Ministry of Foreign Affairs of the Netherlands

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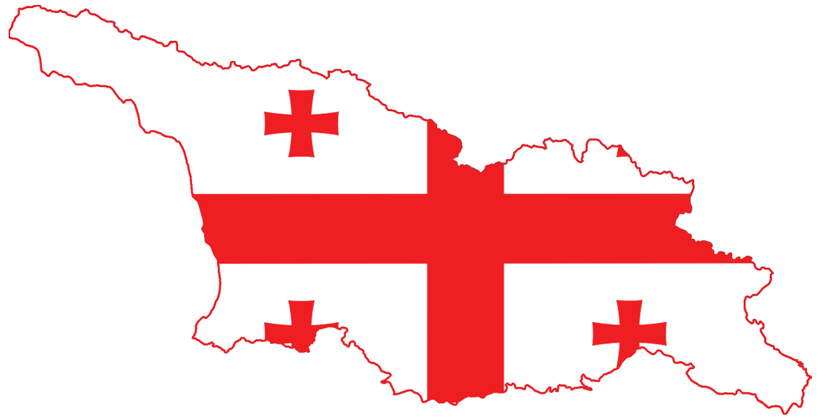
BRIDGING THE GAPS
Health and rights for key populations

HIV AND PWUD
CONTEXT ANALYSIS GEORGIA



PREPARED BY
TAMAR SIRBILADZE

Printed within the project “Bridging the Gaps: Health and Rights for Key Populations”
Funded by the Ministry of Foreign Affairs of the Netherlands

2016

EXECUTIVE SUMMARY

Georgia is among low HIV prevalence countries being at high risk for an expanding epidemic due to widespread injecting drug use and the population movement between Georgia and neighbouring high HIV prevalence countries such as Ukraine and Russia. The first case of HIV in Georgia was detected in 1989. From 1989 to 1996 only few cases of HIV infection were registered in the country. Since 1997 the number of newly registered cases started to increase and Georgia is one of those very few countries in the world and in the region where the HIV incidence has been increasing steadily during the last decade. The latest available evidence indicate that the HIV epidemic in Georgia is largely concentrated among key affected populations: men having sex with men (MSM), people who inject drugs (PWID), and sex workers (SW). HIV prevalence among pregnant women and blood donors is lower (0.04% in both sub-populations) than in general population (0.07%). By February 25th 2016 a total of 5,525 HIV/AIDS cases have been registered in the Infectious Diseases, AIDS & Clinical Immunology Research Centre, including 4,084 men and 1,441 women. The majority of patients are within the age group of 29-40. 3,228 patients developed AIDS. 1,098 patients have died.

Georgia has the problem of late HIV diagnosis and its association with a high mortality rate. Georgia is among the 27 high multidrug-resistant (MDR) TB burden countries in the world. One of the major challenges remains MDR-TB and TB/HIV co-infection. Georgia has one of the highest estimated HCV prevalence in the world. In 2015 the Government started National Hepatitis C elimination programme.

The national response has failed to place equal importance on each component of the core packages of HIV prevention. State-funded programmes include the following: HIV Prevention Programme among Key Populations; Post-Exposure Prevention; Opioid Substitution Therapy (OST) for PWID; Drug Addiction Treatment and Rehabilitation. In addition, the Government of Georgia (GoG) supports the Safe Blood Programme and Prevention of Mother-to-child Transmission Programme, offering routine testing of blood donors and pregnant women for HIV and other blood borne infections. According to the Bio-BSS survey results, preventive programme coverage varies by region in Georgia. HCT, needle and syringe programmes (NSP), OST, ART, HIV education, provision of safe sex, and safe injection commodities represent a core package of HIV prevention among key populations at high risk of HIV.

Despite the impressive expansion of HIV prevention efforts over the last several years, coverage of key populations with preventive services and HIV testing remains low for all key populations. It should be highlighted that the state programme does not procure 4th generation HIV tests, which identify HIV positive cases earlier. There are no services addressing the specific needs of young people (between the ages of 14 and 24) who are vulnerable and most at risk of HIV in Georgia. The government does not have a separate youth-oriented sexual and reproductive health programme. It should be also mentioned that the National HIV/AIDS Strategic Plan does not address specifically HIV prevention among most-at-risk young people (MARA). Neither the State, nor the Global Fund and other donors support the programmes that are designed specifically to address the needs of MARA. Stigma and discrimination of HIV + groups continues to be a major barrier to HIV prevention and service utilisation. Negative social attitudes and low public awareness also remain obstacles, especially for IDU and MSM population. Besides societal attitudes, state criminal laws, regulations, and policies relevant to drug use and preventive work among IDUs and prisoners are among limiting factors. Despite the accomplishments in various areas of national HIV response, the epidemic continues to grow.

Over the last decade, funds mobilised through the Global Fund and USAID have been critical for scaling up the national response for HIV prevention among key populations (PWIDs and their

partners, MSM, and FSWs). Opioid substitution therapy (OST) started in the country in 2005. Nowadays OST is functional through three different stakeholders in the country: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), The State Treatment Programme and the private sector. Two different types of OST are available in the country: (1) methadone maintenance programme and (2) the programme using buprenorphine preparations – buprenorphine alone and combined preparation with buprenorphine and naloxone (Suboxone®). There are 12 OST sites operated by the state in the different regions of Georgia and GFATM provides treatment via four OST sites, free of charge. Additionally, two GFATM sites are running in the penitentiary institutions. TB testing and treatment services are offered within the State TB programme and USAID supported TB Project. HCV testing and treatment is funded by the Government National Hepatitis C elimination Programme. According to UNAIDS data Georgia has the highest ART coverage in the region of Eastern Europe and Central Asia.

HIV/AIDS prevention and control interventions in Georgia have been mainstreamed into several state programmes: the HIV/AIDS Prevention and Treatment Programme (8,424,000 GEL7 in 2016); the Safe Blood Programme (1,650,000 GEL); and the Prevention of Mother to Child Transmission (PMTCT) Programme. Funding of substance-use-related services has remained a major issue affecting the availability and accessibility of treatment for substance-use-related disorders. The significant part of services provision, in particular low-threshold harm reduction services, relies solely on international funding. The State Substance Abuse Treatment Programme (5,000,000 GEL in 2016) covers in-patient and out-patient detoxification and primary rehabilitation and agonist maintenance treatment.

Georgia has attained all three targets within the Joint United Nations Programme on HIV/AIDS (UNAIDS) “Three Ones” Principle. All HIV stakeholders act within the frames of endorsed national HIV strategies that are regularly revised and updated. The Country Coordinating Mechanism (CCM) functions as a main platform for country dialogue and participatory decision-making on HIV related issues. Greater involvement of civil society institutions has been achieved through effective collaboration of the state institution with the HIV prevention task force (PTF), which is composed of NGOs and professionals working on HIV. Since 2013, PTF elects four instead of two members to represent PTF at the CCM board. Three out of these four members represent communities affected by HIV/AIDS – drug users, LGBT and PLHA.

Heavy reliance on donor support for funding preventive interventions is a challenge that Georgia aims to address. The state will gradually take over the responsibility for funding preventive interventions currently financed by the Global Fund including, but not limited to, OST, harm reduction services, VCT etc. In 2014, NCDCPH has become Principle Recipient of the GFATM grant to Georgia. This provides opportunity to line up state and donor-supported programmes in order to achieve better results in the coming years.

Psychological support and social reintegration of individuals with substance abuse disorders has never been on the list of the government’s priorities. Although Control of HIV/AIDS was identified as one of the public health priorities by the National Health Care Strategy 2011–2015 (NHCS) endorsed by the GoG in 2010, the strategy does not properly acknowledge the magnitude of substance abuse related problems in the country and sets no targets for drug addiction services, psycho-social support or rehabilitation services. Over the last decade, there have been no out-patient or in-patient rehabilitation services for substance users funded by national funds that would aim towards psycho-social rehabilitation and reintegration of persons with substance abuse related problems.

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[7]GEL – Georgian Lari – 1 GEL = 0.38 EUR (Mid-market rates: 2016-03-28)

Women who use drugs remain one of the most marginalised and underserved groups in Georgia. Health services for women drug users often are either limited or inaccessible due to stigma, discrimination and shame associated with the drug use. There are no psycho-social rehabilitation services targeting female drug users. Access to Opioid Substitution Therapy (OST), Needle and Syringe Exchange Programmes (NSP), as well as general healthcare services including reproductive health, is particularly limited and in many cases ignored. Fear of revealing drug use status, fear of being denied healthcare, lack of information on drug treatment services, lack of confidentiality, lack of services based on the needs of women drug users, stigma and judgmental and discriminatory attitude of health service providers are some of the major problems impeding women from accessing healthcare.

Georgia remains the only country in the region where drug use is considered a criminal offence instead of a public health problem. Starting from the mid-2000s, as a result of a zero tolerance policy on drugs and so called “Georgian drug war”, Georgia introduced strict administrative and criminal sanctions for drug use and other drug-related crimes. In recent years there has been a dramatic increase in random street drug testing by the police, leading to the urine drug screening of tens of thousands of people under the “reasonable doubt” of drug use by a police officer. E.g. in 2011 more than 27,000 cases of police drug testing were recorded, while only 6,500 adults received any kind of substance use treatment. In case of drug use, the law does not provide any alternative to punishment and there is no mechanism in place that would allow police to refer individuals in need of assistance to medical treatment services or other assistance.

In recent years, the Georgian Parliament and the government have shown themselves to be very willing to improve the response to dealing with the risks of illicit drug use in the country and they have committed substantial time to considering the issues involved. However, it has been argued that the political commitment to reducing harms and various risks due to drug use could be better focused on developing a balanced approach with specific attention to effectiveness for which EU standards and approaches can provide guidelines.

Although, the state funding allocation for HIV programmes is increasing, the pace of this development is not adequate for effective planning of the future takeover of the Global Fund supported major interventions, including harm reduction programmes. Without the proactive strategic planning for increasing the state HIV programmes' budgets it will be extremely challenging to face and cover the large funding gap developed due to planned decrease in Global Fund allocations for Georgia.

While Georgia has yet to be officially declared an upper-middle income country by the World Bank, as a result of the 2014 census, it’s likely to be labelled one after the final census results are published in April of 2016. The preliminary 2014 census results tell us that the Georgian population is about 3.7 million (excluding South Ossetia and Abkhazia). In 2014, using the preliminary census data, Georgia’s Gross National Income per capita (GNI) was $4489/capita. Georgia is not the first and surely not the last country to have a major economic indicator readjustment based on something besides economic growth. Since the reclassification of Georgia from the lower-income country to upper–middle income country donors will redirect their funding to more poor countries, leaving local NGOs in a financial squeeze.

