HIV cascade among MSM and Trans Persons in Georgia

2018

EQUALITY MOVEMENT

CONTENT

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral therapy
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
EECA	Eastern Europe and Central Asia
GFATM	Global Fund to fight AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
IDACIRC	Infectious Diseases, AIDS and Clinical Immunology Research Center
IBBS	Integrated Bio Behavioral Surveillance Survey
KP	Key Population
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
MDM	Médecins du Monde
MOLHSA	Ministry of IDPs from the Occupied Terittories, Labour, Health and Social Affairs of Georgia
MSM	Men who have Sex with Men
NTP	National Transition Plan
NCDCPH	National Center of Disease Control and Public Health
NGO	Non-Governmental Organization
NSU	Network Scale-Up
NSP	The Georgian HIV/AIDS National Strategic Plan for 2016-2018
PHC	Primary Health Care
PLHIV	People Living with HIV
PrEP	Pre-exposure prophylaxis (PrEP)
PWID	People Who Inject Drugs
SE	Size Estimation
SRHR	Sexual and Reproductive Health and Rights
SW	Sex Worker

INTRODUCTION

The report has been elaborated with technical and financial support of ECOM within the framework of the GFATM program "Right to Health".

The aim of this report is to present the Cascade of HIV services for MSM and Trans* people barriers and obstacles for their inclusion in various stages of HIV diagnostics, treatment and care. Overall HIV situation and targeted to MSM HIV prevention services and their provision is also discussed in the report. It has to be mentioned right in the beginning that no data on trans* people exists in Georgia and there are no HIV services designed for Trans* people either. Therefore, all data and information reflected in the report is about MSM only.

This report would not have been accomplished without collaboration with the Infectious Disease, AIDS and Clinical Immunology Research Center and particularly Dr. Nikoloz Chkhartishvili PhD and Dr. Otar Chokoshvili MPH for providing the latest spectrum data for HIV cascade in Georgia.

Authors express the gratitude to the organizations "Equality Movement" and "Tanadgoma" for providing data on HIV services among MSM.

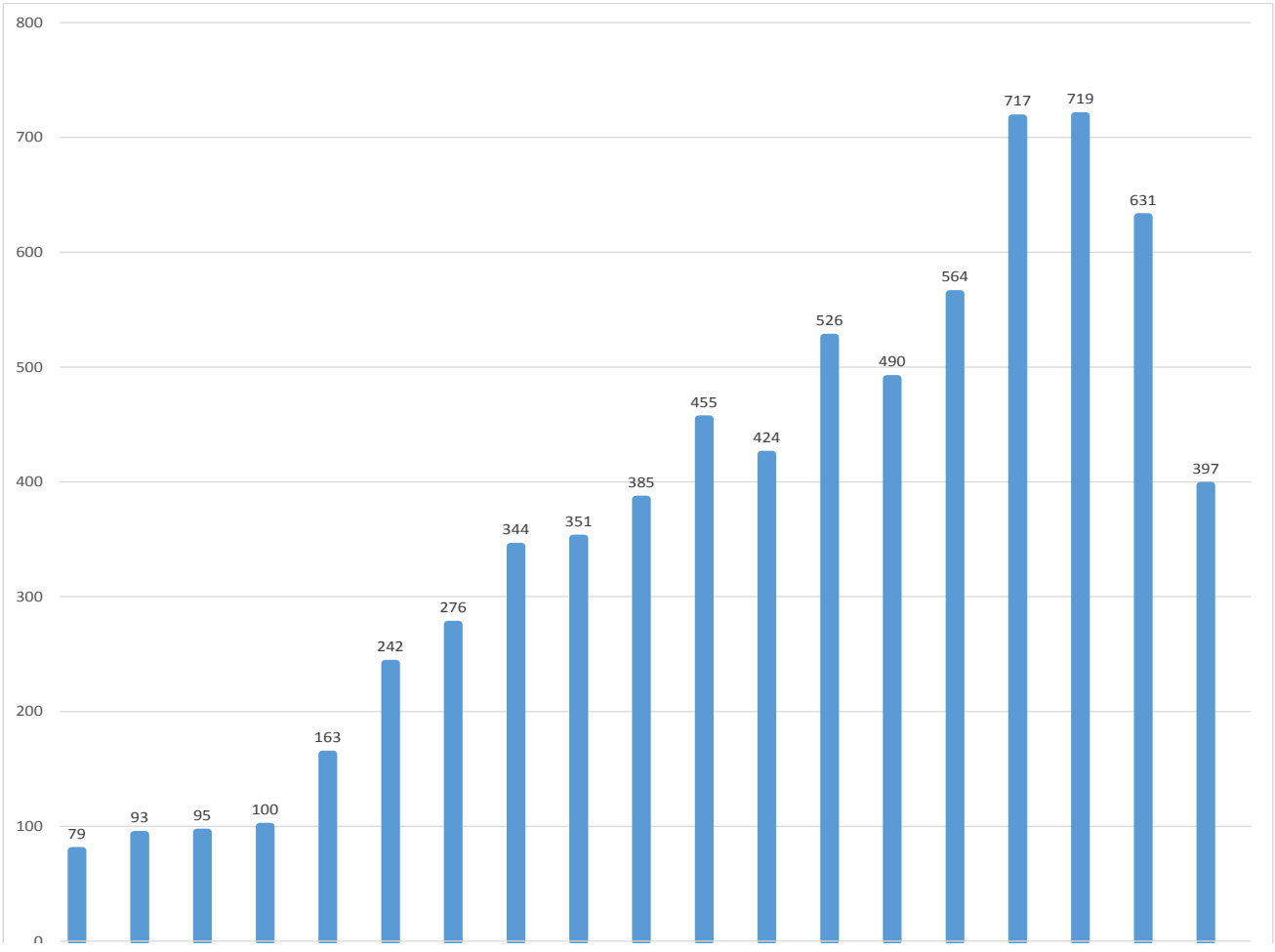
Special thanks to all stakeholders and community activists participating in country round table and validating meeting. The first round table was conducted on April 5, 2018 where HIV cascade, barriers and ways for improvement were discussed. The second validating round table was conducted on August 16, 2018. During the meeting statistical data was updated and recommendations how to increase the HIV test uptake by MSM/Trans* were discussed. The meetings were attended by representatives of the following organizations. Tanadgoma: Ratibor Kozharov-Tsuleiskiri, Beqa Gabadadze. Equality Movement: Giorgi Kakabadze, Giorgi Tabagari, David Kakhaberi, Tamaz Sozashvili, Abel Uznadze. HIV/AIDS Patients Support Foundation: Giorgi Tsoskolauri. Temida: Koba Bitsadze. MDM France in Georgia: Ms. Ina Inaridze and Mr. Giorgi Soselia. NCDCPH: Dr. Ketevan Stvilia, Dr. Lela Serebryakova. IDACIRC: Dr. Ekaterine Karkashadze, Dr. Nino Badridze, Dr. Otar Chokoshvili, Dr. Ekaterine Rukhadze. The meeting was facilitated by Dr. Sergo Chikhladze and Mariam Kvaratskhelia (Equality Movement).

HIV SITUATION IN GEORGIA

The first case of HIV in the country was detected in 1989. Since then, the number of new cases has been steadily increasing and by the end of 2013 it reached 10,9 per 100,00[1]. Georgia is a low HIV/AIDS prevalence country among adult population with estimated prevalence of 0.4% (0.3%-0.5%).[2] According to the latest data from the Infectious Diseases, AIDS and Clinical Immunology

Research Center (IDACIRC), as of August 1, 2018, 7159 HIV cases were registered in total; males – 5355, females - 1804. The number of new HIV diagnoses in the country was increasing steadily, but slightly reduced in 2017 (Figure 1).

