in the target groups. Although many politicians have expressed concerns that increasing availability of injection equipment will lead to increased drug use, criminal activity and discarded contaminated syringes, studies have found no scientifically reliable evidence of these negative effects.

Comprehensive Sex Education and Condom Availability in Schools

Teenagers and young adults are at an increased risk of acquiring HIV. The majority of infections among adolescents and young adults are STDs. Adolescents are at higher risk to acquire HIV than adults for several reasons: they are more likely to have multiple (either sequential or concurrent) sexual partners, they are more likely to engage in unprotected sex, and they are more likely to select partners that are high-risk. This high-risk behavior also place youth at increased risk for other STDs and for unwanted pregnancies. In the light of these facts, youth constitute an extremely important segment of population for HIV, STD and pregnancy prevention efforts.

The school setting is an obvious venue for providing such information, given that nearly 95 percent of youth are enrolled in the primary and secondary schools. To a large extent, policies regarding sex education and condom availability in schools are determined by the state mandate and by policies established within local school districts. Decisions regarding the content of sex curricula and whether or not to make condoms available at schools will generate a considerable debate and controversy. Proponents of the assistance-only policies will argue that providing information about contraception or providing condoms to adolescent sets a mixed message to youth and may promote sexual activity. Proponents of comprehensive programs argue that while assistance should be encouraged until youth are emotionally and physically ready for sex, it is critical to provide young people who may be sexually active with information and contraceptive methods that can protect them from STDs and unintended pregnancies.

Studies reviewing the scientific literature, as well as expert panels that have studied this issue, have concluded that comprehensive sex and HIV/AIDS education programs and condom availability programs can be effective in reducing high-risk sexual behaviors among adolescents. Moreover, these reviews and expert panels conclude that school-based sex education and condom availability programs do not increase sexual activity among adolescents.

HIV & TB Prevention and treatment in Penitentiary Settings

The correctional system constitutes a critical setting for HIV prevention. The benefits of such efforts will extend beyond the correctional system as well, since the circulation of infected or high-risk individuals between correctional facilities and communities is an incessant dynamic that is maintaining the epidemic at its current levels and adding new cases each year.

The primary barrier to implementing the HIV preventive activities and strategies in correctional settings is the difference in priorities between public health officials and correctional system officials. The primary focus for the public health officials is to improve the health of inmates and to protect the community to which they return from the spread of infection. On the other hand, the primary focus of correctional officers is to ensure a controlled and secure environment. To do so they must uphold the policies and regulations of the correctional system that expressly forbids the very same activities.

Implementation of acceptable and effective HIV prevention in correctional settings will require extensive collaboration among correctional systems, public health officials and community-based organizations. The failure to address HIV prevention needs in prisons is a shortsighted strategy that will lead to unnecessary new infections and wasted expenditures. There are four primary routes for addressing this issues: helping inmates when they are released, providing HIV/AIDS education to inmates, providing drug abuse treatment in correctional settings, and implementing harm reduction programs.

Many inmates, particularly those with a history of substance abuse, have difficulty successfully transforming from correctional settings to the community. The transition can be especially difficult for inmates with TB, given their increased needs for health care and support services. Discharge planning is critical for these populations, as it facilitates linkages with appropriate public health and community based resources for follow-up care, treatment and support services.

Other factors such as staffing constraints, lack of cooperation between the criminal justice system and health sector, maintaining accurate records, and communicational difficulties are also impediments to effective transitions between correctional settings and community.

BOX 11: PRIORITY AREAS AND STRATEGIC ACTIONS FOR STRENGTHENING NATIONAL RESPONSE CAPABILITIES

Objectives	Priority Areas of Intervention	Strategic Actions
Mitigating the impact of the epidemic on social and economic development	Strengthening country's capacity to develop and implement policies aimed at reducing the incidence of HIV/AIDS:	Target leadership in critical sectors;
	Policy Development	Strengthen policy analysis through enhanced research on effectiveness of intervention, social and economic impact assessment, behavior assessment, define best practices etc;
		Development of mechanism and procedures for the involvement of stakeholders from different sectors and civil society in the process of policy development;
		Strengthen HIV/AIDS surveillance.
	Development of enabling legal environment for policy implementation	Promote human rights and nondiscrimination through careful analysis of existing legislation and enhance and/or modify areas where necessary
	Priority Setting and resource allocation	Develop coordinated approaches for resource mobilization;
		Base resource allocation on the investment justification and efficiency;
	Establishment of capacity in both public and private sectors to address the HIV/AIDS epidemic	Support capacity building in key agencies;
		Strengthen monitoring and evaluation capacity;
		Network with regional/district agencies and NGOs

(continued)