- Strategic advocacy for legal reform on the alignment of drug control legislation with international drug control treaties and international best practices, keeping in mind public health goals being a priority. First of all, decriminalise individual drug use; provide alternatives to incarceration for non-violent drug-related crime.
- Provide adequate federal funding of harm reduction with strong, coordinated linkage to intensive case management, drug treatment, and HIV medical services. Harm reduction services should be strengthened not only in the civil sector but also in the penitentiary system.
- Prevention interventions targeting PWID and their partners should be scaled up through enhanced outreach and peer-driven and community-level interventions. Comprehensive packages of HIV prevention targeted to each key population should be defined and endorsed by the GoG at national level. Programmes are needed that place motivated peer outreach workers in communities with large numbers of IDUs to advocate and promote HIV/viral Hepatitis/STI/TB prevention. Women who are sex partners of MWID but do not inject drugs themselves are vulnerable to HIV infection through their partners risk behaviours, as condom use with intimate partners is very low. Couple-based interventions and partner counselling and referral services should be established to assist individuals at high risk in learning their sero-status and raising awareness about HIV/AIDS and substance abuse. Community-Level Intervention (CLI) Model could be implemented involving representatives of the PWID's micro-social environment and business advocates in order to increase the scale and scope of comprehensive preventive interventions targeted to IDUs and their partners.
- Establish and operate youth friendly HIV prevention services for MARA, addressing the specific needs of young people - addressing young people more holistically can meet a wide range of health, social, and developmental needs, including security, hygiene, job and skills training, psychological and legal services, and recreation and leisure activities. To attract MARA, outreach is needed, often by peers. Services need to offer a safe, welcoming, and comfortable environment. Services must be confidential, private, non-judgmental and friendly to young people.
- Drug treatment and rehabilitation services, including residential-type services, should be scaled up to become effective care and social reintegration programmes available and accessible to target groups.
- Provide gender-sensitive and evidence-based drug treatment services for women who use drugs and harm reduction programmes for women in detention.
- Use churches and faith-based organisations to promote interventions for PWID, as well as reduce stigma associated with drug use and HIV-positive people. Church is recognised as the most reputable and trusted institution in Georgian population, including youth. Religious leaders are actively involved in drug prevention and rehabilitation activities; advice received from the religious leaders are valuable for IDUs, their partners and family members.
- Sensitise legal professionals, law enforcement officers, the judicial system and communities of people living with HIV and PWID on the role of the law in creating and enabling environment for the national HIV response. Sensitisation can focus on legal rights, HIV prevention, harm reduction and the harmful effects of drug laws - there is a concerning scarcity of knowledge regarding the rights-based approach to HIV responses. Affected communities, including key populations, need information and evidence to deepen their awareness of the law on human rights. Exposure to such knowledge would prepare these communities to demand remedies from the justice system. Key actors in the legal and human rights arena, law enforcers, implementers, and legal practitioners need to reinforce their understanding of important issues and controversies related to a rights-based approach to HIV. By reflecting on topical issues, these actors would be enabled to put forward competent arguments on human rights issues affecting PLHIV or those vulnerable to HIV, including key populations.
- Monitoring of rights violations: mechanisms should be established, implemented and promoted for NGOs and community-based organisations to systematically monitor and document cases of violations of the legal and human rights of HIV-positive people and people who use drugs. Due to

existing stigma and fear of disclosure and further violations, many cases of assault and extortion in Georgia remained unreported and unrecognised.

- Creating a supportive environment and fostering social change - advocacy initiatives, public awareness campaigns involving mass media, vulnerable populations, and human rights activists, should be widely implemented to reduce HIV-associated stigma and discrimination. Wide-scale public awareness raising campaigns dedicated to HIV/AIDS should not be occurring occasionally as it is happening in most countries including Georgia. Due to the fact that Georgia is categorised as having a low-prevalence HIV epidemic, most state-funded or donor supported programmes in the country are focused on most-at-risk populations, and educational campaigns targeting general public as well as interventions aimed at combating stigma and discrimination of PLHA are mostly planned only twice a year – on World AIDS Day and AIDS Memorial Day. It is obvious, that HIV public awareness raising campaigns should be implemented on a more regular basis and should be utilising all potential media outlets and other means of communication.

STATE OF THE HIV EPIDEMIC AND RESPONSE IN THE COUNTRY

EPIDEMIOLOGY

Georgia is among low HIV prevalence countries being at high risk for an expanding epidemic due to widespread injecting drug use and the population movement between Georgia and neighbouring high HIV prevalence countries such as Ukraine and Russia. The first case of HIV in Georgia was detected in 1989. From 1989 to 1996 only few cases of HIV infection were registered in the country. Since 1997 the number of newly registered cases started to increase and Georgia is one of those very few countries in the world and in the region where the HIV incidence has been increasing steadily during the last decade. The latest available evidence indicate that the HIV epidemic in Georgia is largely concentrated among key affected populations: men having sex with men (MSM), people who inject drugs (PWID), and sex workers (SW). HIV prevalence among pregnant women and blood donors is lower (0.04% in both sub-populations) than in general population (0.07%).

By February 25, 2016 a total of 5525 HIV/AIDS cases have been registered in the Infectious Diseases, AIDS & Clinical Immunology Research Center, including 4084 men and 1441 women. The majority of patients are within the age group of 29-40. 3228 patients developed AIDS. 1098 patients have died.

The epidemiological distribution of the disease by gender and age indicates more cases among the 25-40 age groups. The biggest difference between the number of infected men and women was also detected in this age group (25+), while the gender difference is minimal among the 15-24 year olds. In previous years, the proportions of male and female HIV-positive cases were 75% and 25% respectively. In 2011, the proportion was changed, with males accounting for 70% of cases and females for 30%. The trend has been maintained for the last years. Similar to the most Eastern European countries, injecting drug use was the major transmission mode in the early years of the HIV epidemic in Georgia. Since 2010, transmission has shifted towards the heterosexual mode, which became dominant by 2011. The share of drug use as a transmission mode among newly registered HIV cases decreased to 43.2 % in 2012, and 35.0% in 2013 while heterosexual transmission increased up to 44.8% in 2012 and 49.0% in 2013 (Figure 1). Both these trends indicate the growing spread of HIV among the sexual partners of PWID.

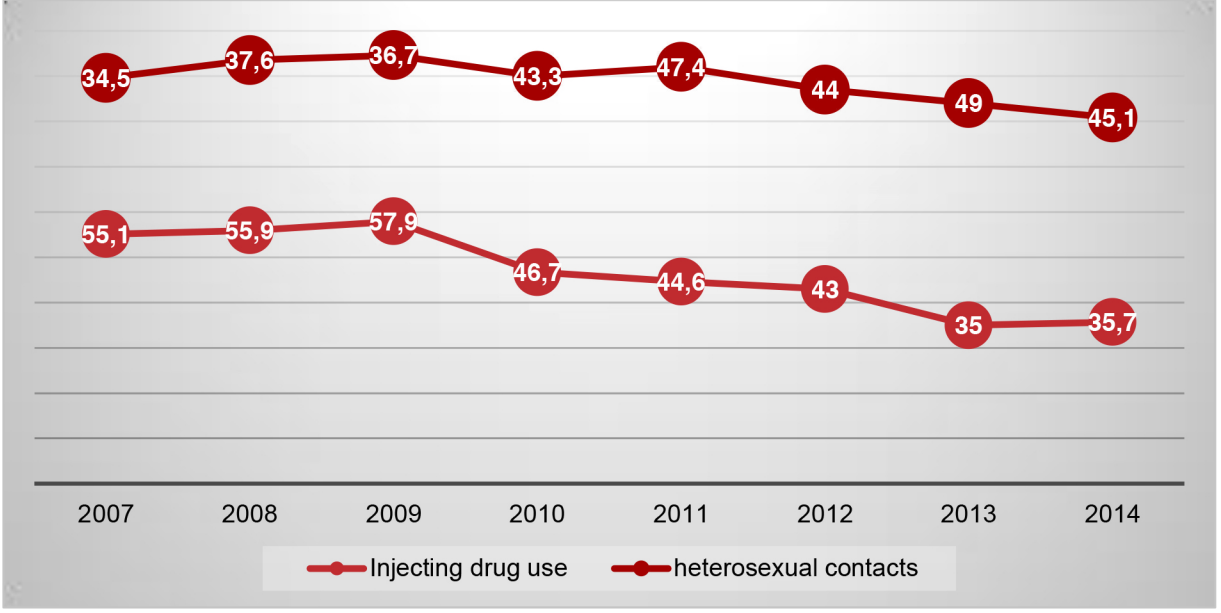

Figure 1. Shifting modes of HIV transmission by year, in %

HIV prevalence	HIV prevalence in General Population - 0.07%[8] Prevalence among PWID – 2,2%[9]
Population estimate	N of PLHIV - 7000[10] N of PWID – 49,700[11]
Number of needles per IDU	79.41[12]
Prevalence ofTB as co-infection	In Country - 1.7 - 2.2% (2008).[13]; 3-4% (2013)[14] Among PWID – N/A
Annual number of aids deaths	In Country - <100[15]

Table 4: HIV prevalence

[8] GARPR 2014

[9] HIV risk and prevention behaviors among People who Inject Drugs in seven cities of Georgia. Bio-behavioral Surveillance Survey Report. Curatio International Foundation and Bemoni Public Union. 2015

[10] Infectious Disease, AIDS and Clinical Immunology Research Center (IDACIRC). http://www.aidscenter.ge

[11] Population Size Estimation of People who Inject Drugs in Georgia 2014. Study Report. Curatio International Foundation and Bemoni Public Union

[12] Georgia. Country progress report, January - December 2014. Global AIDS Response Progress Report (GARPR). National Centre for Disease Control and Public Health. Tbilisi; 2015

[13] Gabunia P, Salakaia A, Kiria N, Kandelaki G, Tsertsvadze T. TB/HIV co infection in Georgia. Georgian Med News. 2008 Dec; (165):7-10. http://www.ncbi.nlm.nih.gov/pubmed/19124909

[14] GARPR 2014

[15] UNAIDS. http://www.unaids.org/en/regionscountries/countries/georgia

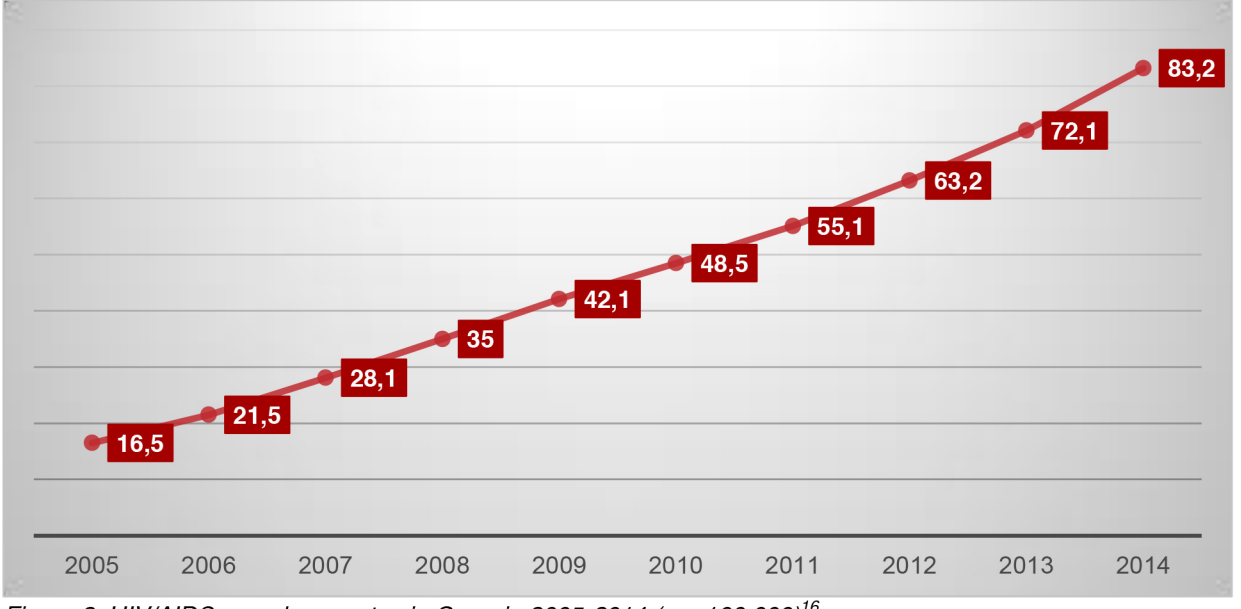

Figure 2. HIV/AIDS prevalence rates in Georgia 2005-2014 (per 100,000)[16]

Prevalence of HIV among PWID. According to the latest Bio-behavioral Surveillance Survey[17], prevalence of HIV across all cities ranges between the lowest 0.9% in Rustavi to the highest 4.8% in Zugdidi but with large confidence intervals (95%CI, 0.2%-11%).