Figure 1: Newly registered HIV cases in Georgia -1989-2017[3]



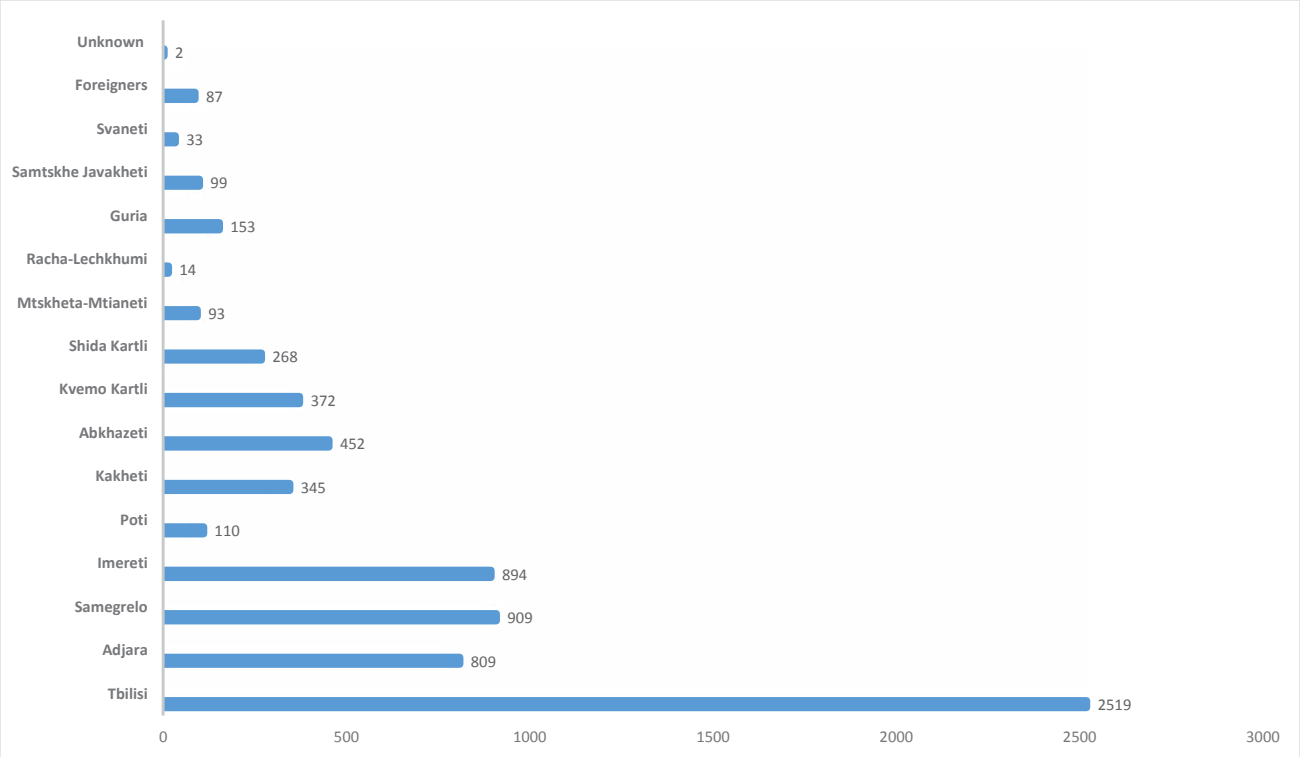
1 World Health Organization. HIV/AIDS treatment and care in Georgia. Evaluation report, Prepared by WHO Collaborating Centre for HIV and Viral Hepatitis, WHO, September 2014.

2 HIV risk and prevention behavior among MSM in Tbilisi and Batumi, Georgia. Bio-behavioural Surveillance Survey in 2015. Study Report. Curatio International Foundation; Information Counseling Center on Reproductive Health – Tanadgoma. Tbilisi, 2016.

3 www.aidscenter.ge (as of August 1, 2018)

At the initial phase of HIV epidemic in Georgia, injecting drug use was the major route for HIV transmission accounting for more than 70% of all cases. Over the last few years, HIV transmission through sexual contacts has become more dominant: as of 2017, 45,8% of all cases are attributed to heterosexual contacts while sexual contacts between men account for 10,8% of all registered HIV cases. Tbilisi, as the most populated city in Georgia, remains to be most affected with the largest number of PLHIV residing in the capital city (Figure 2).

Figure 2: Distribution of HIV registered cases by cities/geographic regions



SIZE OF MSM POPULATION IN GEORGIA

MSM SE study was conducted in Georgia in 2014. There are approximately 17,200 MSM in Georgia, with lower acceptable bound of 11,700 MSM and an upper acceptable bound of 27,600 MSM. This overall estimate suggests that the prevalence of MSM in Georgia is 1.32% (acceptable interval 0.89-2.11%) of the adult (18-59 y) male population.

Taking into account the different MSM population size estimated by various methods in Tbilisi, the median estimates for size of MSM population are 5,100 (acceptable interval

3,243-9,088). This is the 1.42% (acceptable interval 0.9 - 2.53%) of the adult male population in Tbilisi. Batumi Based on NSU findings and ad hoc corrections, the size of MSM population is 450 (acceptable interval 344-566) in Batumi. It means the prevalence of MSM in Batumi is 1.15% (acceptable interval 0.88-1.42%)[4]. The next SE study with IBBS among MSM is due to September 2018.

KEY AFFECTED POPULATION GROUPS AND TARGETED- SERVICES FOR MSM

Research-based evidences indicate that HIV epidemic is concentrated among key affected populations: men who have sex with men (MSM), people who inject drugs (PWIDs) and sex workers (SWs). Sharp increase of HIV prevalence among MSM population has been a serious public health concern in Georgia. BSS among MSM in 2015 revealed that HIV prevalence among this group increased from 7% in 2010 to 25.1% in 2015 in Tbilisi.[5] The prevalence among PWIDs has been contained under 5%. HIV prevalence among SWs based on the IBBS conducted periodically in two major cities- Tbilisi and Batumi have shown that HIV prevalence has been contained under 1% among this group.

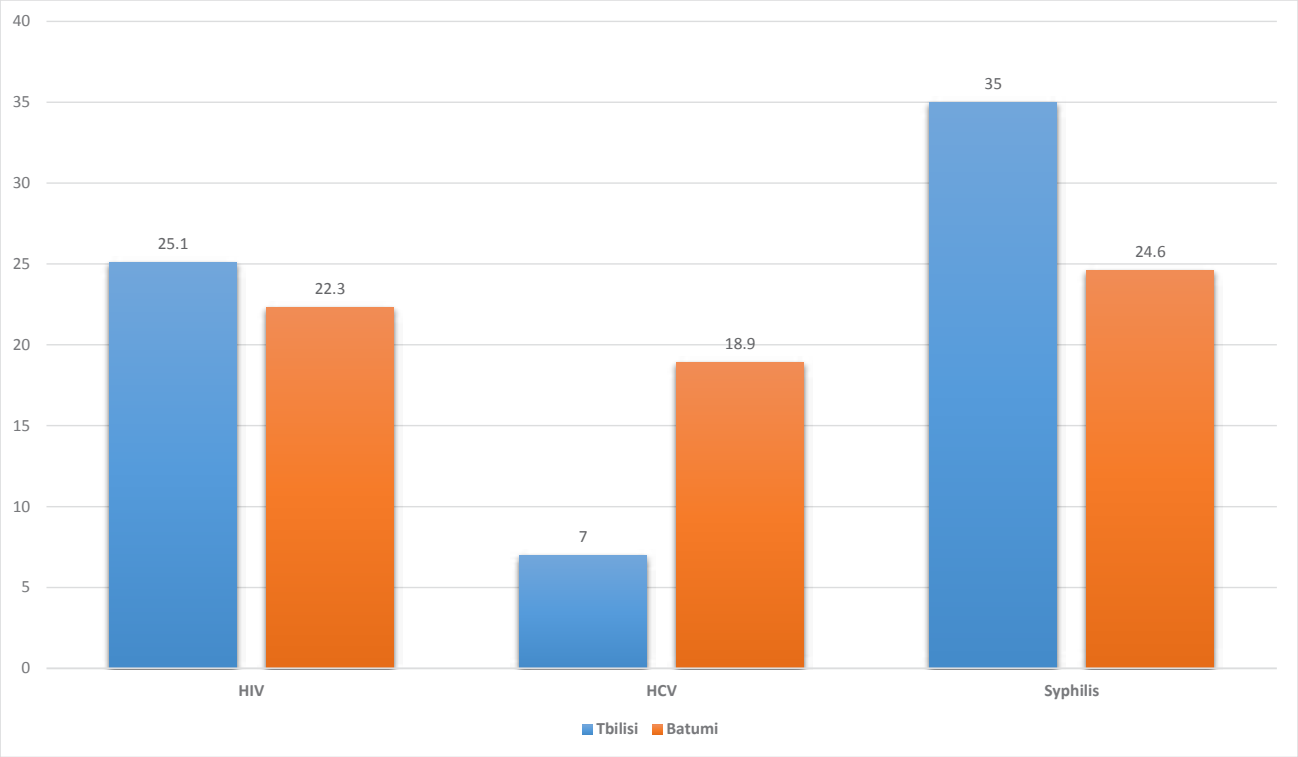
MSM represent most affected by HIV population in Georgia with the highest HIV prevalence: 20.7% of MSM in the country are HIV+ and every fourth MSM in Tbilisi (25.1%) test positive on HIV. Syphilis prevalence is high among MSM. Hepatitis C prevalence is higher in Batumi than Tbilisi (Figure 3). Injected drug use is very low among MSM. Only 0.6% in Tbilisi and 4.9% in Batumi had injected drugs during the last 12 months. Out of them, Subutex was the most frequently cited injecting drug; only one respondent in Tbilisi used shared needle/syringe at the last injection[6].

4 Population Size Estimation of Men Who Have Sex with Men in Georgia, 2014

5 HIV risk and prevention behavior among MSM in Tbilisi and Batumi. Georgia. Bio-behavioral Surveillance Survey in 2015. Study Report. Curatio International Foundation; Information Counseling Center on Reproductive Health – Tanadgoma. Tbilisi, 2016.