**BOX 11: PRIORITY AREAS AND STRATEGIC ACTIONS FOR STRENGTHENING
NATIONAL RESPONSE CAPABILITIES (CONTINUED)**

Objectives	Priority Areas of Intervention	Strategic Actions
Expand access to care and treatment for people living with HIV/AIDS		<p>Conduct situation analysis on the access and quality of services;</p> <p>Develop standards of care;</p> <p>Extend counseling and diagnostic facilities;</p> <p>Extend network of persons living with HIV/AIDS and support them</p>
Prevention of new infections	<p>Prevention of HIV transmission among most vulnerable population:</p> <ul style="list-style-type: none"> ■ IDUs ■ CSWs ■ MSMs ■ Institutionalized population ■ Mobile population ■ TB patients ■ Prisoners 	<p>Support research and development to define best practices;</p> <p>Targeted information, education and communication;</p> <p>Include HIV/AIDS prevention and IEC in all sector reform agenda</p>

STRATEGIC OPTIONS FOR WORLD BANK INVOLVEMENT

In response to the ever-changing nature of the epidemic, the World Bank can play a key role in intensifying action against AIDS and in strengthening country's response. This could be achieved by adopting country/sub-regional specific strategy, which may encompass the following:

Advocacy

The World Bank is well positioned to advocate and lead policy dialogue with the government to ensure that HIV/AIDS is placed at the top of the development agenda. To be instrumental and convincing, the institution has to enhance its knowledge on the best practice stories, country experiences available, as well as other country and sub-regional studies undertaken by others institutions and authors. Another area, where the Bank can play an important role is to advocate the government on strengthening and extensive involvement of the civil society in development and implementation of HIV/AIDS strategy.

Research

The Bank, as well as government, has to extend knowledge base through the support of operational research, increase resources and technical support to mainstream HIV/AIDS into all sectors. This is an area where the Bank could play an active role by supporting the technical expertise as well as providing funding to the committed governments.

Coordination

HIV/AIDS response needs to be stretched well beyond the health sector domain, and there is a need and opportunity for the World Bank to further enhance its active participation in the UN Theme Group on HIV/AIDS. Moreover, it needs to strengthen and expand partnership with UNAIDS, other co-sponsors and interested bilateral agencies with a view toward implementation of the National HIV/AIDS strategy in the country.

Apart from coordination with the outside world, the World Bank may focus on introducing innovative coordination mechanisms between different sector teams working in the country.

Moreover, coordination with the International Finance Corporation (IFC) to promote private sector involvement could be explored. Building upon IFC-supported private/public partnerships, efforts could be made to enlist the participation of private firms interested to invest in Georgia to support HIV/AIDS prevention and to control efforts as part of risk-minimization strategies.

Technical Assistance

The World Bank can consider providing technical assistance to Georgia on issues such as: (i) economic impact of HIV on fragile economy of the country; (ii) the process of governmental planning for HIV/AIDS within the context of evolving economic and social conditions; (iii) support efforts of the HIV/AIDS State Commission to mobilize Georgian leaders, civil society organizations, religious groups, and the private sector to intensify action against HIV/AIDS.

Lending

The World Bank’s presence in the health sector is fairly small. Nevertheless, as the challenges posed by HIV/AIDS stretch well beyond the health sector, there is a need to incorporate HIV/AIDS prevention and control activities into its country assistance program and lending portfolio. While funding of the stand alone operation seems to be long-term objective, the short term comparative advantage of the organization would be to use ongoing projects as an entry point of channeling and promoting HIV/AIDS related activities. Particularly in the health sector, the World Bank could assist in strengthening country’s response to HIV/AIDS epidemic as part of the broader health reform efforts. The details of possible interventions are outlined in the table.

World Bank support may help promote active involvement of civil society organizations in HIV/AIDS prevention and control. To this end, a promising approach to stimulate innovative multi-sectoral activities might be:

- Creation of a demand-driven fund managed by an inter-sectoral group headed by the Ministry of Health officials and financed by public and private sources that could channel resources to public and private organizations, including community groups. Activities that could be financed by such a fund would include pilot interventions or their replication at the community level, media campaigns, and applied research on risk factor prevalence and effectiveness of interventions;
- Using World Bank’s Small Grants Program to mobilize civil organizations from different HIV/AIDS related sectors to design and proliferate preventive measures in certain geographical locations focusing on priority risk groups and/or risk factors.