People living with HIV	
Number of people living with HIV	5525[18]
Adults living with HIV (2014)	6,500 [5,200 - 8,200][19]
Male adults (2014) living with HIV	5,200 [4,100 - 6,500]
Female adults (2014) living with HIV	1,300 [1,100 - 1,700]
HIV prevalence among adults (2014)	0.3% [0.2% - 0.4%]
HIV prevalence among young men	0.3[20]
HIV prevalence among young women	<0.1

Table 5: People living with HIV in Georgia

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[16] GARPR 2015 http://www.unaids.org/sites/default/files/country/documents/GEO_narrative_report_2015.pdf

[17] HIV risk and prevention behaviors among People who Inject Drugs in seven cities of Georgia. Bio-behavioral Surveillance Survey Report. Curatio International Foundation and Bemoni Public Union. 2015

[18] By February 25, 2016.Infectious Disease, AIDS and Clinical Immunology Research Center (IDACIRC). http://www.aidscenter.ge

[19] UNAIDS. http://www.unaids.org/en/regionscountries/countries/georgia

[20] UNICEF. State of The World's Children 2015 Country Statistical Information

New HIV Infections	
New HIV infections (all ages)	564 (2014) 717 (2015) 113 (2016)
New HIV infections among adults (2013)	435
New HIV infections among male adults (2013)	325
Incidence rate among adults	12.7 per 100,000[21]

Table 6: New HIV infections

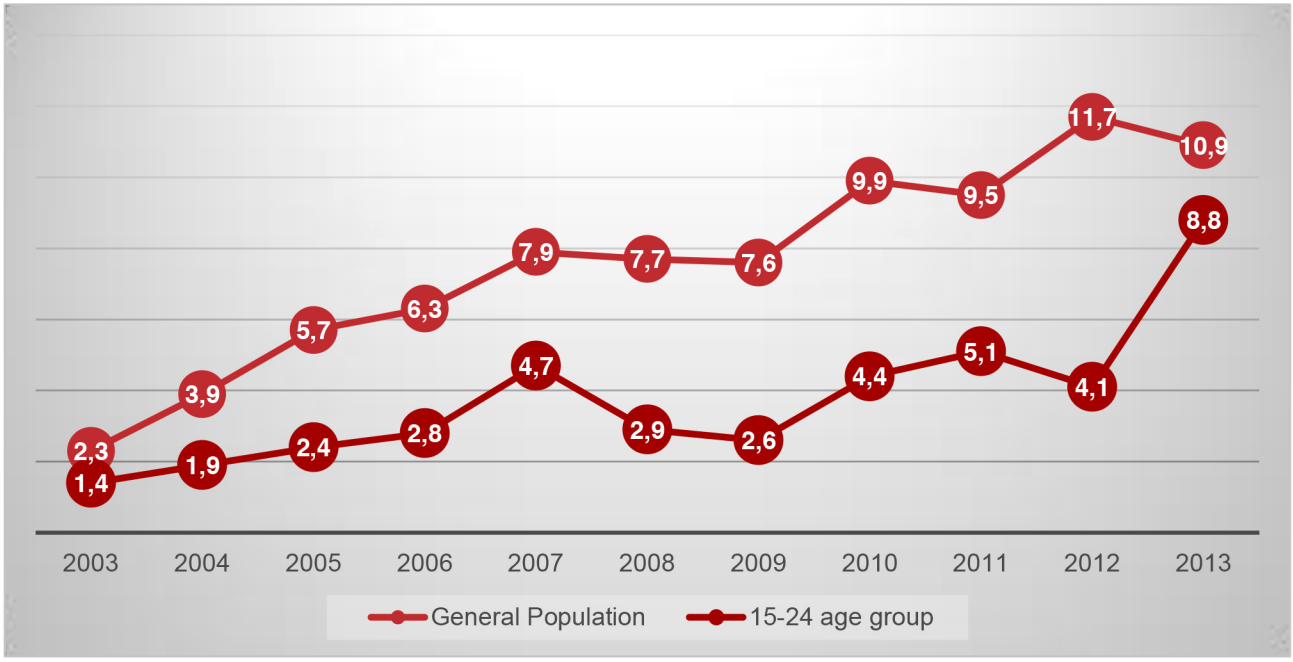

Figure 3. HIV Incidence (per 100,000 population of the appropriate age)[22]

AIDS related deaths	
AIDS related deaths (all ages)	<100 [<100 - <200][23]
AIDS related deaths among adults	<100 96 (2013) 84 (2014)
AIDS related deaths among male adults (2014)	<100
AIDS related deaths among female adults	<100

Table 6: AIDS related deaths

[21] GARPR 2015 http://www.unaids.org/sites/default/files/country/documents/GEO_narrative_report_2015.pdf

[22] NCDC Youth Health Statistical overview 2015 (in Georgian) http://www.ncdc.ge/AttachedFiles/NCDC%20Youth_Health_Statistical%20Overview_20.02.2014_d68e1957-a8f2-45af-a143-1af5a3e890c8.pdf

[23] http://www.aidsinfo.unaids.org

Georgia has the problem of late HIV diagnosis and its association with a high mortality rate. Overall, 48% of patients already had AIDS at the time of HIV diagnosis and 51% of deaths occurred within the first 6 months after entering care. The mortality rate in 2004 was 10.74 deaths per 100 person-years compared to 4.02 per 100 person-years reported in 2012[24]. Additionally, TB continues to be the number one cause of death (21%). Georgia remains the only country in the region that has achieved and sustained universal access to ART. According to UNAIDS data Georgia has the highest ART coverage in the region of Eastern Europe and Central Asia (EECA)[25]. Latest data indicates that 95% of those diagnosed and known to be in need of treatment were on ART by the end of 2014.

Universal access to ART has led to significant reduction in mortality among people living with HIV in Georgia. 12-month survival significantly increased from 79% in 2011 to 86% in 2012 (p=0.01) and remained stable through 2014. The indicator measuring 36-month survival varied substantially over time, with rates reaching 76% in 2012, them dropping to 69% in 2013 and again increasing to 77% in 2014. The recent ART program data further confirm that persons with history of IDU are at higher risk of attrition both at 12 and 24 months after starting ART. Also IDUs have been shown to be at higher risk of disengagement for the entire HIV care. These data underscore the need for directing additional efforts towards HIV positive persons with history of IDU.

TB	
Prevalence of TB in total population	5.900 (2,800 – 10,000); 145 (70-248) per 100,000 population (2014)[26]
TB-related deaths among people living with HIV (2014)	17 (1 - 25); O,42 (0,26 – 0,63) per 100,000 population (2014)
Prevalence of TB as co-infection among PLHIV	80 (58-110); 1.5 (1.1-1.9)%
Co-management of TB and HIV treatment	56 (2014) (48 males, 8 females)
TB patients living with HIV receiving ART	56 (2014)

Table 7: TB prevalence

Georgia is among the 27 high multidrug-resistant (MDR) TB burden countries in the world. The context for TB control is changing as Georgia is fundamentally reforming its health system. The majority of both primary health care facilities and hospitals have been privatized, and insurance coverage has expanded. In 2012, most TB dispensaries were absorbed into private general medical facilities. Some of the responsibilities for the national TB program have been transferred from the National Center for TB and Lung Diseases (NCTBLD) to the National Center for Disease Control and Public Health (NCDC), and currently both centers are partially responsible for TB surveillance, key parts of the TB laboratory network, and the of initiation of TB contact investigations.

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[24] Mortality and Causes of Death among HIV-Infected Individuals in the Country of Georgia: 1989–2012. AIDS research and human retroviruses. Volume 30, Number 6, 2014 http://www.georgia-ccm.ge/wp-content/uploads/Mortality-and-causes-of-death-among-HIV.-1989-20121.pdf

[25] The Gap Report. Geneva: UNAIDS; 2014 http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

One of the major challenges remains MDR-TB and TB/HIV co-infection. TB and HIV control activities are not very well integrated. Analysis of the 2009 cohort of MDR-TB patients showed a high default rate. Georgia has implemented diagnostics for rapid detection of TB and drug resistance, enabling Georgia to identify 63% of the estimated MDR-TB cases among notified TB cases in 2011. However, this suggests that about one third of the MDR-TB cases were not detected and, hence, continues to transmit this drug resistant form of disease. Currently a number of essential TB control functions are largely depending on The Global Fund project and the United States Agency for International Development (USAID) TB Prevention Project, which end in 2016, after which country has to sustain TB control through domestic resources.

HCV	
Estimated prevalence of chronic HCV infection	6,7%
Estimated number of chronic hepatitis C cases	1689; Incidence rate – 37,5 (2012) 1760; Incidence rate – 39.2 (2013)
Estimated number of deaths due to hep C	N/A
Proportion of HCV infection among people living with HIV	47%

Table 8: HCV infections

Georgia has one of the highest estimated HCV prevalence in the world. Based on the finding of 6.7% anti-HCV seroprevalence in a survey in Tbilisi, Georgia's capital, in 2002, an estimated 250,000 persons among the country's 3.7 million inhabitants might be infected with HCV. The prevalence of HCV infection is high among prisoners (50%) (Georgia's Ministry of Labor, Health, and Social Affairs [MoLHSA], unpublished data, 2015), injection drug users (66%, Bio-Bihavioral Survey, 2014), and persons infected with HIV.

In 2011, Georgia began offering treatment to a limited number of HCV-infected persons. Beginning in 2013, when new oral medications that can cure >90% of HCV infections were licensed, Georgia engaged partners to develop a comprehensive HCV prevention and control plan, during which the concept of elimination of HCV transmission and disease emerged. To prepare for the launch of a National HCV elimination program, Georgia requested CDC's assistance to describe HCV epidemiology, evaluate laboratory and health care capacity, and conduct program monitoring and evaluation. This report describes the activities undertaken to prepare for the program, launched in April 2015, and early results of its initial phase, focused on improving access to affordable diagnostics and free curative treatment for 5,000 HCV-infected persons with severe liver disease. The next phase aims treatment of 20,000 patients per year.

STI		
	General population	**Specific KP:**
Number of people living with active syphilis	N/A	N/A
New infections (syphilis)	622 (2012)[27] 1105 (2013) 1431 (2014)	210 (2013)[28]
Number of people living with gonorrhea	N/A	N/A
New infections (gonorrhea)	514 (2012) 728 (2013) 705 (2014)	N/A
Number of people living with chlamydia	N/A	N/A
New infections (chlamydia)	737 (2012) 1748 (2013) 2133 (2014)	N/A
Number of people living with Trichomoniasis	N/A	N/A
New infections (Trichomoniasis)	4695 (2012) 7488 (2013) 8134 (2014)	N/A
Other (i.e. genital infection with herpes simplex virus (HSV), human papillomavirus (HPV) infection)	HSV – 1019 (2014) Other STIs – 1781 (2014)	N/A

Table 9: STI infections

RISK FACTORS

The Bio-BSS study[29] (2014) revealed that on average any type of drug use (swallowing, smoking and/or injecting) starts in the teen years. The median age for starting drug use is 16 years; the median age when participants report first injecting drugs ranges between 18 to 20 years. The study indicated various types of drugs consumed and/or injected by PWIDs during the month preceding the survey. 72.5% had consumed drugs by a non-injection route of consumption during the previous month. CNS depressants and hallucinogens were reported as the most popular drugs for non-injection. As for injected drugs, heroin reported as the mostly commonly used drugs during the last month, followed by buprenorphine (Subutex, Suboxon). The other commonly used injected drug reported by survey participants were Desomorphine ("krokodil") - a homemade opium-type synthetic drug (17.3%). The highest levels of amphetamine type stimulants Methamphetamine (known as "Vint") and Methcathinone ("Jeff") were reported in Tbilisi at 33.5% and 4.1%, respectively.