6 http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/152.pdf

Figure 3: HIV, HCV and Syphilis prevalence among MSM in Tbilisi and Batumi. IBBS 2015[7]



HIV prevention interventions among MSM are largely funded by the Global Fund to fight AIDS, Tuberculosis and Malaria. A wide spectrum of targeted HIV prevention interventions include the following:

- Anonymous, confidential and voluntary counseling and Testing on HIV
- STI testing and treatment
- Popular Opinion leader (POL) HIV prevention program
- Peer Education trainings
- Educational events, including educational meeting with MSM in prisons
- Provision of safe sex commodities – condoms and lubricants
- Pre-exposure prophylaxis (PrEP) - initiated in 2017.

PrEP was initiated in September 2017 and by the end of 2017, only limited number of MSM were enrolled, and more MSM were undergoing eligibility screening. PrEP is provided by CBO Equality Movement with support of GFATM funding, and the program aims at enrolling around 100 MSM by the end of 2018 year. As of August 2018, 90 MSM are enrolled in piloting.

7 HIV risk and prevention behaviors among MSM in Tbilisi and Batumi. CIF 2015

MSM population is considered to be reached with HIV prevention programs if received at least two services from the list of basic package, and one of them has to be condoms/lubricants at least once within a 6-month period.

MSM-focused prevention services are provided by civil society organizations:

- Tanadgoma Tbilisi office with its branches in four major cities (Batumi, Kutaisi, Zugdidi and Telavi). Tanadgoma is a non-community organization, however its outreach workers working with MSM are recruited from the LGBT community).
- Two community-based organizations – Equality Movement (formerly LGBT Georgia), and Identoba.

Major quantitative results for 2016 are: 3826 - MSM (unique individuals) covered by counseling and information provision on HIV/STI and reproductive health issues (90% of set indicator planned in NSP), 2035 (67% of set indicator). During 2017, 3846 MSM (unique individuals) were covered by consultation and provision of information on HIV/STIs and reproductive health issues. 2291 MSM underwent VCT on HIV. 882 MSM were treated on various STIs within GFATM funded services. Additionally, 1114 MSM were screened with rapid HIV tests in 2017 on the premises of community organizations in 5 locations of Georgia (Tbilisi, Batumi, Kutaisi, Zugdidi and Telavi).

HIV TREATMENT

Universal access to ART has led to a significant reduction in mortality among people living with HIV in Georgia. HIV population analysis shows that AIDS-related deaths among HIV patients in Georgia has substantially decreased from 11 deaths per 100 person-years in 2004 to 2 deaths per 100 person-years in 2015.[8] Georgia was one of the few countries in the region that have adopted "test and treat" approach offering free ARV treatment to all PLHIV regardless CD4 count level starting from the end of 2015[9].

The delivery of clinical HIV care is centralized: HIV treatment is provided by the Infectious Diseases, AIDS and Clinical Immunology Research Center (AIDS Center), which is the country's referral institution for HIV diagnosis, treatment and care. HIV clinical care in regions is provided by the dedicated departments of the infectious diseases centers/hospitals in Kutaisi, Batumi, Zugdidi and Sokhumi – the breakaway region of Georgia. These facilities include AIDS outpatient, as well as inpatient

8 Chkhartishvili et al. AIDS Res Hum Retroviruses. 2014;30: 560-6. / Infectious Diseases, AIDS and Clinical Immunology Research Center

9 Chkhartishvili et al Journal of the International Association of Providers of AIDS Care 2016, Vol. 15(6) 451–454

department with 39 beds (18 in Tbilisi, and the rest in 4 regional cities).[10] HIV treatment sites (except that in Sokhumi) also operate mobile units that are used to improve treatment adherence among the patients. All abovementioned HIV prevention and treatment services are free of charge.

The major challenge in Georgia is a high proportion of undiagnosed PLHIV, as well as a very high proportion of late presentation for care, with 73% presenting for HIV care with a CD4 count <350 and 50% with AIDS.[11]

At present HIV/AIDS medical products are purchased and distributed by NCDCPH through the GFATM grant financing. The system works smoothly but biggest gap is that so far there has been no decision on who will implement this function after the Global Fund grant completes, which is extremely important for effective implementation of the programs to meet the needs of PLHIV, including MSM living with HIV, and benefit to their wellbeing. The MOLHSA of Georgia is currently exploring the possibility for procuring the ARV drugs locally through the existing state procurement mechanism, but so far no problem solving routs are proposed in the National Transition Plan . The plan deals with the full transition to state funding that needs to be urgently addressed. Very important aspect is the direct involvement of PLHIV community that are equipped with the sufficient knowledge and skills of protecting their fundamental right to access to high quality continuum treatment and care. Moreover, taking into account the regional experience regarding the non flexible state procurement mechanisms and pharma monopolizations, there is a challenge to ensure universal ART coverage that corresponds to reasonable balance of quality and price of ARV drugs[12]. As the state started taking over some treatment components (1st and 2nd lines of ARV treatment) the medication for liver function restoration, dermatological problems and mycosis have been already reduced covering only the most urgent cases. Therefore, there is constant need to community mobilization to give them the skills regarding budget advocacy and monitoring for the procurement system and chain supply. Besides, there is also continuous need to increase knowledge and skills regarding ARV treatment and adherence.

10 GFATM HIV grant. Georgia. 2014

11 Dorthe Raben, Stine Finne Jakobsen, et al. HIV/AIDS Treatment and Care in Georgia. Evaluation report. September 2014. WHO; Center for Health and Infectious Disease Center

12 Khmelidze M., HIV/TB situation assessment in Tbilisi. 2017. Assessment done within GFATM funded project "Fast-track TB/HIV responses for key populations in EECA cities"

GEORGIAN HIV STRATEGY 2016-2018[13]

HIV/AIDS National Strategic Plan 2016-2018 was accepted in 2016. The overarching goal of the national strategy for 2016 -2018 is to turn the HIV epidemic in Georgia in the reversal phase through strengthened interventions targeting key affected populations (KAP), and significant improvement in health outcomes for PLHIV. In order to achieve this goal NSP will concentrate on the following three objectives:

1. HIV Prevention and Detection: Improve the effectiveness of outreach and prevention and ensure timely detection of HIV and progression to care.
2. HIV Care and Treatment: Improve HIV health outcomes through ensuring universal access to quality treatment care and support.
3. Leadership and Policy Development: Ensure sustainably strong response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society.

According to NSP 2016-2018 the following expected outcomes from effective implementation of preventive efforts should be achieved by 2018:

- ✓ By the end of 2018, HIV prevalence among PWID, SW and prisoners is contained under 5% each.
- ✓ By the end of 2018, HIV prevalence among MSM is contained under 15%.
- ✓ Rate of late HIV detection is reduced from 62% to 30% by 2018.

Targets for coverage MSM population by essential prevention services and HIV testing by the end of 2018 are as follows (Table 1).

Table 1. Targets for MSM coverage (2016-2018)

Risk groups	2016	2017	2018	
MSM coverage	4250 (25%)	5950 (35%)	8500 (50%)	cumulative
MSM testing	3060 (18%)	4250 (25%)	6800 (40%)	cumulative

2016-2018 NSP also defines the indicative list of preventive service to be offered to MSM in accordance with identified needs:

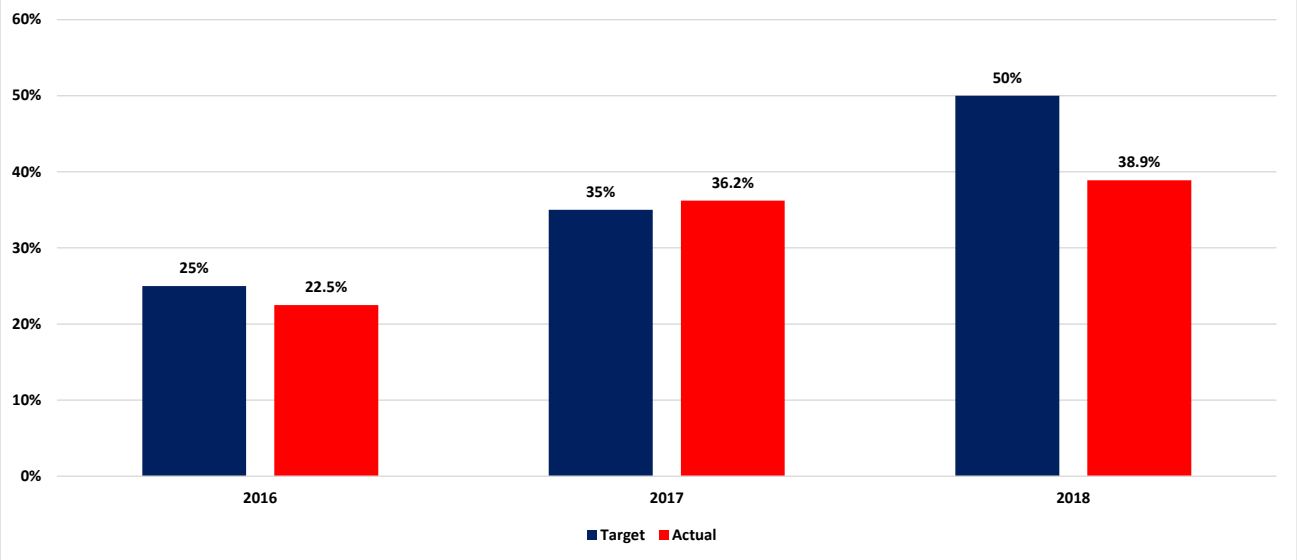
- ✓ Distribution of condoms and lubricants

