

GEORGIA FINAL REPORT

March–April 2000

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



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**Georgia Final Report
March–April 2000**

for

**USAID’s Implementing AIDS Prevention
and Care (IMPACT) Project**



Georgia Final Report

*Submitted to USAID
By Family Health International*

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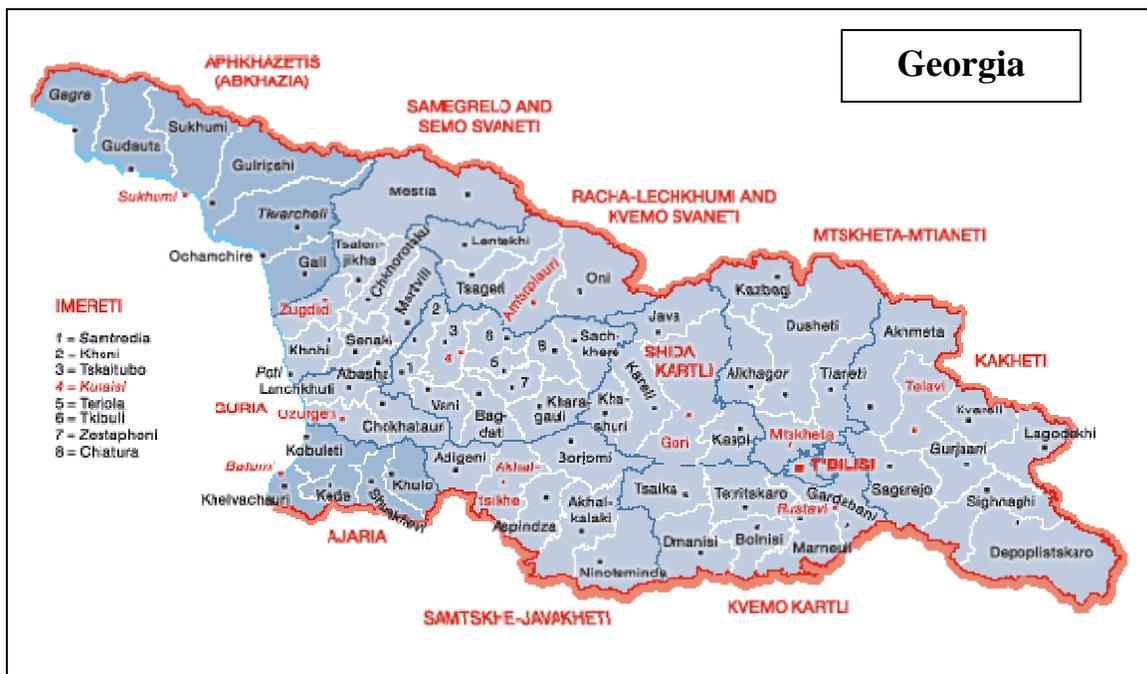
GLOSSARY OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
FHI	Family Health International
FSWs	Female sex workers
HIV	Human Immunodeficiency Virus
IDUs	Injection drug users
IMPACT	Implementing AIDS Prevention and Care Project
MSM	Men who have sex with men
NGO	Nongovernmental organization
PSI	Population Services International
STD/STI	Sexually transmitted disease/infection
UNAIDS	United Nations Program on HIV/AIDS
USAID	US Agency for International Development

EXECUTIVE SUMMARY

The Implementing AIDS Prevention and Care (IMPACT) Project in collaboration with Population Services International (PSI) conducted a technical assessment in 2000 of the potential for an HIV epidemic, programmatic needs and intervention options in Georgia. IMPACT received US\$50,000 from USAID/Caucasus/Georgia in field support to conduct the assessment. Managed by Family Health International (FHI), IMPACT worked with PSI on the assessment from March–April 2000 and submitted an assessment report to USAID/Caucasus/Georgia. The report included recommendations for potential prevention and care interventions and an illustrative budget (see Appendix). There were no further activities under IMPACT/Georgia since the USAID mission did not fund the proposed activities.

Country Context



Georgia is a Eurasian country in the Caucasus at the east coast of the Black Sea. A transcontinental country located at the juncture of Eastern Europe and Western Asia, Georgia has extensive sociopolitical and cultural connections to Europe. In 2003, the United Nations estimated the population of Georgia to be 5,126,000. The life expectancy for the population overall is 76.1 years while that of males is 72.8 years and that of females is 79.9 years. The primary ethnic group is Georgian, composing 70.1 percent of the total population. Other groups include Armenians (8.1 percent), Russians (6.3 percent), Azeris (5.7 percent), Ossetians (3.0 percent), and Abkhazis (1.8 percent).

Georgia has an adult HIV prevalence of .13 percent. Injection drug users (IDUs) account for 67 percent of the cases. Twenty-two percent of the cases are among the heterosexual population, six percent are among the homosexual population, and four percent are blood recipients.

PROGRAM OBJECTIVES, STRATEGIES, AND ACTIVITIES

The objective of the technical assessment was to evaluate the HIV/AIDS situation in Georgia and make recommendations to USAID regarding prevention support.

The study methodology included site visits and literature review. Researchers visited local NGOs, HIV/AIDS centers, reproductive health research/service centers, and prisons. They collected data through in-depth interviews, focused discussions, and direct observation. They reviewed both gray and published literature produced or sponsored by multilateral organizations, bilateral agencies, international and local NGOs, and the Georgian national government.

Topics covered include

- HIV/STD monitoring and surveillance data on behavior, HIV, and STIs
- HIV/STD service delivery and provision of information, education, and communication on HIV/STDs
- characteristics of potential target groups and current prevention interventions among IDUs, female sex workers (FSWs), men who have sex with men (MSM), youth, prisoners, and mobile populations, along with the potential maternal and child health implications

RECOMMENDATIONS

Based on the HIV data collected, Georgia was found to be a low-level HIV country by UNAIDS standards—with less than 5 percent prevalence of HIV infection in all groups. However, Georgia had extremely vulnerable populations, including IDUs, FSWs, MSM, and prisoners. In an effort to prevent HIV infection in these vulnerable populations and the ensuing spread of HIV to the general population, IMPACT/Georgia made the following recommendations:

Direct Interventions

- Implement targeted prevention interventions in high-risk groups (IDUs, FSWs, their clients, MSM, prisoners). The priority group for immediate intervention was IDUs.
- Institute/support comprehensive HIV prevention activities in Georgia's 12 detention centers.
- Support the Georgian AIDS and Clinical Immunology Research Center of the Ministry of Health to develop a comprehensive behavioral and biologic

- monitoring plan (second generation surveillance) to monitor HIV/AIDS/STDs in Georgia and to implement the plan.
- Support programs to improve commercial private sector delivery of HIV/AIDS prevention information and products and services for Georgian youth, as well as for high-risk groups.

Supportive Interventions

- Increase communication/coordination among donors supporting HIV/AIDS interventions.
- Support Georgian National AIDS Committee and other key stakeholders (including health, legal, and regulatory bodies) to develop a national HIV/AIDS strategic action plan.
- Foster linkages between nascent Georgian HIV/AIDS NGOs and regional and international groups already engaged in and experienced with the proposed intervention activities.
- Facilitate communication, planning, and information sharing among government, the private sector, NGOs, and beneficiary communities to harness the resources of each sector for integrated HIV/AIDS activities.

IMPACT/Georgia recognized that many of the recommendations proposed in this technical assessment were beyond the scope of USAID's strategic interests and policy in Georgia. However, a comprehensive report was considered most useful to the USAID mission in making strategic decisions about HIV/AIDS programs. Although the mission did not fund the proposed activities, the assessment report provided a practical technical framework response to effective prevention strategies in low HIV prevalence settings.