BOX 12: INTEGRATING HIV/AIDS PREVENTION ACTIVITIES IN GEORGIA’S LENDING PORTFOLIO			
Operation	Status	Component/Subcomponent and its Objective	Issues that Could Be Addressed
PHC Development Project	AP	Institutional Development	<ul style="list-style-type: none"> ■ Strengthening analysis and policy development capacity of the Ministry of Health through promoting research and evidence based policy formulation practices;
		To support capacity building and institutional development in policy formulation and implementation, establishment of regulatory environment of Primary Health Care, training of human resources, as well as Management of the PHC services through an integrated health management information system	<ul style="list-style-type: none"> ■ Integration of STD and AIDS early diagnosis and treatment in the PHC package of services; ■ Enhancement of the Surveillance system;

BOX 12: INTEGRATING HIV/AIDS PREVENTION ACTIVITIES IN GEORGIA'S LENDING PORTFOLIO (CONTINUED)

Operation	Status	Component/Subcomponent and its Objective	Issues that Could Be Addressed
			<ul style="list-style-type: none"> ■ Strengthening the implementation capacity of the health system reform through training of service providers; ■ Allocation of public financing and efficient use of available resources for HIV/AIDS, STDs, TB, Safe Blood and Drug preventive programs; ■ Patients' IEC.
Structural Reform Support Project Hospital Restructuring component	UI	Improve Hospital Operations and Management practices	<ul style="list-style-type: none"> ■ Improved strategic budget planning practices; ■ Introduction of Safety Measures (safe injections, waste management, etc) and avoiding risks as a part of an effort to improve hospital management; ■ Education of hospital personnel; ■ Patients' IEC.
Education	UI	Realignment of the system objectives by further developing curriculum standards for basic/general secondary education core subjects, teachers training, provision of basic learning materials, and developing mechanisms to promote innovations at the school level.	<ul style="list-style-type: none"> ■ Promote introduction and development of healthy life style subject in the basic school curriculum; ■ Assist the Ministry of Education in design of the course, as well as learning materials, and training of teachers.
Judicial	UI	<p>Assistance to the Ministry of Justice</p> <p>Assist the MoJ in becoming the leading entity in Georgia for legal drafting and legal harmonization.</p>	<ul style="list-style-type: none"> ■ Advocate and provide technical assistance to the MoJ to draft laws and regulations that would set up conducive legal environment for implementation of preventive activities; ■ Advocate and assist to Reform the penitentiary system; ■ Advocate high government authorities to unify the health systems in the country and avoid existence of the parallel systems, such as ones for Enforcement Ministries and other for the Health ministry.
Integrated Coastal Management	UI	<p>One of the specific objectives of the project is to:</p> <p>Assist establishment of a legal and institutional framework for integrated planning and management of Georgia's coastal resources, including strengthen-</p>	<p>As the HIV/AIDS, along with STDs, drug abuse and TB is one of the leading public health problems in the coastal zone, the World Bank can use the institutional framework developed by the project as an entry point to improve analysis and HIV/AIDS policy development, enhance</p>

(continued)

BOX 12: INTEGRATING HIV/AIDS PREVENTION ACTIVITIES IN GEORGIA'S LENDING PORTFOLIO (CONTINUED)

Operation	Status	Component/Subcomponent and its Objective	Issues that Could Be Addressed
		ing the country's technical capacity to address urgent costal protection and safety issues such as public health, oil spills and costal erosion.	control over drug invasion into the country via sea ports and land, as well as channel specific HIV/AIDS prevention and IEC activities targeted at high-risk groups.
Social Protection Reform	UP	<p>Improving family welfare.</p> <p>The project would provide equipment, technical assistance and training to strengthen support to families at risk and reduce the need for substitute care for children from such families</p>	<p>It would include the following:</p> <ul style="list-style-type: none"> ■ Strengthening everyday management, administration and client processing of social work services for children and youth at risk; ■ Introducing new standards in social work; ■ Developing a capacity for policy analysis related to the Ministry of Social Protection; ■ Monitoring capacity and appeals process in the Ministry of Social Protection; and ■ Developing new strategies for dealing with disabled and AIDS affected children.
Adjustment Loans	P	NA	<ul style="list-style-type: none"> ■ Budget planning and allocation of adequate resources for HIV/AIDS mitigation measures;

P–Planned; UI–Under Implementation; UP–Under Preparation; AP–Approved

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This report analyzes the complex mechanics of the epidemic, its seriousness, and the threat it poses in the future. It draws upon a range of data to synthesize an explanation of the current crisis and the national response that has been launched. It assesses the institutional arrangements, political commitment, enabling legal environment, government program, resource availability, and donor and civil society engagement.

The study provides projections and potential implications on population demography, outlining the possible development of the epidemic by 2015. It also examines the impact of the epidemic on households and orphans as well as the economic impact on agriculture, transport, labor, health care, social security, and the deepening of poverty. The paper outlines the main barriers to the development of a comprehensive multi-sectoral national action plan and defines options for World Bank involvement.

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