The study shows that more than half of the PWIDs in all cities shared needles, syringes and/or other equipment at least once during their lifetime. 87.2% used sterile needle/syringe/ other injecting equipment at last injection. 74.3%reported safe injection practice at last injection.[30]Approximately one in five respondents reported cleaning the needle/syringe before usage with boiled or not boiled water.

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[27] NCDC Statistical Yearbook 2014

[28] Georgian Harm Reduction Network (GHRN, 2014)

[29] HIV risk and prevention behaviors among People who Inject Drugs in seven cities of Georgia. Bio-behavioural Surveillance Survey Report. Curatio International Foundation and Bemoni Public Union. 2015

[30] not usage of needle/syringe previously used by somebody else or him/herself, not usage of needle/syringe left at a place of gathering, not usage of syringe prefilled by somebody else without his presence, not usage of syringe filled from previously used syringe, not usage of possibly contaminated shared equipment (container, cotton, filter, water), not usage of drug solution from shared container prepared without his presence.

This study revealed that more than half of the respondents (from the combined sample) had injected drugs outside of their permanent residence during the last 12 months. Among all cases who reported injection outside of their county, Turkey was the most common (79.5%) followed by Ukraine, Russia and Azerbaijan. 35.6% of survey respondents used condom at last intercourse;

Knowledge concerning HIV transmission is relatively good among the studied individuals. The majority are aware that the main transmission risks are unsafe injection practices as well as unprotected sex with an infected person.43.5% of IDUs correctly identify ways of preventing and transmission of HIV (Answers 5 GARPR indictor questions correctly)[31]. On the other hand, misconceptions about HIV transmission still exist that may contribute to the stigmatization and discrimination of people living with HIV. This might be reflective of the level of stigma among the general population.

In recent years, the Georgian Parliament and the government have shown themselves to be very willing to improve the response to dealing with the risks of illicit drug use within the country and they have committed substantial time to considering the issues involved. However, it has been argued that the political commitment to reducing harms and various risks due to drug use could be better focused on developing a balanced approach with specific attention to effectiveness for which EU standards and approaches can provide guidelines.

Drug policy development and coordination of policy implementation is mainly conducted by the Interagency Coordinating Council for Combating Drug Abuse. The council was established by the Presidential Order on 22 November 2011. Council comprises members from all the significant governmental institutions, and is working in cooperation with the representatives of the international organizations as well as of non-governmental organizations, and with the independent experts, working on drug related issues. The main objectives of the Council are to elaborate state strategy on the combating drug abuse in line with the human rights standards and considering the situation analysis of the country, as well as to draft, periodically revise and monitor the implementation of the strategy and action plan, and to coordinate intergovernmental activities.

In 2012, Coordinating Council created four working groups for the purpose of elaboration of national drug strategy and relevant action plan. Working groups were established according to the following strategic directions: Information, research, assessment working group, Supply reduction working group, Demand reduction and harm reduction working group, International cooperation and internal coordination working group. Working groups were comprised by representatives of relevant governmental agencies, civil society, international organizations and independent experts. Developed strategy and action plan were reviewed and assessed as being in line with existing international principles and trends and covering all relevant areas of drug policy by the Cooperation Group to Combat Drug Abuse and illicit trafficking in Drugs (Pompidiou Group) of Council of Europe. All the recommendations provided by the Pompidiou group were reflected in the both documents. The final version of the Strategy and Action Plan was approved by the Inter-Agency Council on December 4, 2013.

The strategy is based on the following basic principles: assisting harmonious development of a human being, safeguarding personal and public security, respect for human dignity and rights, and facilitating informing and educating the public. The goal of the present strategy is to reduce medical, social and economic harm caused by illicit drug traffic on the individual, family, community, public and national level. The main directions/components of the strategy are: working on reducing demand and harm; reducing supply; coordination and international cooperation; and monitoring drug situation in the

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[31] One may protect oneself from HIV/AIDS by having one uninfected and reliable sexual partner; Can reduce the HIV risk if one properly uses condoms during every sexual contact; healthy looking person can be infected with HIV; no one can get HIV as a result of a mosquito's bite; no one can get HIV by taking food or drink with infected person.

country. Action Plan determines specific tasks and respective measures to be undertaken; implementation assessment indicators and clear timeframe, for each responsible body and partner organization. Furthermore, the document foresees the necessary resources for each activity and the source of funding.

Georgia remains the only country in the region where drug use is considered as a criminal offence instead of a public health problem. Starting from mid-2000s, as a result of a zero tolerance policy on drugs and so called "Georgian drug war", Georgia introduced strict administrative and criminal sanctions for drug use and other drug-related crimes. In recent years there has been a dramatic increase in random street drug testing by the police, leading to the urine drug screening of tens of thousands of persons under the "reasonable doubt" of drug use by a police officer. E.g. in 2011 more than 27 000 cases of police drug testing were recorded, while only 6500 adults received any kind of substance use treatment.[32] In case of drug use, the law does not provide any alternative to punishment and there is no mechanism in place that would allow police to refer individuals in need of assistance to medical treatment services or other assistance.

Information on drug offenses in the country are collected by a number of state agencies and kept in their own information systems. The Ministry of Internal Affairs collects and maintains data on drug related offences, including statistics on drug testing. The Prosecutor General's office collects data on drug related criminal charges and proceedings. The Supreme Court of Georgia collects statistics regarding drug-related court hearings and convictions. Ministry of Corrections maintains data on drug-related convicts and prisoners. There is no Crime Prevention Strategy adopted by the country. Subsequently, no specific prevention interventions targeting drug-related crime are implemented. In 2012, the Ministry of Justice established a Centre for Crime Prevention and launched a Rehabilitation and Re-socialization State Program. The main goal of the program is to support the rehabilitation of former prisoners released from the penitentiary system and to support their successful reintegration into the society. Former prisoners with a history of drug use or drug-related crime are eligible for this support, however, no specific drug-related interventions are provided.

Since 2008, there have been several advocacy and policy initiatives to amend national drug legislation. However, none of the packages submitted to the Parliament were successful. Legal sanctions remain especially strict and oriented on criminal penalties, where a more balanced public health–oriented approach is essential, particularly to amend criminal liability.

SOCIAL REINTEGRATION

Psychological support and social reintegration of individuals with substance abuse disorders has never been on the list of the government's priorities. Although Control of HIV/AIDS was identified as one of the public health priorities by the National Health Care Strategy 2011–2015 (NHCS) endorsed by the GoG in 2010, the strategy does not properly acknowledge the magnitude of substance abuse related problems in the country and sets no targets for drug addiction services, psycho-social support or rehabilitation services. Over the last decade, there have been no outpatient or in-patient rehabilitation services for substance users funded by some national fund that would aim towards psycho-social rehabilitation and reintegration of persons with substance abuse related problems. The first attempt to introduce residential treatment and psycho-social rehabilitation services in Georgia was made in 2012 when the Government of Georgia established a new entity under the Public Law – the

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[32] Javakhishvili, D. J., Balanchivadze, N., Kirtadze, I., Sturua, L., Otiashvili, D., & Zabransky, T. (2012). Overview of the Drug Situation in Georgia, 2012. Tbilisi: Global Initiative on Psychiatry/ Alternative Georgia.

Drug Addiction and Psycho-social Rehabilitation Centre. A total of GEL 2 million (€ 921,658) was budgeted to build a residential type treatment centre in Bazaleti. A technical proposal about the mission of the centre and service modalities was developed. Based on the proposal, the centre should have the capacity of providing residential type services to 60-64 patients during 3-6 month period. The proposal was submitted to MoLHSA for approval. However, since 2013, no formal review has taken place. Apparently, due to very high unit cost per beneficiary, the service was deemed financially nonviable and the topic of establishing a residential type service was dropped from the political agenda. The designated funds for this activity remained in the state budget for 2012 and 2013, but were excluded from the 2014 budget. The public legal body *Drug Addiction and Psycho-social Rehabilitation Centre* was annulled in 2015.

Historically, the first psychosocial rehabilitation program for drug users in Georgia was initiated within the penitentiary system in early 2000. At different times, the program was funded by various donor organizations, including EC, Poland Stefan Batory Foundation, Polish Embassy to Georgia, and Open Society Georgia Foundation (OSGF). Through the financial support of the listed donors, the 12 Steps approach based program "ATLANTIS" for drug and alcohol was functional in the penitentiary system of Georgia until 2012.

In 2006, an Anti-drug Centre at the Patriarchy of Georgia was established that provided psychosocial rehabilitation services to dependent and co-dependent persons in civil sector. The programme became most popular in 2007-2012 when two monasteries at the Tabori Mountain started offering to individuals with substance use related problems residential type of psychosocial services. Every year, around 80-100 alcohol and drug dependent persons were residing at the monasteries to receive psychological and mental health rehabilitation services and to stay sober and drug free. However, since 2012, due to unavailability of funds, services have become unable to serve many people, and as of 2013-2014, only a few people sought these services.

Another psycho-social rehabilitation centre – Kamara, a local NGO, specifically targeting drug users and their micro-social environment, was established in 2010. Kamara's operations in Tbilisi provide various services to alcohol and drug users after they complete detoxification course. Services available at Kamara include cognitive-behavioural therapy, yoga, psycho-diagnostics, group psychotherapy sessions, art-therapy, and music-therapy. Similar types of services are also provided by the Psycho-Social and VCT Centre, a local NGO which is operational within the government institution – the Centre of Mental Health and Drug Prevention. Services offered by the Centre are funded by the GFATM. The first social bureau for drug users offering case management services was opened by Bemoni Public Union in 2012 in Telavi, within the Georgia with the support of AIDS Foundation East-West, within the BtG Project. Under the EC funded a project "Promotion of Social Reintegration: establishment of social bureaus for former prisoners and probationers and improving pre-release programs in prisons", Centre for Information and Counselling Tanadgoma provides vulnerable populations counselling on HIV, HBV and HCV, psychological and medical counselling, overdose prevention, psychological rehabilitation based on the 12-step approach and training in communication skills for job seekers in four major cities of Georgia: Tbilisi, Kutaisi, Batumi and Zugdidi[33].

[33] The Drug Situation in Georgia. Annual Report 2013. Addiction Research development in Georgia Project

WOMEN

Women in Georgia continue to be more socially disadvantaged. Early marriage appears to be increasingly common in Georgia, indicating that the law on minimum age of marriage (18 years) is not effectively enforced. One report by UNICEF argues that poverty and the importance of female virginity prior to marriage are the two primary factors pushing girls into early marriages. The report notes that early marriages primarily affect girls aged 14 and over, but that in some cases, girls as young as 12 are married. According to the Public Defender's Report on the Human Rights Situation in Georgia (2012), 7,367 girls dropped out of school at the level of basic education (7-9th grades, ages 12-15) from October 2011 until January 2013. According to a 2010 USAID (Gender Assessment, USAID/Georgia) report, men are usually considered the head of the household in Georgia, and have the ultimate say in decision-making. The report notes that while women are usually responsible for the day-to-day care of children and related decision-making, they do not necessarily make decisions about expenditure for services such as healthcare and education. The 2006 CEDAW shadow report notes that women's equal rights in marriage under civil law are often ignored, and customary and / or religious laws dictate family relationships. Particularly in rural areas, women often have little involvement in economic decision making, and lack information about their rights under civil law. USAID reports that in some Azeri communities, husbands are reluctant to let their wives work outside the home. Research conducted by the United Nations Population Fund (The National Research on Domestic Violence against Women in Georgia) in 2010 found that on the whole, women experiencing domestic violence sought help from friends and relatives rather than from official institutions. The most common reasons cited for this were feelings of shame or embarrassment and that they would not be believed or would be blamed for the violence, fear of giving the family a bad name, and thinking that the violence was not serious enough to warrant seeking help.