13 http://www.georgia-ccm.ge/wp-content/uploads/HIV-NSP-2016-20181.pdf

- ✓ Behavior change communication and counselling (including ICT-based)
- ✓ Voluntary counselling and testing for HIV, including introduction of saliva tests
- ✓ Facilitated progression to care and treatment for PLHIV
- ✓ STI (inclusion of STI testing and treatment in case management agenda)
- ✓ HCV and HBV testing and referrals for treatment, inclusion of HCV treatment and HBV vaccination in case management agenda
- ✓ Questionnaire-based screening for TB and referrals for further TB diagnostics and treatment
- ✓ Legal aid
- ✓ Psychosocial support.

Actual coverage of MSM population with HIV prevention services have been steadily increasing from 22, 5% up to 38, 9% in 2018. In 2017 36, 2% of actual coverage was achieved against planned target of 35%. In 2018 38, 9% achieved in first six months against 50% of target planned. Already achieved results shows that the target of 50% will be accomplished successfully by the end of 2018 (Figure 4).

Figure 4. Actual Coverage with preventive services (MSM population)[14]



14 THE GEORGIAN NATIONAL HIV/AIDS STRATEGIC PLAN FOR 2019-2022 (not published yet)

According to NSP 2016-2018, the government will collaborate with community-based organizations representing PLHIV and KPs to design and implement effective stigma reduction strategies, which will have beneficial impact on service uptake and retention.

Taking into account the expected significant decrease in funding available from external sources, the government of Georgia is planning to increase state budget allocations for HIV prevention and treatment to the level required to sustain and scale-up the country response to HIV and start reversing the HIV epidemic[15].

According to Global Fund Grant Concept Note, new areas of work where the government is planning to allocate funding are community-based HIV and HCV testing. The procurement of rapid tests for both infections by the government for distribution among NGOs implementing outreach and basic prevention activities among KPs is planned for 2017 and to fully cover the needs is planned by 2018.

In order to increase number of MSM reached by HIV prevention program it is planned to increase involvement of CBOs in HIV prevention activities. Three community resource centers already run by CBOs (established in 2015) were expended to 5 locations (Tbilisi, Batumi, Kutaisi, Zugdidi and Telavi) in 2017 and are expected to improve linkage of MSM communities to HIV prevention and treatment services. An interactive web site will be developed to MSM community that will be used for increasing the knowledge regarding HIV and STI prevention among MSM, risk reduction communication and promoting condom use; three members of MSM community will be recruited and trained for on-line communication

with MSM, including the chat room communications. The site will be widely used for referral of MSM to HIV prevention, ART and STI diagnostic and treatment services and popularization of PrEP[16].

Global Fung Grant Concept Note also envisages strengthening of LGBT community capacity on HIV prevention and advocacy effort through training activities as well.

15 THE GEORGIAN NATIONAL HIV/AIDS STRATEGIC PLAN FOR 2016–2018. Endorsed by the CCM Georgia on April 15th 2015

16 Global Fung Grant Standard Concept Note (2016-2018). Investing for impact against HIV, tuberculosis or malaria.

GEORGIAN HIV STRATEGY 2019-2022[17]

The overarching goal of 2019-2022 National Strategic Plan (NSP) is to reverse the HIV epidemic in Georgia, through sustainable, targeted interventions for key populations and their sexual partners, improvement of the quality of the services and outcomes of the treatment. To achieve this goal, NSP 2019-2022 emphasizes on three strategic objectives as it was in NSP 2016-2018. Those objectives are the same as in previous National Plan, as well as majority of activities proposed, as the major challenge remains the same, timely detection and progression to care. The new activities proposed mainly aim to expand the coverage of KP's with preventive services and testing and make services more attractive.

To increase the coverage with preventive activities, NSP 2019 – 2022 proposes to make them more attractive through expansion of services offered. NSP offers to develop and launch effective behaviour change communication and counselling services for all KP's including MSM. Introduction of self-testing and saliva testing might expand the testing uptake. Improvement of quality of VCT services provided might also contribute to the testing uptake. Obviously, Georgia has to implement the system of reporting in case of self-testing for reporting, so that positive cases are not lost to follow up and those who will decide to use the self-testing are protected in terms of confidentiality. New NSP also calls for expansion of PrEP and PEP, not only for MSM, but PWID and SW as well. To expand the availability of PrEP and PEP, it is proposed to make them available at community level service points as well, not only at clinical settings. According to NSP 2019-2022, number of MSM who receive PrEP should increase from 100 in 2018 up to 500 in 2022.

NSP 2019-2022 also highlights the importance of signing the contracts with NGOs as non-governmental sector is a very important player in effective implementation of preventive measures. Despite the fact that Georgian legislation allows such contracting, many organizations face problems with meeting requirement of the Public Procurement Law to present a bank guarantee worth 1-2% of the total budget specified in a respective tender proposal. Thus, ability of organizations to participate in public tenders is limited.

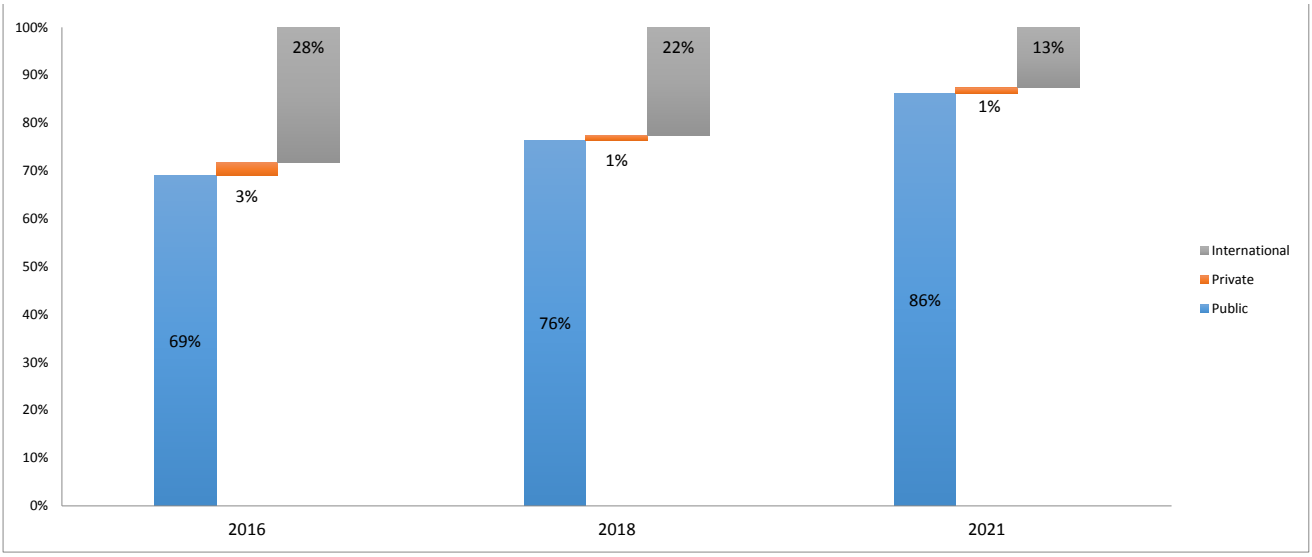
Primary sources of funding of HIV response in Georgia are domestic (76% in 2018) and international funds (22% in 2018). Private, out-of-pocket expenditures are insignificant source of funding (≈1%) and include only expenses related to substitution

17 THE GEORGIAN NATIONAL HIV/AIDS STRATEGIC PLAN FOR 2019-2022 (not published yet)

treatment for substance use.

As the transition process from the Global Fund funding to domestic sources intensify, national HIV funding undergoes profound transformation in terms of sources of funding. Overall, compared with 2016, the annual rate of domestic expenditures are planned to increase and will cover 86% of total expenditures (Figure 5).

Figure 5: HIV Expenditures by source for selected years



International funding, mostly received from the Global Fund is projected to nearly halve from 2016 to 2021 and will amount 13% of total HIV funding, compared to 28% in 2016. According to the Global Fund new transition funding policy, Georgia is projected to complete transition by 2025.