Technical Assessment of HIV/AIDS in the Republic of Georgia
Recommendations for Interventions

Prepared for USAID/Caucasus/Georgia

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Executive Summary

Based on current HIV data, Georgia is a low-level HIV country, defined by UNAIDS as having less than 5% prevalence of HIV infection in all groups. Georgia, however, has extremely vulnerable populations, injecting drug users (IDUs), female sex workers (FSWs) and possibly others, to HIV infection. The vulnerable populations of IDUs, FSWs and their partners represent core and bridge populations. HIV prevalence rises first in these groups and then gains a critical mass, which allows the epidemic to be sustained and spread to the general population. The HIV epidemics in Ukraine, Belarus and Russia have occurred quicker than an appropriate policy response and HIV prevention interventions could be developed. *Aggressive efforts now to prevent HIV infection in these populations can avert an HIV epidemic in Georgia protecting these immediately vulnerable individuals and ultimately the general population as a whole.*

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
BSS	Behavioral Surveillance Surveys
BD	Blood Donor
CDC	Centers for Disease Control
CEE	Central and Eastern Europe
DIF	Direct Immuno-fluorescence
ELISA	Enzyme-Linked Immunosorbant Assay
EU	European Union
FHI	Family Health International
FP	Family Planning
FSW	Female Sex Worker
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
IDU	Injecting Drug Use
IEC	Information, Education, Communication
KAP	Knowledge, Attitude, Practice
MOH	Ministry of Health
MSF	Medecins Sans Frontieres
MSM	Men Who Have Sex with Men
NGO	Non-governmental Organization
NIS	Newly Independent States
OSI	Open Society Institute
PCR	Polymerase Chain Reaction
PSI	Population Services International
PY	Person-years
RH	Reproductive Health
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
SO	Strategic Objective
STD	Sexually Transmitted Disease
TB	Tuberculosis
TPHA	<i>Treponema pallidum</i> Hemagglutination Assay
UNAIDS	United Nations AIDS Program
UNDP	United Nations Development Program
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

I. Introduction

This technical assessment responds to the request by the USAID/Caucasus to do an assessment of the HIV/AIDS situation in Georgia and make recommendations regarding prevention support. The authors recognize that many of the recommendations in this technical assessment are beyond the scope of USAID's strategic interests and their policy of working in Georgia. Nonetheless, the authors felt that a more comprehensive report would be the most useful format to assist the USAID mission in making strategic decisions regarding support.

II. Background

A. *HIV/STD Epidemic in Eastern Europe:*

The cumulative numbers of HIV cases reported in the Eastern European region increased between 1995 and 1997 from 9,111 to 46,573, a five-fold increase in just 2 years. Ukraine, Russian and Belarus accounted for about 90% of all new cases.^{1,2} Two thirds of these infections were believed to have occurred in the last year. Injecting drug users (IDU) accounted for the majority of these reported HIV cases, from 49% to 85% of the total. In Ukraine, new HIV infections soared from a total of 47 cases between 1992, to about 1500 in 1995, 12,228 in 1996 and 15,433 in 1997 with 80% of new infections associated with IDU.² In Ukraine HIV is continuing to spread among IDUs in other cities and is penetrating the rural areas. Additionally, the number of reported syphilis cases have risen sharply in the countries of the former Soviet Union highlighting the increased vulnerability of the general population to further spread of HIV via heterosexual intercourse.¹

Based on 15 years of experience in HIV infection in IDU populations, it is estimated that once HIV prevalence among IDUs reach 10%, it can surpass 40 to 50% within 1 to 4 years.^{2,3} The epidemics have occurred quicker than an appropriate policy and HIV prevention interventions responses can be developed.

B. *HIV/STD Epidemic in Republic of Georgia*

1. HIV/AIDS

HIV/AIDS was first diagnosed in Georgia in 1989. As of March 2000, a total of 114 HIV/AIDS cases has been reported to the National AIDS Control and Prevention Service of the Ministry of Health (MOH). IDUs account for 67% of the cases, heterosexual contacts for 22% (1/3 of these heterosexual contacts were with known IDUs); homosexual contacts for 6%, and 4 % were blood recipients. The majority of these reported cases come from Tbilisi, the capital city, and the coastal urban areas of the republic. Cases are mainly identified through blood donor screening or through the HIV Voluntary Counseling and Testing (VCT) centers. All HIV infections to date have been caused by HIV-1; there is no HIV-2.⁴ The isolates are the same A/B recombinant virus found elsewhere in Russian and the Ukraine (personal communication, Dr. T. Tsertsvadze). These reported HIV/AIDS cases are felt to be a substantial underestimate due to weak passive surveillance systems.

Prevalence and incidence data for HIV infection was obtained by the Georgian AIDS and Clinical Immunology Research Center among a cohort study of 2,406 adults in the following population groups recruited from the cities of Tbilisi, Poti and Botumi: (1) present or past history of IDU (n=926), (2) men with STDs attending treatment centers (n=556); (3) female sex workers (FSW) (n=71); (4) professional blood donors (BD) (n=553) and tuberculosis (TB) patients (n=300).⁴ The highest prevalence and incidence was in the IDU population. Baseline prevalence data was obtained between October 1997 and June 1998.

Table 1: Cross sectional HIV sero-prevalence in high-risk groups at 0 and 12 months and HIV incidence per 100 person-years (PY) (1997-1999) and baseline Hepatitis B (HBV) and Hepatitis C (HCV) serology.

	Baseline HIV prevalence	12-month HIV prev.	HIV incidence per 100 PY	Baseline HBV	Baseline HCV
IDU	0.54	1.62	1.48	40.9	53.3
STD pts.	0.36	0.90	0.68	16.0	17.6
FSW	1.40	1.40	--	15.5	15.5
Blood donor	0.36	0.54	0.21	7.1	8.1
TB	0.67	0.57	--	9.0	13

2. Sexually Transmitted Diseases (STDs)

There is a paucity of data regarding STDs in Georgia. What data exists consists of the passive reporting system of the STD program in Georgia and suffers all the biases of passive reporting systems – fluctuating in response to access and availability of services (see full discussion in section below). There are also some active laboratory data collection on patients seen in the STD Institute, although this data is biased due to the types of patients visiting the STD Institute (patients with genitourinary complaints or infertility) and the availability and quality of STD diagnostics.

III. Technical Framework for Proposed Response

A low prevalence strategy – focusing on core groups: HIV epidemics in all countries have started and subsequently flourished in at least one or more of the following groups – female sex workers, injection drug users or men who have sex with men—before spreading to the general population. HIV prevalence rises first in these groups and then gains a critical mass, which allows the epidemic to be sustained and spread. The converse is also true and critical for the planning of prevention resources: *If HIV prevalence can be kept low in such core population groups, then it will not attain a critical mass to spread to the general population in any significant amount.*

This process of epidemic spread strongly supports a focus on core-transmitter and “bridge” populations groups whereby prevention resources are targeted to changing their behaviors with the goal of keeping HIV prevalence low. If successful in these core groups, resources directed at larger population groups will be minimized. Historically, interventions directed at general population groups are more costly, less efficient and historically less effective. This strategy forms the core of a *Low Prevalence Prevention Strategy* by FHI with funding from USAID and UNAIDS and due out in mid-2000. The strategy advocates for concentrating resources on the so-called “high transmitter” population groups which ultimately protects the whole population through the efficient use of resources in an early, concentrated HIV epidemic setting. HIV/AIDS prevention activities with these high-risk groups must be carefully crafted in order to target these high-risk groups but not stigmatize. Groups with experience and an orientation and theoretical framework for such populations can best accomplish these interventions.

The effectiveness of any HIV/AIDS program requires the development of an environment that will support effective risk reduction interventions and behavioral changes among high-risk groups. This refers to the context in which risk behaviors take place and the factors, which tend to sustain or inhibit them. These include social, political, economic and legal factors, as well as stake holders (e.g. pimps, and police) who may control access to beneficiary groups and who may influence or control their ability to adopt safe practices.