Women who use drugs remain one of the most marginalized and underserved groups in Georgia. Health services for women drug users often are either limited or inaccessible due to stigma, discrimination and shame associated with the drug use. There are no psycho-social rehabilitation services targeting female drug users. Access to Opioid Substitution Therapy, Needle and Syringe Exchange Programmes (NSP), as well as general health care services including reproductive health, is particularly limited and in many cases ignored. Fear of revealing drug use status, fear of being rejected of health care, Lack of information on drug treatment services, lack of confidentiality, lack of services based on the needs of women drug users, stigma and judgmental and discriminatory attitude of health service providers are some of the major problems impeding women from accessing health care.

In places of detention women who use drugs are largely absent from state health programme. Under the Public Defender"s Office of Georgia, „there are no gender-sensitive, accessible, and evidence-based drug treatment programmes in the community both in urban and rural areas. Neither such programmes are discussed to be introduced near future. At the same time, such gender sensitive programmes are largely absent from the places of detention. No investments have been made to establish women-friendly services that would provide social assistance to females who are under the pressure of the double social stigma triggered by their gender and drug behaviour. In addition to drug-related vulnerabilities, female drug users oftentimes become victims of domestic and gender-based violence. Therefore, neglecting the severity of the problem of drug use among women may have serious negative consequences at the national and societal level. There are no adequate health care services for pregnant women who use drugs. Medical professionals lack awareness of treatment for drug dependency during pregnancy. In many cases doctors avoid or refuse providing consultations to women who use drugs and are pregnant, leading women to hiding their drug use.

Within the context of orthodox Georgian society, low self-esteem and self-blame, combined with severe social stigma, labeling on the part of family, friends, and society, and an often hostile and judgmental attitude of health service providers plays a critical role in creating barriers to both general

health and substance-use-related services for women with substance use problems. There is an urgent need to develop comprehensive women-specific substance use treatment services with a focus on long-term sustainability[34].

More attention should be paid to the spouses and partners of male PWID. Many partners of IDUs may not be aware of their partner's injection practices or may be unwilling or unable to acknowledge this behavior. Women may fear the confrontation that might occur if drug use practices are openly addressed. Without recognition or acknowledgment of their partners' risky practices, these women may perceive their risks as unrealistically low and have little reason or opportunity to use condoms.

TRANSITION FROM THE GLOBAL FUND TO NATIONAL FUNDING

To boost country contributions by recipient governments, in 2011 the **Global Fund** issued eligibility and counterpart financing guidelines, requiring countries to match the grant funds with a contribution based on their income level. The share of the Global Fund's participation in the program overall will be gradually decreasing and the state's share will be increasing.

In September 2015 the **Ministry of Labour, Health and Social Affairs** of Georgia and **Eurasian Harm Reduction Network** signed a Memorandum of Understanding regarding the Regional High Level Dialogue "Road to Success" held in Tbilisi. Based on the memorandum, both sides worked in collaboration to prepare, organize and conduct the event dedicated to ensure successful transition to domestic funding of HIV and TB response in the region of Eastern Europe and Central Asia. The main objective of the high-level policy meeting was to provide a regional platform for government representatives, donors and civil society to agree on terms and timeline of transition to government funding of HIV and TB response activities, namely the harm reduction programs, as well as to ensure their sustainability.

The government held a lengthy discussion on this issue, and the share of the state funding have already been included in the four-year budget planning cycle. Therefore, during 2017–2019 all programs in Georgia will transition to national funding. The state funded opioid substitution treatment program already provides treatment to about 2,400 patients that constitutes about 75% of all patients receiving this treatment, and beginning in 2017 Government of Georgia will take on funding of the substitution treatment programs that are currently funded by the Global Fund.

Although, the state funding allocation for HIV programs is increasing, but the pace of this development is not adequate for effective planning of the future takeover of the GF supported major interventions, including harm reduction programs. Without the proactive strategic planning for increasing the state HIV programmes' budgets it will be extremely challenging to face and cover the large funding gap developed due to planned decrease in GF funds allocations for Georgia.

While Georgia has yet to be officially declared an upper middle income country by the World Bank, as a result of the 2014 census, it's likely to be labeled one after the final census results are published in April of 2016[35]. The preliminary 2014 census results tell us that the Georgian population is about 3.7 million people in (excluding South Ossetia and Abkhazia).In 2014, using the preliminary census data,

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[34] David Otiashvili et al.Access to treatment for substance-using women in the Republic of Georgia: Socio-cultural and structural barriers. *Int J Drug Policy*. 2013 November ; 24(6): . doi:10.1016/j.drugpo.2013.05.004.

[35] An interesting implication of the 2014 census: Georgia is likely an upper middle income country. Caucasus resource Research Centers AUGUST 17, 2015 http://crrc-caucasus.blogspot.com/2015/08/an-interesting-implication-of-2014.html

Georgia's GNI[36] was $4489/capita.Georgia is not the first and surely not the last country to have a major economic indicator readjustment based on something besides economic growth. Since the reclassification of Georgia from the lower-income country to upper–middle income country donors will redirect their funding to more poor countries, leaving local NGOs in financial squeeze.

Georgia is currently engaged in an important and timely policy discussion about the future direction of its national drug policy, including how this policy fits with international agreements and developments.

On 27 June, 2014 Georgia signed an **Association Agreement with the EU**[37].Concerning the drug policy, the agreement specifies the following:

> ***Article 18. Illicit drugs***
> *1. Within their respective powers and competencies, the Parties shall cooperate to ensure a balanced and integrated approach towards drug issues. Drug policies and actions shall be aimed at reinforcing structures for preventing and combating illicit drugs, reducing the supply of, trafficking in and the demand for illicit drugs, addressing the health and social consequences of drug abuse with a view to reducing harm as well as at a more effective prevention of diversion of chemical precursors used for the illicit manufacture of narcotic drugs and psychotropic substances.*
> *2. The Parties shall agree on the necessary methods of cooperation to attain these objectives. Actions shall be based on commonly agreed principles along the lines of the relevant international conventions, and the EU Drug Strategy (2013- 20), the Political Declaration on the guiding principles of drug demand reduction, approved by the Twentieth United Nations General Assembly Special Session on Drugs in June 1998.*

Within the framework of this agreement, Georgia undertakes to gradually approximate its legislation to the following EU legislation and international instruments within the stipulated timeframes:
Drug dependence. Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence (2003/488/EC)[38].

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[36] The World Bank classifies countries by Gross National Income per capita (GNI). Countries below $12,736 but above $4,125 GNI/capita are considered upper middle income countries.
[37] Association Agreement between the European Union and the European Atomic Energy Community and their Member States, of the one part, and Georgia, of the other parthttp://eeas.europa.eu/georgia/pdf/eu-ge_aa-dcfta_en.pdf
[38] http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32003H0488&from=EN

According to the **UN Human Rights Committee** concluding observations[39] on the fourth periodic report of Georgia, the criminalization of drug use in the context of the zero tolerance drug policy and allegations that the plea-bargaining system has been used to extort money from drug offenders. The Committee finally notes that legislative amendments have been drafted that are aimed at reforming both the plea bargaining system and the zero tolerance drug policy. The State party should pursue its efforts to reform the current plea bargaining system and the zero tolerance drug policy; Adopt a human rights-based approach in addressing the problem of drug use, with a focus on appropriate health care, psychological support services and rehabilitation for drug users, including drug dependence treatment such as opioid substitution therapy and harm reduction programmes. The Committee requests the State party to provide in its next periodic report, due for submission on 31 July 2019, specific, up-to-date information on the implementation of all its recommendations. The Committee also requests the State party, when preparing its next periodic report, to broadly consult civil society and non-governmental organizations operating in the country.

Three leaders from Georgia – First Lady, Minister of Health and Social Affairs and the Vice-Speaker of Parliament demonstrated their support for evidence-based drug policy by signing the **Vienna Declaration** in 2010. Mrs. Tea Tsulukiani, Minister of Justice of Georgia signed the major regional resolution during the 23rd International Harm Reduction Conference held in Vilnius, Lithuania, June, 2013. The resolution calls for reallocation of resources from ineffective prosecution and punishment of drug users to providing effective prevention and treatment.

ACCESSIBILITY

PRIMARY PREVENTION PROGRAMMES

According to the Bio-BSS survey results, preventive program coverage varies by regions of Georgia. PWIDs are provided with different interventions by harm reduction programs, including free HIV testing, distribution of injecting equipment, condoms, information materials, and risk-reduction counselling services. Different packages are distributed according to different programs. Results from the Bio-BSS study showed that at least one fifth of the respondents mention they have heard information about syringe exchange programs during the last month across all cities and sterile injecting equipment was received by a small proportions of PWIDs in all cities. Coverage of preventive programs measured by awareness of HIV testing possibilities and reception of sterile injecting equipment and condoms during last 12 months is significantly lower compared to the program minimal coverage which is defined as receiving at least one of the following program commodities: sterile injecting equipment, condom, brochure/leaflet/booklet on HIV/AIDS and qualified information on HIV with the combination of awareness of HIV testing possibilities (Program full coverage varies between 8% (Telavi) to 30.9% (Gori).

Since 2009, Georgian harm Reduction network (GHRN) has been implementing the “Take Home Naloxone” project within the framework of the GFATM funded HIV prevention program. The aim of the project is to raise awareness of overdose prevention among PWIDs and to build corresponding

[39] UN Human Rights Committee. Concluding observations on the fourth periodic report of Georgia. Adopted by the Committee at its 111th session (7–25 July 2014).

capacity via provision of the first medical aid trainings, distribution of relevant informational material and naloxone ampoules.

There are no services addressing the specific needs of young people (between the ages of 14 and 24) who are vulnerable and most at risk of HIV in Georgia. The government does not have a separate youth-oriented sexual and reproductive health programme. It should be also mentioned that the National HIV/AIDS Strategic Plan does not address specifically HIV prevention among MARA. Neither the State, nor Global Fund and other donors support the programs that are designed specifically to address the needs of most-at-risk young people (MARA). There is a need for youth friendly HIV prevention services for young people including MARA.

The mechanisms of collection of the information on drug related health correlates and consequences differ in the country. Institutional mechanisms of collection and processing HIV/AIDS related data are well developed. As drug use was a leading route of transmission for previous decades, HIV/AIDS prevalence among drug users was under focus of attention of the AIDS Centre. The less developed are institutional mechanisms of data collection on newly diagnosed cases of drug-related viral hepatitis and even less tuberculosis, as well as information on drug-related death (DRD).

SECONDARY AND TERTIARY PREVENTION PROGRAMMES (TESTING AND TREATMENT)

The national response has failed to place equal importance on each component of the core packages of HIV prevention. State-funded programs include the following: HIV Prevention Program among Key Populations; Post-Exposure Prevention; Opioid Substitution Therapy (OST) for PWID; Drug Addiction Treatment and Rehabilitation. In addition, the Government of Georgia (GoG) supports the Safe Blood Program and Prevention of Mother-to-child Transmission Program, offering routine testing of blood donors and pregnant women on HIV and other blood borne infections. HCT, needle and syringe programs (NSP), OST, ART, HIV education, provision of safe sex, and safe injection commodities represent a core package of HIV prevention among key populations at high risk of HIV. HIV testing and counselling is provided by the AIDS Center in Tbilisi, in regional centres in Batumi and Zugdidi, and in approximately 60 other laboratories. This program covers voluntary counselling and testing for high risk groups, including PWIDs. HIV counselling and testing is increasingly being offered to by non-governmental organizations (NGOs) through various donor-funded programs.