HIV CASCADE

The HIV care continuum is a model that outlines the sequential steps of HIV medical care that people living with HIV (PLWHIV) go through from initial diagnosis to achieving viral suppression and shows the proportion/percentage of individuals living with HIV who are engaged at each stage[18]. The HIV estimates produced using Spectrum rely on a number of data sources. These can be broadly categorized as 1) program data, 2) surveillance and survey data, and 3) global or regional epidemiological patterns.

18 HIV/AIDS Care Continuum. U.S. Department of health and human services, https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum (accessed March 2016).

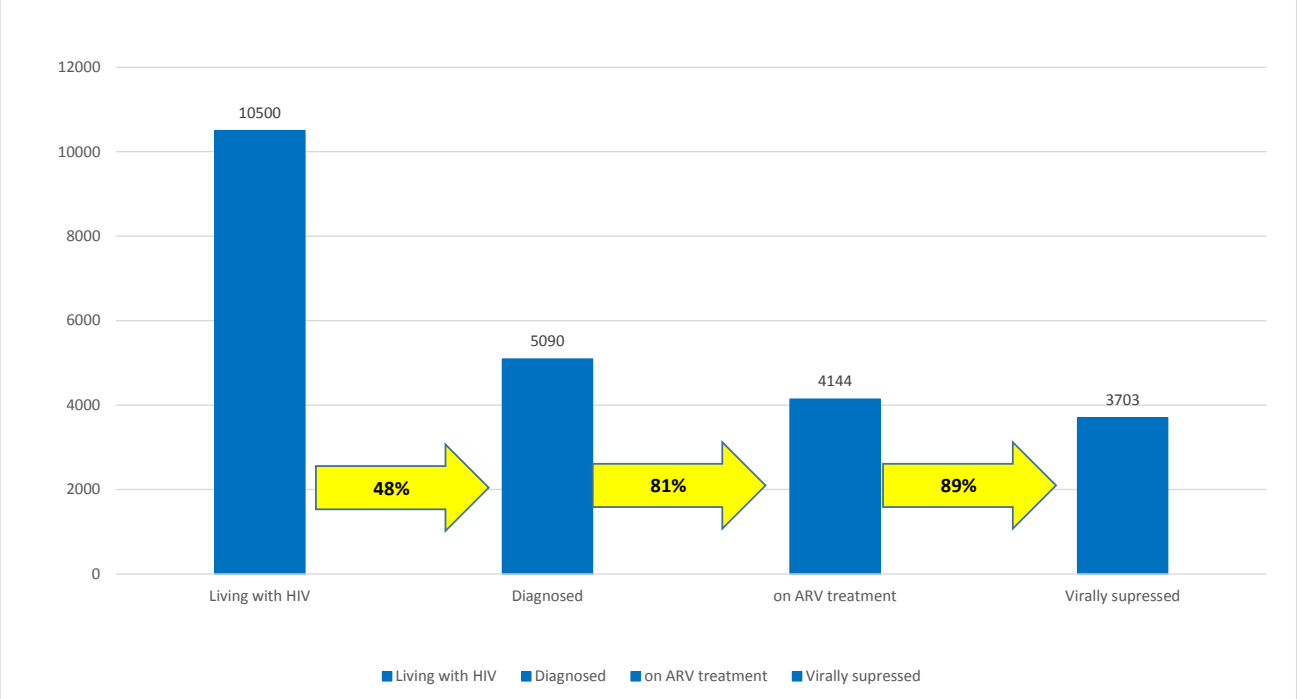
Demographic data are provided by the UNPD or national statistical bureaus. Other country-specific data include program data (number of people receiving treatment or prophylaxis) and surveillance and survey data collected nationally. Epidemiological parameter values are based on a variety of scientific studies including long-running cohort studies[19].

Latest HIV spectrum data were provided from IDACIRC. After analyzing literature and survey data, individual meetings with HIV service provider organizations (Tanadgoma, Equality Movement, IDACIRC, NCDPH) were held. National round table with participation of community members, IDACIRC, CSOs and NGOs providing HIV services was held on April 5, 2018. The meeting aimed to validate the results, highlight the barriers and envisaged the ways for improvement of HIV cascade among MSM.

The number of people living with HIV in Georgia was estimated as 10500. 5090 of them (48%) know their status. 81% out of those 5090 are on ARV treatment. 3703 (89%) achieved the viral suppression (Figure 6).

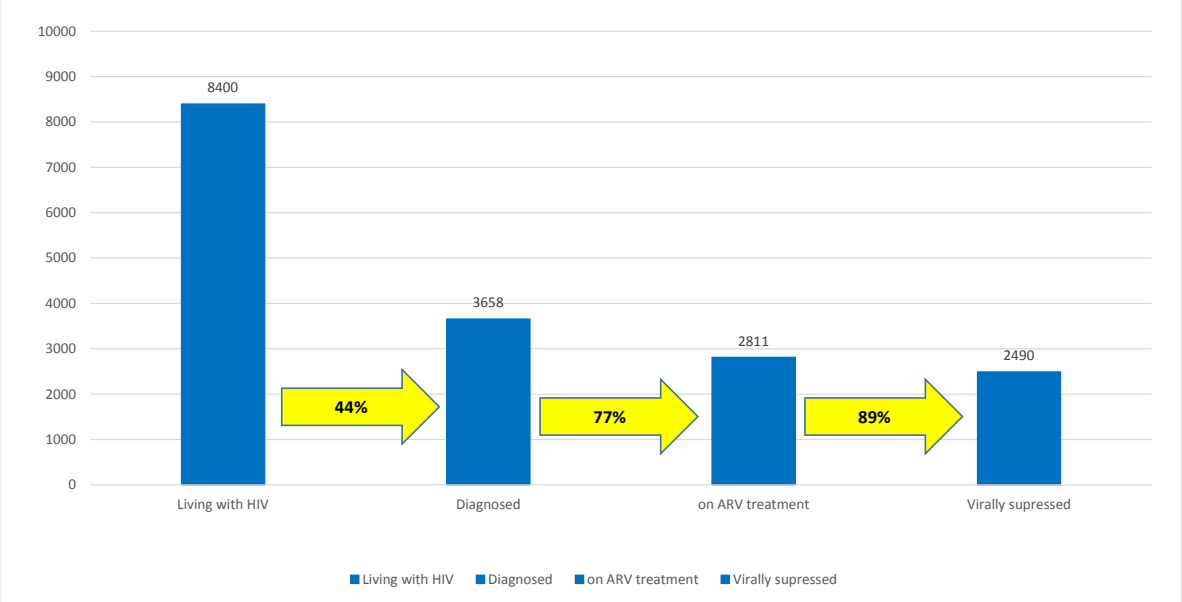
Figure 6. HIV cascade in General Population

The number of men living with HIV in Georgia was estimated as 8400. 3658 of them (44%) know their status. 77% (2811) out of them are on ARV treatment. 2490 (89%) achieved the viral suppression (see Figure 7).



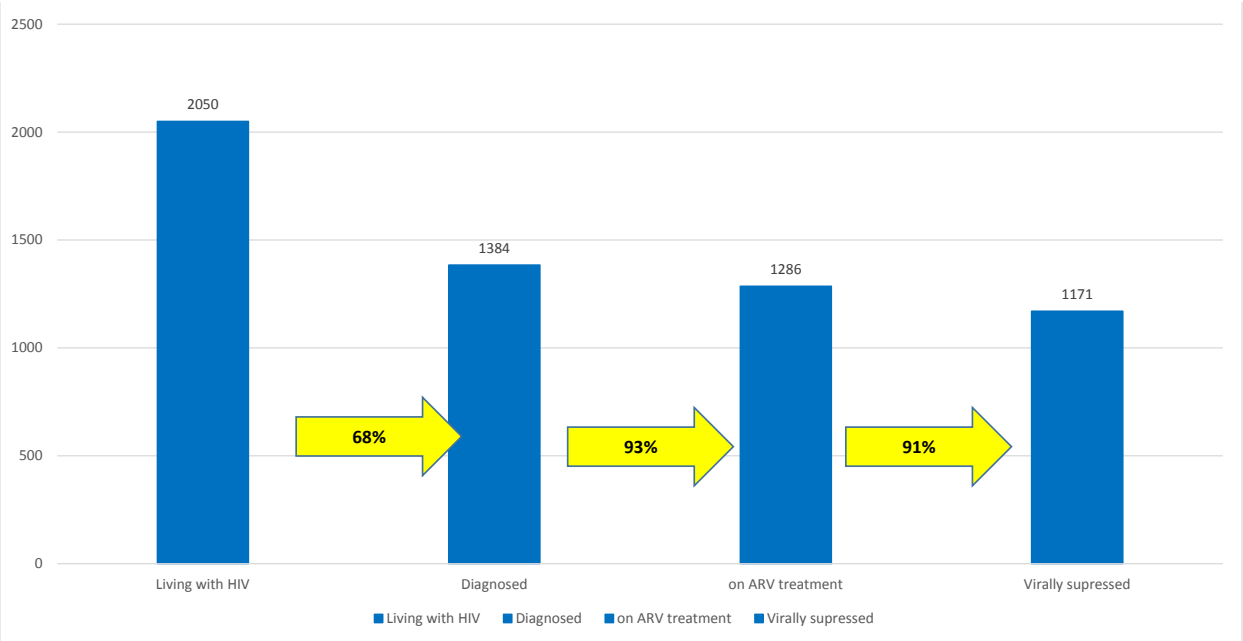
19 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4247263/