While the prevention of HIV infection and the control of other STDs in high-risk populations benefits both the target population and the general population including maternal and child health, HIV/AIDS prevention interventions in the context of RH/FP programs have not proven to be effective for several reasons. Implementing agencies dealing with family planning(FP)/reproductive health (RH) issues have little experience or expertise with high risk groups such as FSW and their clients, MSM or IDUs. Other important issues on the RH/FP agenda (e.g. contraceptive choice, safe pregnancy and delivery, etc) understandably take priority in the implementation of projects. FP/RH programs rarely deal with men. USAID/Global (HIV/AIDS Division and Office of Population) has recommended that targeted interventions rather than integration of HIV/AIDS programs into RH programs be implemented as an HIV prevention strategy.⁵

IV. Findings from Site Visits and Literature (gray and published) Review

A. *HIV/STD Monitoring and Surveillance*

1. Behavior

Behavioral data related to HIV/STDs are more extensive among general population women and youth as a result of the current emphasis on reproductive health. These surveys, while they have not emphasized issues around high-risk behavior, have collected data on number of partners, condoms and history of sexually transmitted diseases. UNICEF and USAID through CDC are just completing a large population-based survey reproductive health survey on 7,500 women of reproductive age. The survey reportedly has several questions regarding STD history,

genitourinary tract symptoms, sexual behavior and condom use. The preliminary report is due out in June 2000. The Georgian AIDS and Clinical Immunology Research Center collected the only fully analyzed data on risk behaviors in IDUs, FSW and MSM.⁴

A summary of some findings of surveys identified is presented below.

- ◆ Family Planning Association in Georgia with funding from Netherlands Trust Fund. KAP survey in 197 schoolchildren from two schools in Tbilisi, ages 12 to 16 years of age, 60% of respondents were male.⁶ Survey also included teachers and parents as was part of a 1-year pilot project on sexual education in schools.
 - 17% percent of youth respondents knew that it was possible to protect oneself from STDs.
 - 67% of respondents considered AIDS the most extensive STD in Georgia
 - 21% of youth age 14 to 16 consider sexual relationships before marriage acceptable.
- ◆ The NGO, National tobacco Control Center, with financial support from UNICEF conducted a nationally representative survey in 1998.⁷ [As original report not seen, details on methodology, sample size, etc. are not known].
 - 43% of females and 43% of males age 12 to 17 years of age know nothing about STDs.
 - 48% of respondents have no, or faulty, information regarding AIDS.
 - 80% of youth, age 12 to 17 years of age, consume alcohol with varying degrees of frequency.
 - 6% were drug users with varying intensities of use.
 - One out of three respondents had a close interaction with a drug user including family members, relatives, neighbors or friends.
- ◆ Curatio International Foundation with funding from UNDP did face-to-face interviews with 1,440 participants ages 14-49 from 9 regions of Georgia in 1996.⁸ A total of 52% of the respondents were female and 48% male. Youth age 14-19 comprised 11.4% of the total sample.
 - 85.4 % of respondents reported that they knew about trichomoniasis and 80.7% knew about gonorrhea.
 - 66.3% of males reported that they tried to protect from STD at least once, while 15% of females reported the same.
 - 77.5% prefer condoms to protect from STDs.
 - 49.6% reported having used condoms as a form on contraception
- ◆ The Georgian AIDS and Clinical Immunology Research Center supported by the Civilian Research and Development Foundation collected behavioral data as part of their three city prevalence and incidence study from 1997 to 1999.⁴
 - The most commonly injected drugs among the IDUs in this study were opium (41.1%), various psychoactive substances obtained from medical facilities (28.3%), heroin (12.6%) and poppy straw (18%).

- 72.9% reported sharing needles and syringes. The majority (83.5%) was borrowed from friends. The rest were borrowed from casual acquaintances at the time of drug sharing, 3.2% from sexual partners and 1.3% from dealers. Rinsing needles and syringes in hot or cold water accounted for 87.9% of the cleaning practices.
- 87.1 % of IDUs reported never-use or rare use of condoms.
- 16.5 percent of male STD patients reported giving money or drugs for sex and 97.8% reported never-use or rare use of condoms.
- 100% of FSW reported never-use or rare use of condoms with male clients and none reported injecting drug use.

These data provide glimpses of potential high-risk behaviors for HIV and STDs in youth in Georgia. There appears to be a low-level of awareness and knowledge about STD and HIV infection, means of transmission and personal risk. Drug and alcohol use is common among youth. The degree of sexual activity, high-risk sexual and STD prevalence among youth is not clear although the CDC survey may provide some insights. The single study done by the Georgian AIDS and Clinical Immunology Research Center also provide some clear data on risk behaviors – high amount of needle sharing among drug users and minimal condom use in high-risk sexual encounters (e.g., IDU and partners, FSW and male clients). These data are adequate to start planning interventions that would involve as part of interventions some formative assessment to address these high-risk activities. A systematic behavioral data collection strategy for high risk groups and youth in conjunction with HIV and STD (dubbed Second Generation Surveillance) would be useful for advocacy, situational assessment, planning programs and evaluation of programs.^{9, 10}

2. HIV

The Georgian AIDS and Clinical Immunology Research Center currently collect HIV/AIDS data through a passive surveillance system. About one third of all HIV cases have been identified through the HIV/VCT centers that have been established in the 12 major cities in Georgia. The majority of HIV cases have been identified through routine blood screening activities. There have been *ad hoc* surveys of HIV prevalence, which are completely dependent on the availability of outside funding. The Georgian AIDS and Clinical Immunology Research Center has been able to get modest funding from the World AIDS Foundation and the Civilian Research and Development Foundation to support specific studies. Additionally, the Research Center has been working closely with researchers from Johns Hopkins University, Emory University, and New York University. Data from these studies give a glimpse of the nature of the HIV/AIDS epidemic in Georgia. Specifically, the *current* data from the recent (1997 – 1999) prevalence and incidence study indicates that the stage of the HIV epidemic can be classified as a low level defined as “HIV prevalence not exceeding five percent in any defined group” (See Table 1).^{9, 10} It also indicates that the group at highest risk is IDUs. Based on epidemics in other countries of Eastern Europe (e.g. Ukraine, Russia and Belarus), HIV prevalence in IDUs can explode rapidly.^{1, 2}

With respect to equipment for HIV testing, the HIV VCT centers were not visited. However, an on-site visit to the Georgian AIDS and Clinical Immunology Research Center laboratory in

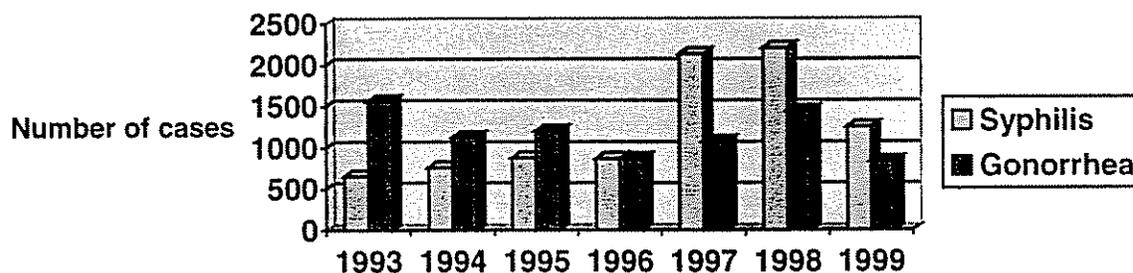
Tbilisi revealed that the center has equipment for syphilis testing (RPR and TPHA), ELISA readers (HIV and Chlamydial testing), Western Blot capabilities, microscopes for gram stains, and hoods, thermocyclers and developing equipment for polymerase chain reaction (PCR). They currently have a technician in training in the US and plan to upgrade their bacteriology facilities. The laboratory also has an antiquated back-up electrical generator. Several computers are located within the Center.