Over the last decade, funds mobilized through TGF and USAID have been critical for scaling up the national response for HIV prevention among key populations (PWIDs and their partners, MSM, and FSWs). TGF continues to support HCT in 10 cities throughout the country: Tbilisi (4 sites), Gori, Zugdidi, Batumi, Sokhumi, Telavi, Kutaisi, Samtredia, Ozurgeti, and Poti. The services include rapid testing for HIV, Hepatitis C and B, and syphilis and distribution of injection paraphernalia.

There are six clinics specializing in *abstinence oriented treatment (AOT)* in Georgia, providing inpatient and outpatient detoxification followed by short-term primary rehabilitation. Five of them are located in Tbilisi, the capital city of Georgia, one in Batumi. The State Program on Addiction Treatment is functional in the country and all of the treatment institutions mentioned above receives governmental funding for the limited number of patients – approximately three hundred persons a year. Risk-groups, such as those with HIV/AIDS, socially vulnerable family' members, patients between 18-25 years of age and those who have not yet been enrolled in the state program are being prioritized. A bigger part of the patients pay out of pocket.

Opioid substitution therapy (OST) started in the country in 2005. Nowadays OST is functional through three different stakeholders in the country: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

(GFATM), The State Treatment Program and the private sector. Two different types of OST are available in the country: (1) methadone maintenance program and (2) the program using buprenorphine preparations – buprenorphine alone and combined preparation with buprenorphine and naloxone (Suboxone®). There are 12 OST sites operated by the state in the different regions of Georgia: 6 sites in Tbilisi and one in each of the following towns: Poti, Kutaisi, Batumi, Zugdidi, Ozurgeti, and Telavi. There is one private Suboxone® substitution treatment program in Tbilisi which was launched in 2012. GFATM provides treatment via four OST sites, free of charge – two in Tbilisi, one in Gori and one in Batumi. Additionally, two GFATM sites are running in the penitentiary institutions – one in Tbilisi and another one in Kutaisi, providing short-term detoxification with methadone. In 2013, 352 prisoners received opioid detoxification services, 2 females among them.[40]

TB testing and treatment services are offered within the State TB program and USAID supported TB Project. HCV testing and treatment is funded by the Government National Hepatitis C elimination Programme.

UNGASS indicator:	Data
% of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results. (UNGASS Indicator 7)	Females - 6.45%[41] Data for males N/A
% of PWUD who received an HIV test in the last 12 months and who know their results (UNGASS Indicator 8)	25.7%[42]

Table 10: UNGASS indicator

Despite the impressive expansion of HIV prevention efforts over the last several years, coverage of key populations with preventive services and HIV testing remains low for all key populations. It should be highlighted that the state program does not procure 4th generation HIV tests, which identify HIV positive cases earlier.

Stigma and discrimination of HIV + groups continues to be a major barrier to HIV prevention and service utilization. Negative social attitudes and low public awareness also remain obstacles, especially for IDU and MSM population. Beyond societal attitudes, state criminal laws, regulations, and policies relevant to drug use and preventive work among IDUs and prisoners are among limiting factors. The laws on drug addiction prevention and control are not supportive to implementing effective interventions in public and penal sectors. Therefore, issue focused and targeted advocacy efforts aimed at improving legal environment is essential for the future success of Georgian HIV policy and response

The National HIV Program pays particular attention to adherence as an important determinant of treatment success. Special approach to promote medication adherence is in place and includes both clinic-based and out of clinic services delivered by mobile units. The best evidence of effectiveness of available adherence services is the significant improvement of levels of viral load suppression.

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[40] The Drug Situation in Georgia. Annual Report 2013. Addiction Research development in Georgia Project
[41] The data has been taken from the Georgian Reproductive Health survey. The survey population included females between the ages 15 and 44 years.
[42] BSS study N=2037. The PWIDs were studied in 7 different locations of Georgia: Tbilisi, Gori, Telavi, Zugdidi, Kutaisi, Rustavi and Batumi in 2014.

Provision of care and support services remains essential component of comprehensive package of care for people living with HIV (PLHIV). Community-based HIV self-support centers operate in Georgia since 2004 that provide psychosocial support through peer groups as well as through trained psychologist and hot-line services. In 2014 the network provided more than 5000 combined hotline, online and face-to-face consultations to PLHIV. The palliative care service provision for PLHIV in Georgia has been established in 2008.

Despite the accomplishments in various areas of national HIV response, the epidemic continues to grow. One of the key drivers of the epidemic in Georgia is undiagnosed HIV. It has been documented that HIV positive persons unaware of their status are primary sources of new infections, therefore identification of those infected not yet diagnosed is considered as critical component of combination HIV prevention. Data indicates that in Georgia significant gap exists between the estimated number of HIV infected individuals and those who are already diagnosed. HIV incidence estimation using recent infection testing algorithm (RITA) indicated that over 2010-2012 period number of new infections in Georgia exceeded the number of new diagnoses by at least 60%.43 Obviously this difference contributes to further expansion of the gap between infected and diagnosed. Spectrum estimation exercise shows that around the half of HIV infected persons are not yet diagnosed.

This has serious implications both from individual and public health perspectives. As mentioned above HIV positive individuals not aware of their status unknowingly transmit the virus and contribute to majority of new infections. In addition to fueling transmission, this gap leads to late HIV diagnosis, which is the leading cause of death among HIV patients in Georgia.

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[43] Tsertsvadze et al. (2014). Estimating HIV Incidence in Eastern European Country of Georgia: 2010-2012. Int J STD AIDS;25(13):913-20.

UNHELPFUL LAWS AND REGULATIONS

HIV/AIDS prevention and control interventions in Georgia have been mainstreamed into several state programs: the HIV/AIDS Prevention and Treatment Program (8,424,000 GEL[44] in 2016); the Safe Blood Program (1,650,000 GEL); and the Prevention of Mother to Child Transmission (PMTCT) Program. The main purpose of the State Program on HIV/AIDS prevention is early detection of new HIV/AIDS cases to reduce the spread of HIV/AIDS and provide access to treatment for HIV/AIDS+ patients. This program covers voluntary counselling and testing for high risk groups, including IDUs, TB patients, STI patients, prisoners, patients with Hepatitis B and C, patients with clinical signs of HIV/AIDS, persons having contact with HIV infected, blood donors, pregnant women, PWID, MSM, and FSWs. The State Program on HIV/AIDS treatment covers outpatient and inpatient services, and ART is fully funded by the Global Fund. The State Program on Safe Blood envisages the mandatory testing of all blood donors for HIV, Hepatitis B and C and Syphilis.

- The new HIV/AIDS Surveillance System was introduced countrywide in January 2010. Within the framework of the GF project, HIV surveillance electronic database was developed. The newly designed routine surveillance system now collects electronic case-based data on every tested individual arranged by epidemiologic group. The software program automatically produces different types of analytical reports which is then used to support data.
- The HIV/AIDS monitoring and evaluation framework for Georgia aims to guide informed decision-making on HIV interventions by providing reliable information towards achieving predefined targets and objectives, and in determining which interventions yield the most productive outcomes. It enables the tracking of progress in the national response to HIV/AIDS and enhances informed and sound decision-making and policy for multi-sector and decentralized HIV/ AIDS interventions.
- Funding of substance-use-related services has remained a major issue affecting the availability and accessibility of treatment for substance-use-related disorders. The significant part of services provision, in particular low-threshold harm reduction services, relies solely on international funding. The State Substance Abuse Treatment Program (5,000,000 GEL in 2016) aims at decreasing of substance-related harm and covers inpatient and outpatient detoxification and primary rehabilitation and agonist maintenance treatment.

Type of service/function	State budget		International sources		Private sources	
	2012	2013	2012	2013	2013	2013
Harm reduction, including agonist maintenance treatment	1,3	1,2	1,3	1,2	0,6	1,2
VCT	0,1	0,1	0,6	0,4	0	0
Inpatient and outpatient drug-free treatment and primary (post-detox) rehabilitation	N/A	0,6	0	0	N/A	N/A
Total	1,4	1,9	1,9	1,6	0,6	1,2

Table 11: Drug-related health care expenditures in 2012-2013 (€ million) (MoLHSA, 2013, 2014)[45]

[44] GEL – Georgian Lari – 1 GEL = 0.38 EUR (Mid-market rates: 2016-03-28)

[45] The Drug Situation in Georgia. Annual Report 2013. Addiction Research development in Georgia Project

Georgia has attained all three targets within the Joint United Nations Program on HIV/AIDS (UNAIDS) "Three Ones" Principle. All HIV stakeholders act within the frames of endorsed national HIV strategies that are regularly revised and updated. The Country Coordinating Mechanism (CCM) functions as a main platform for country dialogue and participatory decision-making on HIV related issues. The CCM umbrella unites representation from all relevant ministries, government institutions, civil society organisations, bilateral and multilateral agencies, as well as organisations representing people living with HIV and key affected populations. National Monitoring and Evaluation framework endorsed by CCM in 2012 serves as the main source for evidence-based decision-making.

Greater involvement of Civil Society Institutions has been achieved through effective collaboration of the state institution with the HIV prevention task force (PTF), which is composed of NGOs and professionals working on HIV. Since 2013 PTF elects 4 instead of 2 members to represent PTF at the CCM board. Three out of these 4 members represent communities affected by HIV/AIDS – drug users, LGBT and PLHA.

The national response to HIV epidemic prioritizes the development of an effective prevention to care continuum. Priority directions include the further scale up of the outreach and basic prevention services targeting key affected populations, radical increase in the uptake of VCT leading to more effective and earlier detection of HIV cases, comprehensive measures to ensure expedient progression to care and treatment for HIV positive people, as well as improved adherence and retention in quality care leading to suppression of viral load. There is a need for Improved accessibility and quality of HIV prevention services, strengthening surveillance and monitoring, removal of legislative and regulatory obstacles to effective service delivery, protection of human rights, and implementation of stigma reduction measures.

Heavy reliance on donor support for funding preventive interventions is a challenge that Georgia aims to address. The state will gradually take over the responsibility for funding preventive interventions currently financed by the GF including but not limited to OST, harm reduction services, VCT etc. In 2014, NCDCPH has become Principle Recipient of the GFATM grant to Georgia. This provides opportunity to line up state and donor-supported programs in order to achieve better results in the coming years.

Legislation of Georgia in the field of Health and Human Rights comprises the Constitution of Georgia, international agreements and treaties to which Georgia is a party, national laws and other legislative and regulatory texts. The "Law of Georgia on Health Care" is considered to be the general framework law, which determines the priorities and sets out fundamental principles of health care legislation of Georgia. The "Law on the Rights of Patients" is the specific law that defines all major principles of patients' rights protection. Such rights are enforceable through the court. The "Law on Doctor's Professional Activity" defines the responsibilities of doctors towards patients and also regulates all major aspects of doctors' training, professional development and activity. Defining legal duties of doctors in relation to patient's rights creates the possibility to introduce disciplinary sanctions in case a doctor fails to fulfil their duties. The "Law on Public Health" is related to the rights of patients, as far as it defines rules of interrelation between individuals and the public health system; and in a few, very specific cases, it restricts the rights of individuals for the sake of public interest. Other laws regulate patients' rights issues in the context of various specific fields of medicine, such as psychiatry, human organ transplants, HIV/Aids etc.