Figure 7. HIV cascade in Men



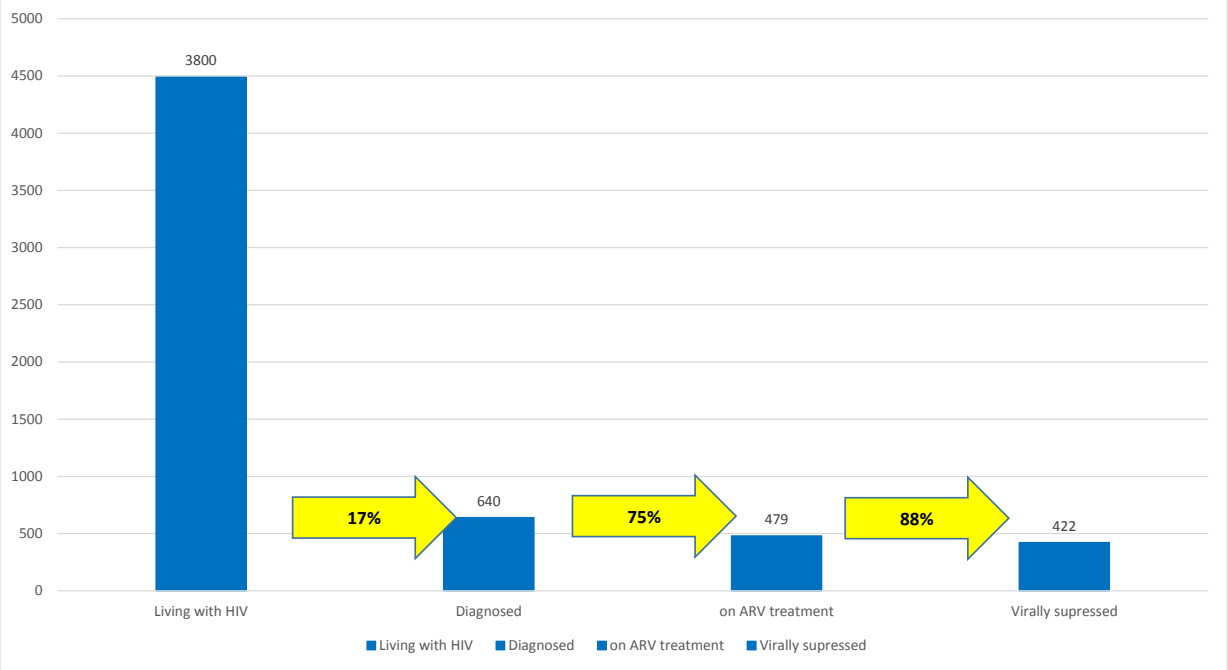
The number of women living with HIV in Georgia was estimated as 2050. 1384 of them (68%) know their status. 93% (1286) out of them are on ARV treatment. 1171 (91%) achieved the viral suppression (Figure 8).

Figure 8. HIV cascade in Women



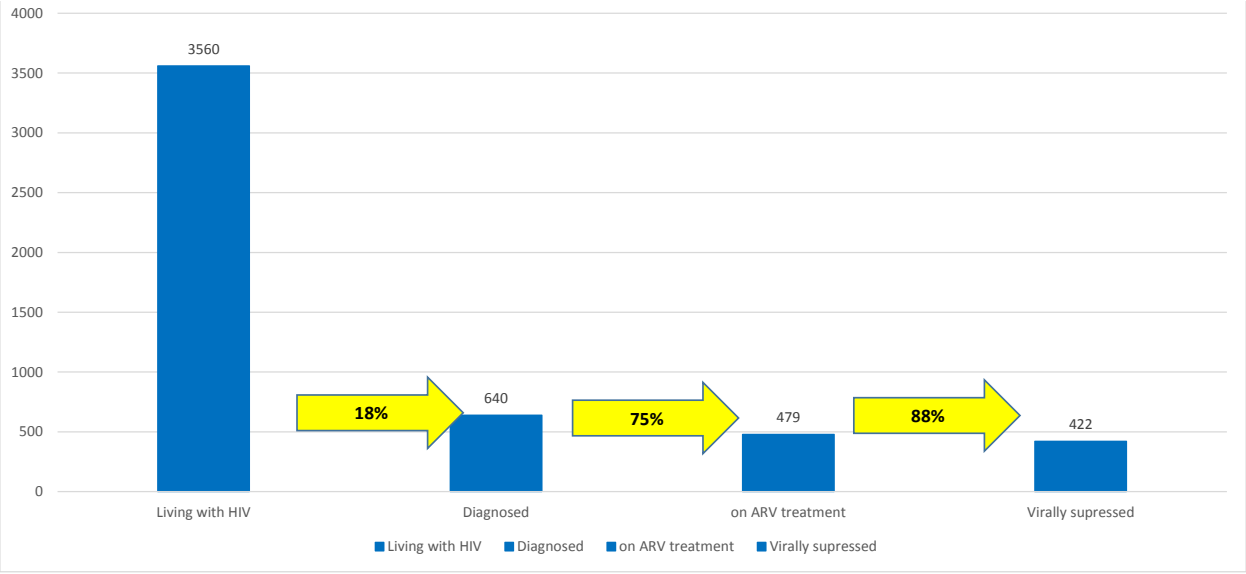
The number of MSM living with HIV in Georgia was estimated by spectrum as 3800. Only 17% among them know their status. 75% of them are on ARV treatment. In 88% of cases the viral suppression has been reached (Figure 9).

Figure 9. HIV cascade in MSM



According to some expert opinions spectrum derived data of MSM living with HIV seems higher. Therefore, estimated number of MSM living with HIV could be calculated by HIV prevalence 20.7% from 17200 MSM calculated by MSM SE. However, even that scenario suggests that only 18% of HIV+ MSM know their status (Vs 17% calculated by spectrum) (Figure 10).

Figure 10. HIV cascade among MSM (using HIV prevalence according to IBBS)



DISCUSSION

The loss of patients occurs at each stage. The analysis of engagement in the HIV care continuum shows that the major gap is at the very stage of HIV testing/diagnosis. Almost half estimated persons living with HIV are undiagnosed in general population. Especially alarming is the situation among MSM where only 14% from MSM living with HIV know their status and that is the result of low HIV testing coverage of key populations. This has consequences on both individual and public health levels. Delay in HIV testing leads to late diagnosis hence increasing the mortality risk. At the same time, individuals with undiagnosed HIV who continue to engage in risk behaviors can contribute to the transmission of the virus.

Comparison of HIV cascades between men and women shows that the characteristics of each level is better among women than in men 68/93/91 Vs 44/77/89. In both General population and MSM shows the target of 90" is almost achieved at the last stage of cascade (88% in GP and 89% MSM). Questionable is to achieve the target on the stage of inclusion in treatment after they are diagnosed HIV positive as 19% in GP and 25% in MSM are lost on second level.

Round table held on April 5, 2018, also consultations with service providers, community organizations and activists discussed the range of reasons which affect negatively the various stages of HIV cascade among MSM.

Homophobia and Transphobia

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

rooted stigma surrounds marginalized and vulnerable populations thus limiting the Ombudsman's effectiveness as people do not make their cases public as they are afraid of further stigmatization. The same report identified stigma and discrimination as a significant barrier to the use of HIV prevention and treatment services by key populations[20].

Stigma and homophobic attitudes negative impact on the lives and everyday experience of MSM. Additionally, instead of promoting diversity, fake and/or biased sexuality education classes replicate harmful stereotypes and misinformation, what puts MSM at greater risk of experiencing violence and creating cultural and structural barriers for accessing HIV and SRHR services.

> *"The recognition of diverse sexual and gender identities and expressions is still problematic in Georgia and homophobia and transphobia starts as early as primary school"[21].*
>
> *"Unfortunately references to „traditional values" to justify homophobic and transphobic actions as well as support of patriarchal values and stereotypical gender patterns of behavior are widely used in the media and reinforced at the political level all over the country".*

The information on the documented cases of Human Rights violations were provided by non-governmental organizations that work on LGBQTI topics and The Public Defender of Georgia (Ombudsman). The National report on the violation of human rights of gay men, other MSM and Trans* people, in particular right to health in Georgia (2017) describes the situation with the human rights of gay men, other MSM, and Trans* people, in particular the right to health, and includes information on the documented cases of such violations as well as a brief legislative analysis. Though there are many cases documented on health rights violation and discrimination among MSM and Trans*, the cases describing discrimination on health rights issues are very seldom. As described below, Trans* person suffered from the violation of the right to inviolability of honour and dignity (art. 17 of The Constitution of Georgia)/ right to health care/patient's rights was violated in penitentiary system of Georgia:

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

21 All the citations are from the participants of round table conducted on April5 2018, at Equality Movement office. Participants and organizations presented are described in Introduction part.