The Georgian AIDS and Clinical Immunology Research Center has the human resource (trained epidemiologist and lab technicians), the laboratory equipment and computer equipment to conduct enhanced, systematic HIV surveillance as a component of second generation surveillance for HIV/AIDS. The physical plant of the laboratory while adequate, would function better if physical plant improvements were made (e.g., more and better spaced electrical outlets, more workspace, less antiquated electrical generator, improved flooring and lighting, etc). One of the major constraints to systematic HIV surveillance is adequate funding to support the procurement of HIV test kits and adequate associated supplies. The epidemiology staff, while exposed to second generation surveillance issues at a UNAIDS workshop in Tashkent, Uzbekistan, would benefit from technical input as part of an overall surveillance design exercise.

3. STDs

Chart 1 illustrates the national reported cases of syphilis and gonorrhea in Georgia from 1993 to 1999. This data is accumulated from the 11 regional treatment and investigation centers in Georgia (e.g. Tbilisi, Zugdidi, Batumi, Kutaisi, Gori, Telavi, Rustavi, Ozurgeti, Poti, Akhaltsikhe and one other).

Chart 1
National Reported Syphilis and Gonorrhea Cases
Georgia, 1993 - 1999



Of note, in 1997 the federal STD program offered free diagnosis and treatment for syphilis and gonorrhea, which may account for the large increase in 1997. In 1999 the STD program was experiencing some financial difficulties and has had to cut back on these free services. Free services for diagnosis and treatment for gonorrhea and syphilis are still theoretically offered to

sex workers and marginalized youth. For 1996 through 1999 there is a breakdown of reported syphilis cases by age (Table 2).

Table 2: Registered syphilis cases by age, 1996 – 1999

	1996	1997	1998	1999
Syphilis				
Total	953	2,172	2,379	1,253
Under 14 years of age (congenital syphilis)	3	12	26 (20)	10 (9)
15 to 19 years of age	45	152	182	59
10 to 19 years of age	424	1,028	1,089	530

Other STD data relayed by the Deputy Director of the STD institute are the following:

- In 1998 of about 300 FSWs brought into the STD Institute by the police, 48% had reactive syphilis serology and 20% had gonorrhea.
- Among 763 patients (288 women and 475 men) seen at the STD polyclinic for various complaints (symptoms, infertility, etc.) *Chlamydia trachomatis* infection was documented in 31.8% of the men and 23.9% of the women using direct immuno-fluorescent (DIF) testing. DIF testing is not widely available in Georgia and only intermittently available at the STD Institute. Routinely screening for chlamydial infection is done using Geimsa stain, an extremely insensitive test.

The STD Institute has developed new guidelines for STD treatment based on WHO Guidelines. One set of guidelines for gonorrhea, chlamydial infection, trichomoniasis, bacterial vaginosis and candidiasis was developed for distribution with training to gynecologists. Training for gynecologists was started in December. A second set of guidelines for the treatment of syphilis was developed only for venerologists. A summary of the content of these guidelines is outlined in Table 3. Syphilis and gonorrhea have traditionally been reportable diseases. Chlamydial infection and trichomoniasis were added to the list of reportable diseases in 1998. Before 1999, reporting forms required personal identifiers but as of 1999 the reporting is now anonymous. Compulsory hospitalization of patients with syphilis was discontinued in 1995. Patients now receive outpatient therapy unless they have tertiary or central nervous system syphilis.

Table 3: Summary of Georgia's Revised STD Diagnostic and Treatment Guidelines

Guidelines for the diagnosis, treatment and prevention of gonorrhea, chlamydial infection, bacterial vaginosis, ureaplasma, trichomoniasis and candidiasis.

Introduction:

- Covers registration/notification procedures. [Regulations now allow for diagnosis and treatment of patient without collection personal identifiers. Notification of syphilis, gonorrhea, chlamydial infection and trichomoniasis is obligatory. Notification is without identifiers.]

- Covers the importance of coordination of treatment between gynecologist, urologists and venereologist;

Chapter 1:

- Covers principles and diagnostic flowcharts for various syndromes including history, examination and diagnostic tests
- *Urethral discharge*: suggested laboratory tests include wet mount, Gram stain microscopy and DIF (or Geimsa stain). If all the tests are negative and the clinician still feels that they may be gonorrhea, a culture is suggested for diagnosis and to direct antibiotic therapy.
- *Cervical discharge*: suggested laboratory tests include wet mount, Gram stain microscopy and DIF (or Geimsa stain). If all the tests are negative and the clinician still feels that they may be gonorrhea, a culture is suggested for diagnosis and to direct antibiotic therapy. Cultures are also done routinely if patient is a young girl.
- *Vaginal discharge*: suggested laboratory tests include wet mount, vaginal fluid pH, 10% KOH test for amine odor and Gram stain. If all tests are negative and the clinician feels that it may be trichomoniasis or candidiasis then culture is suggested.
- *Genital ulcerations*: syphilis serology (RPR or VDRL with TPHA confirmatory testing). If syphilis serology is negative then they are examined for herpes (??? Test). Georgia also reports ulcers caused by *Trichomonas vaginalis* or *Candida albicans* so ulcers are also tested with wet mounts and Gram stain microscopy.

Chapters 2 through 7:

Individual chapters on specific pathogens of *N. gonorrhoeae*, *C. trachomatis*, *T. vaginalis*, bacterial vaginosis, *C. albicans*, and *U. urealyticum*. Chapters cover classification of organisms; collection, processing and interpretation of specimens; and recommended treatments (doses, drugs, duration, etc)

Guidelines for diagnosis, treatment and prevention of syphilis

These guidelines include a discussion of the classification of syphilis, diagnostic tests and treatment.

There are no data on *Neisseria gonorrhoeae* antimicrobial susceptibility in Georgia.

Other information and comments from other sources included the following:

- Pharmacy use and self-treatment for STDs was common by both men and women (numerous sources indicated this, although there are no data).
- Gynecologists and other physicians in Georgia commonly treat STDs including syphilis but don't report it because they currently are not allowed to (one informant).
- STDs are believed to be very common in the IDP population. (Several informants in RH/FP community with similar belief). [There were data available to confirm this belief].

The Deputy Director indicated that the Institute does research on Dermatology and STD epidemiology. They have the capability to do syphilis serology (RPR and TPHA), gram stain, bacteriology, DIF and Geimsa stain for *Chlamydia trachomatis*. The lab does not have the capability to do HIV testing. On-site visits to the laboratories indicated very antiquated

equipment and a large number of staff. Specifically, the microscopes used a mirror as a light source and not a bulb because of the electricity problems, cultures were done in glass test-tubes with cotton tops, not culture plates, incubators were old and workspace was limited. DIF processing was limited by electricity supply also.

MSF/Greece, as part of its outreach efforts to FSWs, is in the process of building a separate STD clinic within the STD Institute. This STD clinic will have the capability to test for common reproductive tract infections including gonorrhea culture, chlamydial infection detection by ELISA, syphilis serology and microscopy.

There are no useful STD data in the country. The reported cases clearly suffer from the biases inherent in any passive system and reflect reporting biases and access issues. The reported increase congenital syphilis cases may reflect increase syphilis among pregnant women or decrease in services or both. While details of the 300 or so sex workers brought in by the police in 1998 are not clear, the high syphilis prevalence (48%) and gonorrhea prevalence (20%) is worrisome. If confirmed, interventions to detect and treat STDs in sex workers would clearly have an impact on general population STD prevalence and be very cost-effective. Officials in Georgia appear to be moving towards the integration of STD care (with the exception of syphilis) into more general medical services. Additional work will need to be done to overcome the routine practice of referring all STD patients to dermato-venerologists even with these policy changes.