LAW ON HIV INFECTION/AIDS

The State has the responsibility to develop and implement measures aimed at preventing the spread of HIV/AIDS. Such measures include the development of universally accessible services, including counselling and lab testing for HIV/AIDS. According to the Law, everyone "shall have the right to

undergo voluntary counselling and testing for HIV infection, including tests conducted anonymously and confidentially." The Law defines the principles of the State policy in the field of HIV infection (Article 5), which include provisions related to prevention of HIV/AIDS: (a) Development and implementation of the State programs aiming at the prevention and treatment of HIV infection/AIDS; (b) Informing individuals about voluntary HIV testing; (c) Informing persons through media and/or individually upon request, about HIV / AIDS prevention; (d) Facilitation of ensuring universal access to HIV voluntary counselling and testing, also prevention; (e) Facilitation of implementation of the HIV/AIDS prevention, diagnostics, treatment, care and support, as well as harm reduction programs in penitentiary institutions; (5) Introduction of the post-exposure prophylaxis of HIV infection.

Health care institutions which provide services to persons with HIV/AIDS are required to offer pre-test and post-test counselling on HIV infection to all patients accessing them for services. Such Institutions are also required to supply information on the applicable preventive measures to the person concerned, in order to ensure the safety of others. The law protects rights of PLWH ensuring guaranteed access to employment, education and treatment, including ART. The discrimination case may be documented and addressed by patients themselves or PLWH support organizations and taken to the relevant authorities (State Medical Activities Regulation Agency and/or Court).

DRUG LEGISLATION[46]

Drug legislation counts the number of laws and regulations governing illegal as well as legal turnover of narcotic drugs and/or psychotropic substances. Drug use per se is an offence under both administrative and criminal legislations of Georgia. Illegal consumption of drugs without medical prescription for the first time during a year or possession of small amount of drugs without an intent to sell stipulates a fine of GEL 500 (approx. € 226) or in exceptional cases, administrative detention up to 15 days under Article 45 of the Code of Administrative Offences (CAO), while the same act committed again during the same year will result in criminal liability (article 273 Penal Code of Georgia). Georgian legislation also stipulates criminal liability for illegal trafficking of narcotic drugs and/or psychotropic substances. Offences other than illegal consumption punishable under criminal legislation include illicit production, possession, cultivation, sale, import or export of narcotic drugs as well as psychotropic substances. Chapter XXXIII of the Penal code of Georgia stipulates all drug related offences.

In 2006 Ministers of Internal Affairs and Labour, Health and Social Affairs of Georgia issued Joint Decree No. 1244–278/n which regulates procedure for drug testing. The newly adopted Law on Police (04.10.2013) introduced a new concept of previously used "reasonable doubt" for a police officer to present a person for drug testing, namely "sufficient ground for suspicion", that authorizes a police officer to deliver a person to a drug testing facility where the fact of drug consumption is established by laboratory (rapid strip tests) and/or clinical examination, and is not necessarily properly confirmed. The Georgian policy of coerced drug testing has significantly increased government income (The net income of the state budget was 18,076,245 million GEL collected from those who tested positive and were punished by fines in 2008[47]), but the policy has failed to reduce the availability of illicit drugs within Georgia. The consequences of a positive test result include the imposition of severe fines.

The new reduction of the law on "Narcotic drugs, Psychotropic substances, Precursors and Narcological Aid" was adopted in 2012. The law provides the overall framework for control of narcotic drugs, defines general rules for authorized handling of narcotic drugs, psychotropic substances and precursors as well as principles of narcological aid. Appendix 2 of the law defines small, large and extremely large quantities for narcotic drugs and psychotropic substances. For a number of currently

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[46] The Drug Situation in Georgia. Annual Report 2013. Addiction Research development in Georgia Project
[47] D. Otiashvili et al., How effective is Street Drug Testing?

widespread substances as are amphetamine, methamphetamine, desomorphine, small amounts are not defined and any amount of the substance is considered a large, leading to a stricter sentence.

In 2014, the Law on “New Psychoactive Substances” was adopted given the increased tendencies in consumption of new psychoactive substances in Georgia as well as special provisions added to the “Penal Code of Georgia” criminalizing illegal production, purchase, storage and other illegal activities. The aim of the law is to prevent potential damage caused by new psychoactive substances to the health of the population, and combat unauthorized handling of these substances, also to ensure the coordinated work of the respective state agencies. The law defines nine classes of chemical compounds for new psychoactive substances and lists twenty distinct new psychoactive substances.

The Law on Combating drug related crime was adopted in 2007 and allows deprivation of certain rights (among others, right to drive a vehicle, right to practice medicine, right to practice law, right to work at national and/or local governmental bodies, etc.) based on the court judgment for 3 years for “drug user” (defined by the law as a person who has committed crime under Article 273 of the Penal Code of Georgia) and for longer periods for the facilitation of drug related activities or sale of drugs. The law was amended several times, the last time being in March of 2014. Important amendments include a) addition of deprivation of the right to engage in pharmaceutical activities or ability to establish a pharmacy; b) possibility to restore rights or reduce the period of deprivation of rights after passage of 1/3 of the time based on “good behaviour”. In cases of plea bargain, deprivation of rights can also be diminished or cancelled.

These current antidrug regulations, which apply administrative and criminal penalties for personal use and possession of illicit drugs, as well as force drug testing and deprivation of certain rights impede implementation of effective prevention interventions in PWID. This punitive approach reinforces social exclusion of and stigma against drug users.

The **Law on Elimination of all Forms of Discrimination** which aims at eliminating all forms of discrimination and envisages efficient mechanisms was adopted in May 2014; The Public Defender is responsible for monitoring the implementation of anti-discrimination legislation. However: (a) the effectiveness of the enforcement mechanism in the absence of an independent body mandated to issue binding decisions and request the imposition of fines on perpetrators; (b) insufficient sanctions to discourage and prevent discrimination; (c) insufficient resources allocated to the Office of the Public Defender to carry out its new functions effectively.[48]

The **National Human Rights Strategy** for 2014–2020 and the National Human Rights Action Plan for 2014-2015 was adopted in 2014. National Anti-Drug strategy fosters elimination of discrimination and stigma against drug users. Law on gender equality more specifically prohibits gender based discrimination. Action plan for gender equality is being implemented by relevant stakeholders under the coordination and monitoring of the Council established under the parliament of Georgia.

The **Law on Prevention of Domestic Violence**, including its criminalization was adopted in 2012, however the domestic violence remains underreported owing to gender stereotypes, lack of due diligence on the part of law enforcement officers in investigating such cases and insufficient protection measures for victims, including insufficient enforcement of restrictive and protective orders and a limited number of State-funded shelters and support services.

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[48] UN Human Rights Committee. Concluding observations on the fourth periodic report of Georgia. Adopted by the Committee at its 111thsession (7–25 July 2014)

The latest **Universal Periodic Review**[49] outlines the problems existing in Georgia with respect to the protection of the right to health. It incorporates health-related topics concerning drug users, persons in need of palliative care, persons with mental health problems, LGBT, and sexual and reproductive health and rights. In cooperation with the Georgian Young Lawyers‟ Association the report was prepared by the following organizations: Union “Step to Future”, Georgian Harm Reduction Network, Alternative Georgia, Partnership for Human Rights, Women’s Initiatives Supporting Group and HERA XXI. Preparation of the report was supported by the Open Society Georgia Foundation. The report covers the period between 2010 and 2014.

One especially active non-governmental actor in the field is the Georgian Harm Reduction Network (GHRN) uniting 26 organizations. GHRN runs fourteen harm reduction service sites in eleven cities across Georgia. Additionally, the Georgian Network of People Who Use Drugs (GeNPWUD) became active during last 3 years. These networks provide information about the rights as well as legal assistance to the people who use drugs. ACESO International for Women is a first self-organization in Georgia. The main focus of organization are women who are in crisis situations, commercial sex workers, women who use drugs, women who are victims of violence and are high risk group representatives in terms of HIV infection, tuberculosis and Hepatitis C. Additionally, there are other human rights NGOs providing free legal aid.

Case of civil activism: Public discussion about liberalizing Georgia’s harsh drug laws, some provisions dating back to the Soviet era, began shortly after the 2012 parliamentary elections, when the Georgian Dream came to power. But no reforms had been introduced by the time Beqa Tsikarishvili was arrested in 2014 for possession of 69 grams of marijuana. Faced with up to 14 years in prison as a first-time offender, the 28-year-old journalist and his friends started a campaign, “Beqa Is Not a Criminal” to promote reform. Crowds of supporters campaigned in support and demanded marijuana decriminalization and the reform of the government’s policy toward drugs. With the assistance of the Education and Monitoring Centre (EMC), Tsikarishvili sued against parliament in Constitutional Court. The Constitutional Court of Georgia announced a historic decision on October 24th, 2015 ruling that the imprisonment of individuals for purchasing and possessing up to 70 grams of marijuana for personal use will no longer be punishable with an unconstitutional 7 to 14 year prison. On November 17, 2015 Georgian courts released 10 individuals who, after the Constitutional Court ruling, had appealed their convictions for marijuana possession. The October 24 decision has created a degree of legal uncertainty: possession rules have been eased, but it remains a crime to use marijuana. Parliament will need to make some changes to the Criminal Code in order for it to conform to the court’s decision.

POLITICAL BARRIERS

Barriers	Opportunities
• Harm reduction is not a top political priority • Low political will is partly a result of the low HIV prevalence rate in Georgia, which decision-makers use as an excuse for not prioritizing HIV prevention activities. • Local governments do not accord good priority to the management of HIV/AIDS • Lack of political will to allocate sufficient resources	• Integration of HIV & AIDS financing with that of general health financing systems has been identified as a potential means of improving efficiency and financial sustainability of HIV & AIDS programs • Strong civil society organizations in the field and their networks

[49] Universal Periodic Review Georgia. 23rd Working Group Session. 2015

in HIV and drug State programs • Criminalization of drug use remains a barrier to implementing harm reduction programs • It is particularly challenging for NSPs, as PWID are unwilling to give outreach workers used NSP materials as this could be evidence of drug use and used to prosecute PWID	

Table 12: Political Barriers and opportunities

SOCIO-ECONOMIC AND CULTURAL BARRIERS

According to the Bio-BSS Study[50], the Tbilisi sample had the largest proportion of respondents with higher education (59.5%), in other cities the majority of respondents reported having secondary or vocational education. Proportion of PWIDs who are currently married varies from 33.6% to 56.5% throughout survey locations. . Study findings still show that PWIDs generally have a low socio-economic status. The vast majority of study participants are unemployed which varies from 51.3% in Gori to 73.2% in Kutaisi. Every third participant mentioned having an average monthly income of 100-300 GEL across all seven survey sites. Every fifth respondent has an income of less than 100 GEL and the same proportion has a monthly income higher than 500 GEL (21%) in the combined sample.

Two studies conducted by GHRN in 2013, analysed data for two data sets: (1) drug users who were recruited to harm reduction services through the peer-driven interventions (2,342 PWIDs); and (2) drug users receiving services at needle-syringe programs (1,154 PWIDs). More than half of respondents in both studies were unemployed looking for a job. More than 15% of surveyed drug users reported not seeking for job opportunities[51].

Activists from community organizations are aware of their human rights and organize advocacy campaigns to support the liberalization of drug policy. The majority of PWID are not fully aware of their rights and mostly are not willing to apply to the court, Public Defender (Ombudsman), or other human rights organization when there rights are violated.