"Case 3 (discrimination): On June 5, 2017, accused transgender woman (in a penitentiary facility) applied the Ombudsman's office, saying that she is kept in unbearable condition; she is treated with disguise as she is HIV positive. As she continued, they do not allow her to enter the certain part of the institution. Ombudsman visited the accused individual and the problem was solved successfully".[22]

The representatives of LGBT community highlight the fact that despite the significant progress, Stigma towards MSM and Trans still exists among Medical personnel. The latest available surveys also shows that the medical staff lack the knowledge on LGBT issues in general. The same time they are open to receive additional knowledge and skills how to deal with MSM/Trans* patients and their specific needs.[23]

Effects and interactions of homo and transphobia and related discrimination at all societal levels negatively affect MSM and Trans* persons' willingness to take care of their health, to ask for medical help, raise knowledge and participate in HIV prevention and treatment programs.

Involvement of communities in service provision and tendering procedures

In order to reach the larger and most hidden groups of MSM it is necessary to use capacities of community based NGOs and groups. The importance of NGOs and communities involvement in HIV prevention service provision is acknowledged at all levels in Georgia. Community involvement and mobilization are essential elements throughout HIV cascade. Community members play a key role in peer-to-peer education, demand creation for services, provision of psychosocial support, facilitation of support groups, income-generating activities, supporting treatment adherence, representation on local health committees and feedback on quality of services provided, etc. Empowered communities and KP led organizations ensure that services along the cascade are appropriate and acceptable to KP members. Without community involvement, improved services can remain under-utilized and inefficient since KPs are hard to reach and will often remain underground due to stigma, homo/transphobia and hostile environment in the society.

The participants of round table mentioned financial and organizational

22 National report on the violation of human rights of gay men, other MSM and trans* people, in particular right to health in Georgia in 2017. Report prepared by Mariami Kvaratskhelia and Nino Bolkvadze, "Equality Movement"

23 http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/118.pdf

sustainability were mentioned as main issues for CBOs and NGOs in general. They identified two main problems related to tender process.

First, they found it difficult to present the bank guarantee document as required in the tender application. As most NGOs working in the field of HIV/AIDS do not have any other permanent source of income than GFATM grants, it was difficult to show the bank guarantee. To overcome the obstacle, some NGOs took a loan from the bank to show the required deposit on their account. Bank interests are shared between program staff members and are cut from their wages and some NGO representatives presented their own personal savings as a bank guarantee. NSP 2019-2022 also highlights that circumstance as a limitation for NGOs to participate in public tenders.

Secondly, NGOs mentioned the bargaining element of the tender, when they had either to reduce the financial proposal or to loose the tender. They said that the final decision was taken based on price criteria, which is not always fair and does not support the quality of the program. One NGO/SR agreed to implement the activities for a lower price than the one in the initial bid, but during the implementation it faced problems to provide quality services without being covered for items such as transportation and accommodation for training participants. One representative acknowledged they lacked realism in the negotiation process and misjudged the need to precisely estimate the optimal minimal cost for implementing listed activities[24].

Continuous funding of prevention services for KPs

All stakeholders mention the high importance of continuity of HIV prevention services provided to KPs. Currently all HIV related prevention services for KPs including community based outreach and testing are funded by GFATM. CBOs and NGOs express their concerns regarding the funding scenario after withdrawal of GFATM from the country. According to Global Fund Grant Concept Note, new areas of work where the government is planning to allocate funding are community-based HIV and HCV testing. The procurement of rapid tests for both infections by the government for distribution among NGOs implementing outreach and basic prevention activities among KPs is planned to fully cover the needs is planned by 2018. Three community resource centers already run by CBOs (established in 2015) were expended to 5 locations (Tbilisi, Batumi, Kutaisi, Zugdidi and Telavi) in 2017 and are expected to

24 http://curatiofoundation.org/wp-content/uploads/2017/01/GEORGIA-TS-CASE-STUDY_Final_Jan25-2016.pdf

improve linkage of MSM communities to HIV prevention and treatment services. That expansion positively affected the scale of community based HIV testing. In total 1114 MSM were tested with rapid HIV tests at community centers run by Equality Movement in 2017. Plus, During 2017, 3846 MSM (unique individuals) were covered by consultation and provision of information on HIV/STIs and reproductive health issues and 2291 MSM were tested on HIV by Tanadgoma's community outreach workers and counselors. 882 MSM were treated on various STIs within GFATM funded services. Though MSM testing on HIV almost tripled from 2014, still it is below the national targets set in NSP (Table 1).

Uninterrupted funding of community-based outreach and prevention services for KPs will prevent the increase in the number of new HIV cases, transmission of HIV to sexual partners of KPs and further to the general population, reduce pressure on the clinical and social care system, as well as the future health care expenditure for treatment of HIV infection. Taking into account the expected significant decrease in funding available from external sources, the government of Georgia is planning to increase state budget allocations for HIV prevention and treatment including key population groups (MSM, SWs and PWID) to the level required to sustain and scale-up the country response to HIV and start reversing the HIV epidemic[25]. However, there is no mention on Trans* people as KP group in NSP and therefore no HIV services are envisaged for them. There is no size estimation and IBBS studies conducted among Trans* population in Georgia. Also there is an absence qualitative surveys on unmet SRHR needs among Trans* people in Georgia[26]. NGO HEPA PLUS with support of Women's Fund Georgia conducted Needs assessment among Trans* people in Georgia based on 14 in-depth interviews conducted in Jan-June 2018. One section of questionnaire was dedicated to accessibility to healthcare services. Most of respondents declared stigma and discrimination as main barrier for Trans* people to access healthcare services including HIV prevention services[27].

The participants of round table mentioned the necessity of existence of approved standards and costing tool for HIV prevention. In 2016, through the financial support from Eurasia Harm Reduction Network (EHRN), national standards for harm reduction services have been developed. UNFPA provides Technical Assistance to elaborate standard packages for comprehensive HIV interventions targeting MSM and sex

25 THE GEORGIAN NATIONAL HIV/AIDS STRATEGIC PLAN FOR 2016–2018. Endorsed by the CCM Georgia on April 15th 2015

26 Assessment of Existing Strategic Information on HIV among MSM and Trans* People in Armenia, Belarus, Georgia, Kyrgyzstan, and Macedonia. 2017. Assessment commissioned by ECOM through the GFATM program "Right to Health"

27 Needs assessment among Transgenders in Tbilisi. HEPA PLUS, Women's Fund in Georgia. 2018.

workers as well as prevention standards for the two KPs in 2016 and 2017. During the transition period, advocacy is planned for approval of national harm reduction and HIV prevention standards for PWIDs, MSM and sex workers. Training of CSO staff on approved standards will be organized to support practical application of the prevention standards.

The participants of round table also stressed the importance of expansion of prevention services available at community level. Representatives of community organizations as well as other service providers believe that the integration of Hepatitis C testing and Hepatitis B vaccination in MSM HIV service package will drastically increase the attractiveness of prevention services. Community activists and outreach workers stressed the importance of implementation of HIV self-testing. Service providers the same time expressed their concerns in terms of proper reference and reporting of self-tested cases so that HIV positive cases are not lost to follow up.

Confidentiality issues

Community representatives mention the fear of non confidential environment when taking monthly ARV drug dosage. According to them, while taking ARV drugs and signing in the journal, they can see the other persons' names who took drugs and thus their HIV status are disclosed.

> *"When I take my dosage I have to leave the signature in the journal. When signing, on the same page I can see the names and surnames and signatures of persons who took drugs before me".*

Representatives of AIDS center also confirmed the circumstances mentioned above and ensured the participants of round table that the issue with journal would be solved soon.

The probability of meeting with other MSM or acquaintance at the site of service provision (HIV testing, taking dosage at Aids center, consultation etc.) was mentioned as other confidentiality issue.

> *"I have experience when after having VCT at one NGO I meet familiar guy. It was a bit embarrassing. He might have thought that I am infected or something like that. And he might tell rumors about me*

to others. That kind of unplanned meetings are quite often at the sites of HIV service provision. I know many similar stories from my friends".

Treatment literacy and adherence

Representatives of communities as well as the service providers mentioned the lack of treatment literacy as the barrier to adherence and that is also linked to the poor treatment outcomes in the individual cases who drop out of treatment. Community organizations and activists mentioned importance of the peer consultation at the sites of ARV treatment. Currently that kind of service is not available at IDACIRC. Also, there is no department/unit of social workers at IDACIRC which negatively affect the treatment adherence of patients and cascade in overall. Peer counseling for HIV+ MSM are available at community-based organizations such as Equality Movement, Identoba and HIV/AIDS Patients Support Foundation (PLHIV community organization). Though this service is not standardized and constant. The experience shows, that usually those who undergo peer counseling rarely refuse to participate in HIV care and support program.