STD prevalence data in general population women, IDP populations and youth are urgently needed to guide programming efforts in the ongoing reproductive health efforts in Georgia. STD prevalence data in high-risk populations is also necessary in order to guide potential interventions that will prevent HIV infection in these populations and reduce STD prevalence and HIV spread in the general population. There appears to be the capability within Georgian institutions (i.e., Georgian AIDS and Clinical Immunology Research Center and the STD Institute) to carry out an STD prevalence assessment. Gonococcal susceptibility testing capability does not exist but isolates could be tested at any number of laboratories around the world.

B. HIV/STD Service Delivery

1. STD services

STD clinical service delivery sites were not visited during this assessment due to time limitations. The following observations are based on discussions with Georgian NGO representatives and the Deputy Director of the STD Institute, knowledge of STD practices in other former Soviet Union Countries and the observer's experience in other countries.

- STD treatment guidelines are undergoing a transition now in Georgia whereby other sub-specialties of medicine, for example, gynecology and urology, are being approved to manage all STDs and RTIs, with the exception of syphilis. While this "decentralization" is welcome,

it will involve significant training and time to change the ingrained deference to dermatovenerologists.

- There is a reported negative attitude towards syndrome management since it is for “underdeveloped countries without the availability of laboratory testing.” This is reflected in the laboratory emphasis of the revised guidelines (Table 3). Given the level of diagnostic capability at the STD Institute, the level of availability of laboratory testing to the average clinic in Georgia is likely be quite limited.
- There appears to be widespread acknowledgment that a significant number of men and women get their care from pharmacies, a practice that is common in most countries. What is not clear from these discussions is where or how these “self-treating” individuals make their therapeutic decision -- that is, how do they decide what medication to buy. Possibilities include (1) advice of medical personnel but treatment procured at cheapest pharmacy, (2) advice from pharmacy personnel, (3) advice from friends/family or previous experience.
- IEC materials specifically for STDs appear to be quite limited and are at the level of information giving (often quite medical in orientation) and awareness raising.

2. HIV services

HIV VCT

The Georgian AIDS Clinical and Immunology Research Center manages HIV VCT centers in the 12 main cities of Georgia. Three of these centers, Tbilisi, Batumi and Kutaisi, have ELISA capabilities for testing. The other 9 centers use simple rapid tests (e.g. Immunocomb, Hexacomb, etc.) for screening. All confirmatory testing is done at the Center in Tbilisi. Turn around time for results is about 2 weeks if test kits are available. The Center employs the WHO recommended testing protocols for low prevalence settings using two serial antibody tests of different formats followed by a Western Blot on dually positive samples. Testing is now anonymous. The cost for VCT services at centers with ELISA testing is 9 Lari and at centers with rapid testing is 12 Lari. All the laboratory technicians running HIV testing were trained at the center. The Center ideally would do supervisory checks twice a year with each technician but this has decreased in frequency due to financial constraints. MSF/Greece trained the epidemiologists and clinicians in HIV pre- and post-test counseling. There are no plans for follow-up training of the counselors. At the HIV VCT centers, condoms are supplied though UNFPA and informational material developed by the center is distributed (quantities are limited by printing costs). The center has developed targeted material for IDUs and safe sex materials for all groups.

In addition, the Center distributes test kits to 42 other laboratories for blood screening for transfusions. There is a limited supply of kits for this distribution.

Care

The Georgian AIDS Clinical and Immunology Research Center provides diagnostic and staging services for HIV/AIDS patients in Georgia. It operates an in-patients unit of 9 beds and outpatient services. Resources exist only for the management of opportunistic infections.

Patients on anti-retroviral (ARV) medication are monitored at the Center but pay for medication through private funds. Some ARV is provided through donation. The Center has also developed a booklet on HIV/AIDS for medical professionals in Georgia and provides occasional training to medical professionals as part of other trainings.

3. Information Education Communication

Small media

Small print media (e.g., brochures, posters, booklets) is the major form of information transfer regarding reproductive health, STDs, HIV/AIDS and IDU risk. All NGOs the assessment team visited had such material. Almost universally this material had been taken from the Internet or from WHO/UNAIDS, adapted for Georgia by the institution, translated and printed. Pre-testing in the target population occurred but was rare. Some of the material developed by UNFPA was based on patient's questions from clinics and hot-line inquiries. Printing quantities appear to be limited and the dissemination of the material was limited in scope. Distribution would be targeted to a limited number of schools, at clinics, at drop-in centers, at counseling centers and for distribution by a limited number of outreach workers. This entire small media was directed at the level of education/awareness-raising. No materials had been developed that the assessment team was able to find that was directed at policy makers.

Mass media

Mass media activities related to HIV/AIDS/STD appear to date to have been developed by the Georgian AIDS and Clinical Immunology Research Center. The few ads that were viewed by the assessment team were of reasonable quality. Some ads imparted information on means of HIV transmission and some were humorous around condom use. The Center has the computer capabilities to do graphics and prepare all of the spots themselves. These spots were not part of an overall communication strategy around HIV/AIDS/STDs and consequently, their impact was likely limited.

Outreach/Peer education

All outreach activities that we observed were limited to an organized information outreach approach instead of working for effective behavior change. They all lacked a strategic vision to effectively link the program to multiple levels of influence needed to create a comprehensive targeted program capable of reducing vulnerabilities and creating an enabling environment for individual and collective behavior change.

In most cases the outreach workers were professionals (physicians or psychologists retrained as social workers). Three organizations interviewed mentioned peer education/peer outreach – STD Institute, the Georgian AIDS and Clinical Immunology Research Center and HIV/AIDS Patient Support Foundation. These peer education efforts lacked many of the elements of good peer education as defined by the *European Guidelines on Youth AIDS Peer Education* from the Europeer Project and *Lessons Learned* from the implementation of peer education programs

during FHI/AIDSCAP (1991-1997). These elements include: (1) active involvement of community actors, (2) a theoretical based reflected in clear aims and objectives, (3) a participatory inventory of the target group, (4) a well thought-out recruitment strategy that reflects the target groups, adequate training composed of the three components of information, skills training and self-development, (5) proper supervision and support and (6) monitoring and evaluation.

C. Characteristics of Potential Target Groups and Current Prevention Interventions

1. IDU

There are no reliable statistics on the prevalence of IDU in Georgia. Official statistics indicated that there are currently 3,500 addicts and there are about 6,000 drug users of whom 60 to 70% inject drugs. Officials from the Institute of Narcology feel that these official numbers underestimate the problem by about 12 to 15-fold. Incidental recreational drug use, perhaps as a result of the economic situation, is reported to be common. Self-injection of drugs for both medical and recreational purposes is a commonly accepted phenomenon among the general population in Georgia. Reasons for this include the belief that injected drugs are more effective than oral drugs. Moreover, it is cheaper to shop around for drugs at pharmacies rather than pay physicians for medications. Report of a small survey done by HealthNet International in January 1998 found that 69 % of 63 Georgians arbitrarily chosen on the streets of Batumi reported keeping syringes and needles at home and reported that 46 percent of their household members had received injections in the previous 6-month period.¹¹ This phenomena was confirmed by the assessment team where pharmacies in Kutaisi, Poti and Tbilisi reported selling between 100 and 200 syringes per day, mainly 2 cc syringes.