HIV-related stigma and discrimination includes prejudice, negative attitudes, violence and verbal abuse, and poor treatment directed at PLHIV. Stigma and discrimination directed at high-risk groups as well as at HIV positive persons remains a major challenge hindering scaling up of HIV prevention interventions. Stigma is fed by poor awareness and lack of understanding among the general population, as well as between and among high-risk groups. Stigmatized and discriminatory attitudes towards PLHIV are prevalent among school pupils and university students in Tbilisi. According to data obtained during Bio-BSS among Youth in Georgia (2012), pupils and students expressed discriminatory attitudes by responding that, theoretically, if a teacher was HIV infected, s/he should not be allowed to teach in school; people with HIV should be isolated; and a student with HIV should not be allowed to attend school.

Poor awareness about HIV transmission among youth makes teens highly vulnerable to HIV infection and also shapes stigmatized and discriminatory attitudes toward PLHIV. Stigma and discrimination of

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[50] HIV risk and prevention behaviors among People who Inject Drugs in seven cities of Georgia. Bio-behavioural Surveillance Survey Report. Curatio International Foundation and Bemoni Public Union. 2015

[51] The Drug Situation in Georgia. Annual Report 2013. Addiction Research development in Georgia Project

PLHIV as well as negative societal attitudes and low public awareness have been identified in 2011–2016 NSPA as important barriers to HIV prevention and service utilization.

The study[52] Conducted by Bemoni Public Union with support from Global Initiative on Psychiatry (GIP), revealed that HIV/AIDS related stigma exists among healthcare workers (HCW). They lack the knowledge, experience, and skills needed for working with PLHIV. Many fear infection and universal safety precautions are not always adequately observed at medical institutions - further increasing the fear. Treatment providers lack basic, necessary safety supplies (gloves, sterilization means, etc.) and even when available they are underused and education addressing their use needs to be urgently implemented. Stigma and discrimination have been hindering HIV prevention among vulnerable, marginalized groups, and will continue to deter them from seeking HIV prevention services unless effective steps are taken to reduce stigma.

According to the Georgia 2013 Human Rights Report[53] of the United States Department of State, NGOs reported that social stigma resulted in individuals avoiding testing and treatment for HIV/AIDS. Some health-care providers, particularly dentists, refused to provide services to HIV-positive persons. Individuals often concealed their HIV-positive status from employers due to fear of losing their jobs.

In August 2006, some amendments were made to the Administrative Code of Georgia. According to these amendments, the simple possession of small amounts or use of illicit drugs without prescription became punishable with an increased fine (500 GEL). These changes resulted in a rapid increase of people forced to undergo drug testing in the country. There was a tenfold increase in a number of people force tested for drugs during the seven months following the introduction of high penalties compared to the same period preceding this amendment (22,755 vs. 2,706) (MOIA & National Forensics Bureau, 2007). According to the same sources, more than 57,000 people were brought in for forced testing in 2007 and only 38% of them turned out to be under the influence of drugs, compared to 78% for the similar indicator in previous year (MOIA, 2008). The presented data indicate that more than 35 thousand law obeying citizens (i.e. non-drug users) were detained and brought in for testing, where they had to wait in long queues to be tested for drugs and often become subjects of unreasonable accusation and humiliation[54]. According to the data from Ministry of Internal Affairs, a total of 60,196 individuals were tested for the presence of drug metabolites in 2013. Rapid toxicological urine analysis yielded 22,711 positive results. Since most Georgian citizens are not fully aware of their constitutional rights, most of PWID are not aware about the legal opportunity to refuse forced drug testing without negative consequences.

Case of discrimination. Crowds demonstrated extremely judgmental, stigmatizing, and discriminatory attitudes toward MSM on International Day against Homophobia, May 17, 2013. There were massive demonstrations, led by church representatives, against a small group of LGBT activists who “dared” to organize a flash mob and silent walk in the capital city. Although police tried to provide some support, they were unprepared and ultimately were unable to protect activists from approximately 10,000 aggressive and violent protesters. This event is a staunch reminder of the level of homophobic attitudes that exist toward LGBT in Georgia.[55]

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[52] Mental health Issues and Support Structures Concerning PLWA in Georgia. 2008 http://bemonidrug.org.ge/wp-content/uploads/2014/07/Mental-Health-Isues-and-Suport-Structures-Concerning-People-Living-with-HIVAIDS_ENG_.pdf

[53] http://www.state.gov/documents/organization/220492.pdf

[54] D. Otiashvili et al. Drug Control in Georgia: Drug Testing and the Reduction of Drug use? The Berkley Foundation. 2008 http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_15.pdf

[55] Sustainable HIV Prevention in Georgia: Challenges, Opportunities, and Recommended Actions. Policy Paper. Georgia HIV Prevention Project. 2014

Barriers	Opportunities
• High level of labor external as well as internal migration due to the unemployment, insufficient income and harsh socio-economic conditions. • more than half of the country's population (57.5%) currently lives in urban settlements • Since the ethnic conflicts of the1990s and 2008 August War, Georgia has experienced a high influx of Internally Displaced Persons (Number of Registered IDPs – 259247 (2014)56, which has further complicated the country's economic and social problems. • Poverty and unemployment remain among the key challenges of Georgia. The poverty rate remains high- 11.6 %57. Official unemployment rate equals 12.4 %, while 68% of the population regard themselves as unemployed, according to the NDI 2014 public opinion survey. • The social structure of rural poverty is related to migration and urban problems, which induce sexually transmitted diseases. The crises of poverty and unemployment forces more sexually active and productive men and women to migrate to cities (mainly to Tbilisi, the Capital city) where there are concentrations of commercial activities. • Inequality regarding access to health services in rural and urban areas • Sensitivity associated with human sexuality and drug use in population • High level of stigmatizing and judgmental attitudes towards PLHA • Patriarchal attitudes and stereotypes on the roles and responsibilities of women and men in the family and society at large • Lack of access to family planning services and contraceptives by women, especially in rural areas, who often resort to abortion as a method of contraception; • High level of early marriage and domestic violence, especially in rural areas; High number of sex-selective abortions, as reflected by the sex ratio of new-born children • Limited access to sexual and reproductive health services by adolescent girls and young women owing to cultural stigma • Lack of gender-sensitive, accessible and evidence-	• Mobility center within the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia that provides information, counselling services and referrals to different programs • The State programme on universal health care that provides health insurance to all citizens free of charge • Georgian church as well as other religious confessions support prevention and intervention activities targeted drug using population • Georgia has the highest estimated ART coverage in the Eastern European region[58]

[56]Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia
[57]Statistical Yearbook Georgia. 2015. National Statistics office of Georgia. http://www.geostat.ge/cms/site_images/_files/yearbook/Yearbook_2015.pdf
[58]Infectious Diseases, HIV/AIDS and Clinical Immunology Research Center www.aidscenter.ge

based drug treatment programmes for women • Nonexistence of 4th generation HIV tests to ensure earlier HIV diagnosis • Lack of provider-initiated testing and counselling (PITC) in health facilities countrywide	

Table 13: Socio-Economic and Cultural Barriers and Opportunities

CONCLUSIONS AND RECOMMENDATIONS

- Strategic advocacy for legal reformon the alignment of drug control legislation with international drug control treaties and international best practices, keeping in mind public health goals being a priority – first of all, decriminalize individual drug use; Provide alternatives to incarceration for nonviolent drug-related crime.
- Provide adequate federal funding of harm reduction with strong, coordinated linkage to intensive case management, drug treatment, and HIV medical services. Harm reduction services should be strengthened not only in the civil sector but also in the penitentiary system.
- Prevention interventions targeted PWID and their partners should be scaled up through enhanced outreach and peer-driven and community-level interventions. Comprehensive packages of HIV prevention targeted to each key population should be defined and endorsed by the GoG at the national level. Programs are needed that place motivated peer outreach workers in communities with large numbers of IDUs to advocate and promote HIV/viral Hepatitis/STI/TB prevention. Women who are sex partners of MWID but do not inject drugs themselves are vulnerable to HIV infection through their partners risk behaviors as condom use with intimate partners is very low59.Couple-based interventions andPartner counseling and referral services should be established to assist individuals at high risk in learning their sero-status and raising awareness about HIV/AIDS and substance abuse. Community-Level Intervention (CLI) Model60 could be implemented involving representatives of the PWID's micro-social environment and Business advocates61 in order to increase the scale and scope of comprehensive preventive interventions targeted to IDUs and their partners.
- Establish and operate youth friendly HIV prevention services for MARA62, addressing the specific needs of young people - addressing young people more holistically can meet a wide range of health, social, and developmental needs, including security, hygiene, job and skills training, psychological and legal services, and recreation and leisure activities. To attract MARA, outreach is needed, often by peers. Services need to offer a safe, welcoming, and comfortable environment. Services must be confidential, private, nonjudgmental, and friendly to young people.
- Drug treatment and rehabilitation services, including residential-type services, should be scaled up to become effective care and social reintegration programs available and accessible to target groups.

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[59]According to the Bio-BSS 2014, a relatively small proportion of respondents in all cities reported using condoms with regular partners.

[60] CLI Model for IDUs was adapted and tested in Georgia (Telavi, Kakheti Region) in 2012, within the USAID-funded Georgia HIV Prevention Project.

[61]Business advocates are individuals who work or are highly involved with businesses, services centers or other community-based sites. Examples include a beautician at beauty parlor, a clerk at totalizator, waiter at pub or cafe, all of whom interact with the target population in the course of their business. The business advocates' activities support and complement the Peer Advocates' activities.

[62] HIV Prevention Standards for MARA were developed by the UNICEF Georgia and Bemoni Public Union in 2014 within the EU–funded project.

- Provide gender-sensitive and evidence-based drug treatment services for women who use drugs and harm reduction programs for women in detention.
- Use churches and faith-based organizations to promote interventions for PWID, as well as reduce stigma associated with drug use and HIV-positive people - Church is recognized as the most reputable and trusted institution in Georgian population, including youth; Religious leaders are actively involved in drug prevention and rehabilitation activities; Advices received from the religious leaders are valuable for IDUs, their partners and family members.
- Sensitize legal professionals, law enforcement officers, the judicial system and communities of people living with HIV and PWID on the role of the law in creating and enabling environment for the national HIV response. Sensitization can focus on legal rights, HIV prevention, harm reduction and the harmful effects of drug laws - there is a concerning scarcity of knowledge regarding the rights-based approach to HIV responses. Affected communities, including key populations, need information and evidence to deepen their awareness of the law on human rights. Exposure to such knowledge would prepare these communities to demand remedies from the justice system. Key actors in the legal and human rights arena, law enforcers, implementers, and legal practitioners need to reinforce their understanding of important issues and controversies related to a rights-based approach to HIV. By reflecting on topical issues, these actors would be enabled to put forward competent arguments on human rights issues affecting PLHIV or those vulnerable to HIV, including key populations.
- Monitoring of rights violations: mechanisms should be established, implemented and promoted for NGOs and community-based organizations to systematically monitor and document cases of violations of the legal and human rights of HIV-positive people and people who use drugs. Due to existing stigma and fear of disclosure and further violations, many cases of assault and extortion in Georgia remained unreported and unrecognized.
- Creating a supportive environment and fostering social change - advocacy initiatives, public awareness campaigns involving mass media, vulnerable populations, and human rights activists, should be widely implemented to reduce HIV-associated stigma and discrimination. Wide-scale public awareness raising campaigns dedicated to HIV/AIDS should not be occurring occasionally as it is happening in most countries including Georgia. Due to the fact that Georgia is categorized as having a low-prevalence HIV epidemic, most state-funded or donor supported programs in the country are focused on most-at-risk populations, and educational campaigns targeting general public as well as interventions aimed at combating stigma and discrimination of PLHA are mostly planned only twice a year – on World AIDS Day and AIDS Memorial Day. It is obvious, that HIV public awareness raising campaigns should be implemented on a more regular basis and should be utilizing all potential media outlets and other means of communication.