"We (community organizations) have to activate our efforts in order to provide the peer support for those who are diagnosed HIV positive. We also need deep the cooperation with AIDS center in that direction. It is less probable that person refuses to undergo ARV treatment if he -the newly diagnosed person received the information from peer on treatment necessity and positive outcomes".

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. The service is implemented by HIV/AIDS Patients Support Foundation. The main challenge is that all outpatient care and support activities are entirely supported by donor funding and includes adherence promotion and support services, home-based palliative care for chronically ill persons and community-based self-support services.

HIV knowledge among MSM

Last IBBS conducted among MSM in Georgia in 2015 also confirms the concerns of communities and service providers. Majority of the interviewed MSM (88.9% in Tbilisi and 86.9% in Batumi) were aware of HIV/AIDS. Only about one third of the respondents in Tbilisi (30.4%) correctly answered all 5 questions according to the Global AIDS Response Progress Report (GARPR) indicator on knowledge of HIV prevention. In Batumi this indicator reached 35.2%. Although majority correctly cited ways of HIV transmission and preventive measures, misconceptions about HIV transmission on mosquito bite and blood group 0still exists among MSM, about half could not give a correct answer to these questions[28].

For last three years, there is a tendency of decreasing knowledge level in KP's regarding HIV, this might be caused by "generation change", younger ones have less information not only about the HIV, but also where to get the information and testing. This requires an attention from the NGO's that are implementing preventive programs[29].

Community representatives indicates misbeliefs and lack of information spread among MSM:

> *"I have buddy who does not believe in existence of HIV at all. He says that this is the conspiracy theory and "they" need to test some pills and medications".*
>
> *"Such myths as if you have certain group of blood you have natural immunity to HIV and any other infectious diseases is quite common among LGBT persons, unfortunately".*

Representatives of communities and service provider organizations indicate necessity of awareness rising and informational campaigns among MSM on HIV issues, especially on testing importance.

HIV testing at PHC units

Representatives of AIDS center mentioned the integration of HIV screening in PHC settings as a promising opportunity to scale up HIV testing and improve the first stage of cascade in the country. According to them, the gap in HIV testing exists

28 http://new.tanadgomaweb.ge/upfiles/dfltcontent/3/152.pdf

29 THE GEORGIAN NATIONAL HIV/AIDS STRATEGIC PLAN FOR 2019-2022 (not published yet)

as among MSM cascade as in general population as well. Along with strengthening community based testing increasing testing on PHC level will affect positively both indicators general population and MSM as well.

> *"Offering HIV testing in PHC units can influence MSM cascade index among MSM too. As all layers of society are using PHC services. Especially if testing is offered free within state financed programs. Of course we need to haver very sensitized medical personnel to avoid stigma and discrimination towards KP groups there".*

Currently, as a pilot program HIV screening is provided at 3 PHC settings in capital Tbilisi. The doctors highlighted the importance of sensitization of PHC medical personnel and their capacity building in order to attract more people in HIV testing, especially people from KPs. Also, careful utilization of available resources are key to widening the reach of HIV testing. All stakeholders mentioned the importance of linkage to care for these populations when tested in PHC settings.

Another opportunity to increase HIV testing uptake, according to AIDS center, is Hepatitis C elimination program in Georgia. Within the program, to achieve the final goal (elimination of Hepatitis C in Georgia) it is planned to test around 2 mln citizens. AIDS center advocate and lobby to offer HIV testing to all beneficiaries in parallel with Hepatitis C testing.

> *"This is unique opportunity to reach the large group of population. We are testing millions of our citizens on Hepatitis C and along with Hepatitis if we offer and provide HIV testing the same time, we can increase HIV testing number drastically. We work on that possibility with the MOLHA and other stakeholders".*

However, representatives from NCDCPH indicated that the similar process was piloted in Samegrelo region of Georgia (with population of 320 000) and so far only 41 HIV positive persons were revealed among general population. According to the round table participants, provision of HIV testing along with Hepatitis C testing is an important public health initiative though, it does not proactively address the HIV testing uptake among MSM.

CONCLUSIONS

It is obvious that unless HIV testing efforts are substantially scaled up in Georgia, the first "90" target for MSM will not be reached by 2020. Despite the improvements, the stage of HIV diagnosis remains the major gap in Georgia's treatment cascade, with 83% of estimated number of HIV+ MSM unaware of their HIV status in 2017. This has profound negative effect on the entire continuum. Also, 25% of diagnosed MSM were lost (Vs 19% among general population) and this affects the target of treating 90% of diagnosed PLHIV by 2020. Georgia appears to be closest to achieving the third "90" target, with 88% of MSM on ART already suppressed in 2017 (Vs 89% among general population).

This immense gap in diagnosis is the result of low HIV testing coverage among MSM. To increase the coverage with preventive activities it is necessary to make them more attractive through expansion of offered services. Such as, adding treatment of Hepatitis C and vaccination of Hepatitis B to HIV case management protocol and getting the multiple services at one point, that will also decrease the travel time and cost associated to it. Besides, introduction of self-testing and saliva testing might expand the testing uptake. Usage of mobile applications and internet tools can also increase the coverage of beneficiaries as more and more MSM and trans* have been using mobile apps and internet sources for connection.

Homophobia and transphobia remains the main threat for MSM which affects the inclusion of MSM in HIV testing and treatment services. Though there are many cases of health right violation among MSM and Trans* at the places where health service are provided (community activists and organizations provided many cases verbally), the documentation of cases are still quite poor. Knowledge of medical personnel on LGBTQI issues is still very low.

MSM and Trans* are more tend to trust services organized on community basis. Therefore, scaling up community-based outreach and prevention services can definitely positively affect the stage of HIV testing among MSM.

Complicated tendering procedures prevent community based NGOs and other CSOs to participate in GFATM or State tender procedures as they face problems with meeting

requirement of the Public Procurement Law to present a bank guarantee worth 1-2% of the total budget specified in a respective tender proposal. Therefore, ability of organizations to participate in public tenders is limited.

Low knowledge on HIV and misbeliefs are still widely existing among MSM and affect their participation in various stages of HIV testing, treatment and care. Threat of confidentiality breach remains an issue at HIV service provision sites on both State and non-State premises. Using peer counseling at HIV treatment and care settings can be considered as strong tool for increasing the ARV treatment literacy and adherence among MSM living with HIV. Besides, it creates the atmosphere of trust at the sites of service provision where peer HIV counseling is available.

There is no HIV services designed specifically for Trans*. There is the lack of surveys among Trans* focusing on SRHR needs which can be used for advocacy reasons.

RECOMMENDATIONS

In order to strengthen the organizations working on HIV prevention among MSM it is recommended:

- To strengthen outreach, testing and counseling capacity of local CBOs and NGOs, who are currently involved in implementation of GFATM program
- To strengthen the management and fundraising capacities of local CBOs working on HIV prevention among MSM
- To explore the need for geographical expansion of community based HIV preventive services and expand the geographical presence of CBOs in selected regions of Georgia (if needed).

In order to increase attractiveness and usage of HIV prevention / treatment services among MSM:

- To introduce the peer counseling procedures at HIV treatment and care setting to ensure the inclusion of HIV+ MSM in treatment scheme and to increase the treatment adherence
- To introduce and scale up of self-testing and saliva testing at CBOs and NGOs providing HIV prevention services
- To increase the usage of modern technologies (mobile applications, social networks etc.). to scale up of community based outreach and coverage, especially in regions
- To add additional services, for example, treatment of Hepatitis C and vaccination of Hepatitis B to HIV prevention package for MSM and to use “one window”

principle to get the multiple services (HIV testing, STI testing and treatment, counseling, Hep B vaccination, materials provision etc.) at one site.

In order to facilitate the advocacy process:

- To improve the documentation of discrimination cases on right to health issues among MSM and Trans*
- To conduct joint advocacy of CBOs and other NGOs towards MOLHSA to approve the standards and costing tool of HIV prevention for KPs
- To advocate to simplify the tendering procedures to remove the bank deposit guarantee for NGOs/CBOs and enabling them to participate in State and/or GFATM tendering processes
- To carry out quantitative and qualitative surveys on the unmet SRHR needs among Trans* people can facilitate the further advocacy work for designing special health services for Trans*.

In order to improve partnership and intersectional cooperation:

- To strengthen the partnership between state and non-state actors for better coordination of HIV services provision and to create the traceable referral scheme to refer HIV diagnosed MSM to ART sites
- To initiate the integration of HIV training modules into postgraduate medical education system
- To elaborate the confidentiality policy at all types of HIV service provision organizations (AIDS center, CBOs, service provider NGOs, etc.).