Discussions regarding recreational injecting drug use were quite easy in Georgia and at one level there appears to be a general acceptance of the activity. However, on an individual basis IDUs and addicts are highly stigmatized. Georgia does not have a visible street based drug activity. Families report shame and fear of police if a family member is an IDU. IDUs, however, usually remain within the families. Recreational drug use appears to occur among friends and acquaintances. In a recent rapid assessment the authors also comment that other indicators of a high prevalence of drug use such as visible drug scenes, discarded syringes in public places, public order problems and drug-related crime were not found in Georgia.¹¹ [Note, anecdotally, one observer commented that there were very large numbers of discarded syringes on the beach at Batumi. Another observer witnessed in Tbilisi a drive-by injection whereby a van pulled up, sold and injected drugs to a customer and then drove away.]

Officials from the Institute of Narcology also indicated that in their experience heroin is now the most common narcotic injected, accounting for 70 to 80% of the patients that they evaluate. The current price of heroin is 100 Lari for 1 gram compared to 25 Lari for 0.25 gram of poppy straw. These data differ from those found by the Georgian AIDS and Clinical Immunology Research Center where the most commonly injected drugs among the 926 participants from Tbilisi, Poti and Batumi were opium (41.1%), various psychoactive substances from medical facilities

(28.3%), poppy straw (18%) and heroin (12.6%). These differences may reflect changes in drug availability over time or the socioeconomic level of the participants/patients seen by each group.

Drug sharing is reportedly a symbolic expression of friendship.¹¹ Needle sharing, which is common, may also reflect expressions of friendship, trust and brotherhood. Other high-risk needle/syringe use practices common in Georgia is reportedly “frontloading” (sharing of drugs by using a single syringe to load others) as well as sharing drugs from a common bowl. Poppy straw is the raw ingredient from which Koknar is extracted. This is the same drug that is injected on a large scale in Ukraine and Belarus and it is the preparation procedure used in these countries that is felt to have contributed to the explosive epidemics there. The drug is prepared by the consumers and used directly after preparation. Preparation involves thinner, calcyglucanate, soda, water and anhydride, cotton and syringes. Reportedly human blood is used in this preparation when certain ingredients are not available. It is not clear in Georgia how common the practice is of using human blood in the preparation of poppy straw.

Drug use among students is not uncommon. In one interview with a patient in the Institute of Narcology hospital, the patient indicated that he started injecting drugs in college with his friends. His major concerns while injecting drugs was fear of overdose and fear of the police. Hepatitis and HIV/AIDS were not concerns.

A full report of a rapid assessment of injection drug use and HIV in Georgia is published in the Journal of Drug Issues.¹¹

In summary,

- Injecting medical and recreational drugs is a common practice in Georgia.
- Syringes and needles are inexpensive and readily available at pharmacies throughout Georgia.
- Syringe and needle sharing is common among IDUs although the social and ethnographic factors around sharing are not clear.
- Hepatitis B and C are prevalent in IDUs suggesting that their injecting practices put them at risk for parenteral transmission of HIV.
- Injecting drug users rarely report condom use with their sexual partners.

Current interventions in the IDU population is limited. The following groups work with IDUs:

SASOEB, Georgian Voluntary Society for the Prophylaxis of Drug Addiction and Medical and Social Rehabilitation, is an NGO started by the father of a former IDU and addict. The group's goal is to prevent drug use and to assist in detoxification and follow-up rehabilitation. They were able to get enough funds from private donations for the detoxification of 12 individuals. They have also received funds from the World Bank to produce some small media print materials for distribution at schools and places where youth gather. They are currently seeking funding to support the opening of a rehabilitation center in Tbilisi but have so far been unsuccessful. They have about 400 dues paying members in Georgia. The NGO is currently run out of the founder's house and there is no staff.

Bemoni is an NGO with an affiliated private detoxification clinic in Tbilisi. The NGO currently has five staff members, Chairman (a psychologist), Executive Director, an accountant, a secretary, and an expert. They have received funding from the European Union and GTZ working with school youth, parents, teachers and school psychologists in an effort to prevent drug use among youth. They have also started a center for drug prevention and counseling and is open to drug users and anyone working with youth. They have never had an outreach program with IDUs but through their detoxification arm would be willing to do such work. They are located only in Tbilisi.

Georgian AIDS and Clinical Immunology Research Center has contact with IDUs through their HIV VCT centers established in the 12 main cities of Georgia. They have a trained counselor at each of these sites. The center produces small print media targeted for IDUs with messages covering issues on the dangers of sharing needles and syringes and suggestions for safe injecting practices. They also have materials on safer sex for all groups. The Center in Tbilisi also has an IDU peer education program. Over the previous two years the VCT centers counseled and tested 5,300 individuals (personnel communication, Dr. T. Tsertsvadze). About one third of the HIV infected individuals in Georgia are identified through HIV VCT centers.¹²

Open Society Institute (OSI) in Georgia now focuses only on public health issues. IDU interventions are included in this. In addition, harm reduction is one of the OSI programs of the New York office. The expert committee of the Georgian OSI has decided that it makes no sense to do a needle exchange program in Georgia. The Georgian and the New York OSI offices had just completed a week seminar in early March 2000 on methadone maintenance (drug substitution) program for Georgia. At the time of this assessment, OSI was awaiting the decision by authorities regarding whether regulations would be changed to allow this type of intervention. According to the OSI/Georgia office OSI would support some of the implementation of methadone maintenance; this support would not include the cost of procurement of the methadone.

MSF/Greece plans to start an IDU outreach and intervention project. They are concentrating their current efforts on the sex worker project but have begun internal discussions on potential approaches.

2. Sex work

There is limited information on sex work in Georgia. [The assessment team was told of a Georgian researcher doing an ethnographic assessment of sex work in Georgia funded by an international organization. The team was unable to track down any further information regarding this activity.] Based on discussions with several individuals it appears that sex work is street-based, house-based and through "escort" services. The street-based sex work was known in Tbilisi but was not described in the port city of Poti. Street-based sex work occurs in known pick-up spots throughout the city. There appears to be an increase in adolescent sex work as a result of the influx of internally displaced people and the economic downturn. There is no estimate of the number of sex workers. The study of 67 female sex workers by the Georgian

AIDS Clinical and Immunology Center indicates that condom use with clients is rare and injecting drug use did not occur.

MSF/Greece is the only group actively working with sex workers. They had just begun their outreach work in January 2000. At the time of our interview they had made contact with 59 sex workers in Tbilisi. Their outreach workers consist of a two-person team, male and female and physician and psychologist. Their outreach messages are to promote healthy lifestyles, discuss HIV/STDs and contraception. They distribute informational materials and condoms. Outreach work is mainly on the street near the railway station but in some instances they have gained access to the "houses". They are also interested in addressing some of the legislation regarding sex workers in Georgia.

The NGO Children and the Environment works with street children in Tbilisi. They recognize that sex work is occurring in the street children population but have not explicitly addressed the issue in this highly vulnerable population.

3. MSM

MSM populations in Georgia are highly stigmatized. The assessment team was able to get a name of a bar where MSM meet. There is information from this population with respect to high-risk behavior such as numbers of partner or condom use or any information on STD or HIV prevalence.

Georgian AIDS Clinical and Immunology Research Center has discussion groups at their center with MSM and distributes safe sex materials to them.

4. Youth

There are data to suggest that youth in Georgia are engaging in potentially high-risk behavior for STDs and HIV. Alcohol use is very common (80% of 12 to 17 year olds report using it), drug use is reported by 6%. About one-fifth of 14 to 16 year olds in the capital city consider sexual relationships before marriage acceptable. There is no information that the assessment team was able to find on actual sexual activity of adolescents or condom use. NGO workers dealing with adolescents indicate that sexual activity occurs and condom use is low. Two data sets, the RH survey by CDC/UNFPA and the MSF/Greece hot-line data, respectively, due out shortly will have more data on this. There is no STD prevalence data in adolescents. In the passive reporting system for STDs in Georgia, persons 19 years of age and under account for 7.5 % of the reported syphilis cases in 1997.

While beyond the scope of this assessment to look at youth projects, it appears that numerous NGOs in Georgia are addressing youth reproductive health and HIV/AIDS/STD as part of their overall RH/FP efforts. One NGO, the Georgian Family Planning Association, has activities dealing with sex education in schools. Bemoni and SASOEBBA both have had small-scale interventions in drug education and prevention in schools, mainly in Tbilisi.

5. Specific Populations

Prisoners

There are 16 (12?) prisons/jails in Georgia with a prison population of about 9,000. To date, there has only been one HIV/AIDS intervention in the prisons. This intervention was conducted by the Georgian AIDS and Clinical Immunology Research Center and consisted of educational session, video clips, newsletter and HIV VCT. A total of 9,000 prisoners were tested during this time, of which 5 were identified as being HIV positive. Additionally, four other prisoners had been identified as HIV-infected (apparently these men were Ukrainians and their HIV status was in their files). The prisons do not test for HIV but indicated that, if they did, it would be anonymous. Of note, as of 1998, funds for the treatment of HIV/AIDS in the prisons are now the responsibility of the Ministry of Justice and not the state health program.

These prisons evidently have well-established hierarchies within the inmate population, similar to US prisons. According to representative of the ICRC and prison officials men having male-to-male sex are numerous and are socially separated from the other prisons within the jails. ICRC reports that at the lower security prisons female sex workers from the community are able to gain entrance. Prison officials denied this. Conjugal visits are also allowed. Tattooing and body piercing appear not to be common among Georgian inmate. According to prison officials, tattooing was a common practice with Russian inmates. Conversations with prison officials indicated that they would be willing to allow condoms in the prisons since conjugal visits do occur. The ICRC currently provides active case screening and treatment for tuberculosis (TB) to 7 of the prisons. They will expand these services to all prisons soon.

According to one report, in most of these facilities inmates are not locked in individual cells but live together in groups of 10 to 30.¹¹ They are free to walk around the courtyard, the chapel and as such have opportunities to socialize. The recent rapid assessment of IDU in Georgia reports that many of their respondents reported that IDU was common in prison although drug supply was irregular. Sharing needles are common although prison doctors occasionally provide syringes to the prisons.¹¹ In discussions between the assessment team and prison medical personnel, drug use in prison was felt not to occur. Controls over what enters the prison are well enforced so that a regular supply could not be ensured. They admitted that occasionally some drugs might get in. There are currently no detoxification facilities within prisons.

In summary, prisons appear to be high-risk environments for HIV/STD:

- IDU is common although intermittent and needle syringe sharing is common
- Men live in groups in a closed community
- Male-to-male sex occurs
- Prostitution in some of the prisons

Obviously, these men will ultimately be released back to their families and communities so STD/HIV in the prisons will not remain a prison issue only.

There appear to be two groups currently positioned to work in the prisons.

Tbilisi State University, Department of Urology will be receiving funding from OSI/Georgia to work in four prisons (Kasani, Geguti, Rustavi, Khoni). The proposal was submitted to OSI under an STD prevention umbrella. The intervention will consist of lectures and interactive workshops, distribution of brochures and provision of a VCR to the medical facilities of the prison. The goal will be health promotion, addressing psychological issues of prisoners, and prevention of STD/HIV/HBV/HCV. The intervention will also be taking urethral swabs for Gram staining. [Note, proposal was not seen. The OSI official described the project].

The Georgian AIDS and Clinical Immunology Research Center also has a proposal in to OSI/New York to work in prisons. Their proposal would be for interventions in all prisons in Georgia. They propose to develop curricula for training of prison staff in HIV/AIDS and provide trainings, to conduct education sessions with the inmates on issues around HIV/STD transmission. Measure knowledge, attitudes and practice (KAP) with pre- and post-KAP surveys. The proposal indicates that the Ministry of Justice would not allow needles/syringes or drug substitution in the prisons.

Mobile men

Men who are at risk for HIV/STDs are difficult to identify. In general, men separated from their families and usual social structures, such as transport workers and uniformed services, are groups that may warrant targeting with prevention services.

Transport workers: Discussions were held with a representative of the Commercial Department of the Port Authority in Poti, the main commercial port in Georgia. The port is currently functioning at about 60% of capacity. There are about 2,500 employees at the port. They have about 500 to 600 ships in the port; most are under Turkish, Greek, Bulgarian or Ukrainian ownership although occasionally there is a US ship. There are about 20 to 25 workers per ship and their stay in the port can vary between 1 to 45 days. The Port Authority has no real relationship with the owners of the ships and the policies on the ships. There are individual agencies with offices in Poti that deal with those issues. However, as part of the disembarkation procedure, a port authority physician visits the ship. In discussing how, for example, one might try to ensure that condoms were available for ship workers, the employee felt that directions and instructions should come from the MOH that could be implemented by the disembarkation team. Otherwise, policy efforts could be directed at the individual agencies. The representative indicated that drug use is commonly recognized as a problem. He admitted that there were sex workers in Poti. They were in general not street-based but solicited clients through the guesthouses in the city or through pimps.

Uniformed services and workers on large construction projects away from home are other potential risk groups. The assessment team during this visit did not address the issues of STDs, STD and HIV prevention services in these populations.

V. Maternal and Child Health Implications

IDUs are a major bridge population for HIV transmission to the general population through heterosexual contact and subsequently mother-to-child-transmission. In many settings, controlling HIV in the general community depends on controlling the infection in IDUs. The vast majority (?all) of IDUs in Georgia are male, many are married and all have sexual relationships. Condom use among IDUs in Georgia is low.

Data from around the world illustrate the profound impact that HIV infection in an IDU population can have on the HIV epidemic in the general population. For example:

- In Brazil, 40% of women infected with HIV through sexual contact reported sex with an IDU.¹³
- In China, while IDU is still the principal mode of transmission, the proportion of cases attributable to IDU is declining, indicating that HIV has spread outside the IDU population.¹³
- In Italy, 60% of new HIV cases in men are related to heterosexual contact with IDU using sex workers and 80% of new HIV cases in women are attributable to heterosexual contact with a men with a current or past IDU history.¹⁴
- In Nepal, a study of male IDUs found a high level of HIV transmission to their wives.¹⁵
- In the US, between 58% and 90% of all perinatal transmissions are attributable to IDU, either directly or indirectly.¹³
- Mother-to-child transmission of HIV is becoming a major problem in Russia, Ukraine and Belarus where the HIV epidemic has been fueled by IDU (see Table 4).¹⁶

Table 4: Number of children born from HIV positive mothers in Ukraine, Russia and Belarus 1997-1999, 2000 projected.

Country	1997	1998	1999	2000 (projected)
Ukraine	272	482	549	1000
Russia	43	132	153	300
Belarus	17	29	38	60

Sexually transmitted diseases enhance HIV transmission. Additionally, untreated STDs also have severe consequence in women and infants including pelvic inflammatory disease, adverse pregnancy outcome and cervical cancer. The variance in rates of partner change within populations greatly influences the rates of spread of STD.¹⁷ Individuals with the highest rates of partner change disproportionately increase the rate of spread of STDs within the population. Thus interventions should have the greatest impact if they are effectively focused and delivered among individuals who have many partners and in dense sexual networks. To the extent that interventions provided through public and private sectors do not reach such populations, the impact on STD spread in the population may be quite limited. Two examples of where targeted STD interventions in sex workers have reduced general population STD levels are Thailand and South Africa.^{18, 19}

The reported high levels of syphilis and gonorrhea in sex workers in Tbilisi, if verified, warrant aggressive outreach and STD service delivery to these women. STD rates in other high risk and vulnerable populations are unknown in Georgia. This information would be extremely valuable in directing appropriate resource and interventions at key groups. STD prevalence information in the general population of women would enhance the current FP/RH efforts in Georgia. Recent STD prevalence assessments in refugee women in Azerbaijan indicated a very low prevalence of chlamydial and gonococcal cervical infection (under 2 percent) and a high prevalence of bacterial vaginosis (personnel communication, W. Brady).

IV. Recommendations for HIV/AIDS Prevention Interventions

Recommendations

Direct Interventions

1. Implement targeted prevention interventions in high-risk groups. The priority group for immediate intervention should be IDUs. Subsequently targeted prevention interventions should be developed for commercial sex workers and their clients, men who have sex with men (MSM).
2. Institute/support comprehensive HIV prevention activities in the 12 detention centers of Georgia.
3. Support technically and materially the Georgian AIDS and Clinical Immunology Research Center of the Ministry of Health to develop a comprehensive behavioral and biologic monitoring plan (second generation surveillance) to monitor HIV/AIDS/STDs in Georgia and to implement the plan.
4. Support programs to improve the private commercial sector delivery of HIV/AIDS prevention information, products and services for Georgian youth, as well as high-risk groups such as IDUs and FSWs.

Supportive Interventions

5. Increase communication/coordination among donors supporting HIV/AIDS interventions.
6. Support Georgian National AIDS Committee and other key stakeholders (including health, legal and regulatory bodies) to develop a national HIV/AIDS strategic plan of action.
7. Foster linkages between nascent Georgian HIV/AIDS NGOs and regional and international groups already engaged and experienced in the proposed intervention activities.
8. Facilitate communication, planning, and information sharing among government, private sector, NGO sector and beneficiary communities to harness the resources of each sector for integrated HIV/AIDS activities.

Direct Interventions

1. *Implement targeted prevention interventions in high-risk groups. The priority group for immediate intervention should be IDUs. Subsequently targeted prevention interventions should be developed for commercial sex workers and their clients, men who have sex with men (MSM).*

IDUs:

IDUs constitute the population sub-group in Georgia in which HIV threatens to rise most rapidly and where both governmental and non-governmental organizational capacity, policy and advocacy efforts, and communities are weakly, or not at all, positioned to mount an effective response. IDUs in Georgia are threatened not only by their behavioral risk, but by a societal response that denies and ostracizes drug use and uses a predominantly punitive model coupled with limited treatment facilities. A comprehensive strategy should be implemented in Georgia whose foundation is a harm reduction approach. The guiding principle of this strategy is based on international lessons learned in keeping HIV prevalence low in IDU populations. These lessons recognized and stress that drug use itself does not cause HIV infection, neither does even drug injecting, but that sharing of contaminated drugs and drug equipment is the major risk factor for rapid HIV spread. The harm reduction approach gives drug users options of reducing their risk at various levels and focuses on supportive, rather than punitive strategies. The approach recognizes that while stopping drug use is often the ideal goal, several intermediate goals such as safer injection techniques and drug treatment (including drug substitution therapy) are just as helpful in reducing HIV infection. A full discussion of harm reduction can be found in the *Manual for Reducing Drug Related Harm in Asia* and other publications.^{20 - X}

The implementation of a harm reduction approach consists of:

- *Gaining support of policy makers and stakeholders (nationally and locally).* UNCEF is beginning a regional and national discussion on this issue with their workshop in Ukraine planned for June 2000. Representatives of USAID, the handful of groups working with drug issues in Georgia (i.e., Bemoni, Sasaebao, MSF/Greece, and the Georgian AIDS Center) and USAID cooperating agencies working on HIV/AIDS should attend this meeting. Follow-up coordination activities with all relevant stakeholders in IDU interventions should be ensured.
- *Penetrating the social networks of IDUs in community locations where they frequent and meet.* This activity is best and likely solely accomplished by members of the target group. Successful interventions have used the peer-mediated approach model sometimes called network leaders, peer-education, gatekeeper access. This approach has been used in the well evaluated interventions such as CDC's AIDS Community Demonstration Project – Peers Influencing AIDS Prevention and the ECHO Project supported by the U.S. National Institute on Drug Abuse and the CDC.^{23, 24} Current intervention activities with IDUs consist of medical or psychologist outreach. Peer-education is mentioned as an activity but lack a full understanding of what is and how to implement a peer education program (see discussion above).

- *Establishing and effective outreach team and potentially establishing drop-in centers to better access IDUs.*
- *Building a peer-driven program whereby IDU network leaders are involved in the actual planning and implementation of harm reduction program and condom promotion.* The assessment team found no examples of target group/community involvement in intervention activities and even very little pre-testing of education materials.
- *Creating necessary linkages to drug treatment and substitution programs where they exist, HIV counseling and testing, and primary health services.* Clear and explicit links between the existing HIV VCT centers should be made to take advantage of the proven prevention benefits which quality HIV testing and counseling can produce.

Environmental interventions for IDUs to support harm reduction is essential because of the sensitivities surrounding IDU interventions. A supporting policy and community environments are necessary for effective interventions to occur. This includes both at the national level with support for the harm reduction approach as well as at the local level with support from community groups and local law enforcement agencies. Finally, as indicated above, the active involvement and participation of IDUs in the design and implementation of interventions are vital for success. IDUs are not to be considered as passive recipients of services but must be viewed as playing a vitally important role in the prevention of HIV/AIDS.

Since injecting drug use for medical purposes is so common in Georgia, public education campaigns at point of purchase and mass media to educate on safer injection practices (e.g. use needles only once, don't reuse and don't share) and proper needle disposal would be beneficial. Additionally, this may make targeted interventions easier with the IDU populations.

Note: USAID's policy on harm reduction is still in draft (Table 5).²⁵ However, it has outlined restrictions and illustrative allowable activities for USAID funding. When fund from other sources are used to fund program components that USAID does not support directly, USAID funds must be segregated and accounted for separately.

Table 5: Outline of USAID restrictions and illustrative allowable activities for HIV/AIDS Prevention Programs among Injecting Drug Users.

Category of intervention	Legal restrictions	Activities that may be funded by USAID (illustrative)	Activities that will not be funded by USAID
Program management	None	Overall program management and operations including salaries, rents, utilities costs, etc.	Direct sub-components of overall programs (e.g. outreach vans or dedicated personnel involved in needle exchange programs)
IEC	None	Production and distribution of materials for educating IDUs about HIV risks; technical assistance to improve communication and outreach	Production or distribution of materials that teach IDUs how to inject, or how to prepare or obtain drugs; or that gives the appearance of supporting or

		strategies of local NGOs	condoning the injecting use of illicit drugs
Access to health/social services for IDUs	None	Support for voluntary counseling and testing for IDUs	
Outreach and peer education	None	Technical assistance for strategies targeting vulnerable populations;	Same restrictions as for IEC interventions
Sterile injecting equipment	Federal law prohibits funding for distribution of needles or syringes	Operational costs, and support for IEC or outreach activities of a program that operates a needle exchange program with separate funding	Procurement, distribution, or social marketing of sterile injecting equipment
Bleach kits	None	Activities associated with social marketing, IEC, or operation of a bleach distribution activity; and the procurement and distribution of bleach to be used for disinfecting IDU equipment	
Condom distribution	None	Any condom distribution or social marketing activity that is consistent with current USAID best practices	
Substitution treatment	None	Technical assistance to local organizations to strengthen outreach and referral mechanisms for substitution treatment programs;	Procurement of pharmaceutical supplies for treatment programs; or the direct operational costs of substitution treatment programs
Drug use prevention	None	IEC campaigns about the risks of drug use; assistance to programs providing social services to groups at risk for drug abuse	
Research and surveillance	Federal law prohibits purchase of syringes	Research and surveillance activities consistent with current USAID strategy and practice	Provision of sterile injecting equipment as part of a research activity
Improvement of policy environment	None	Assistance to community organizations, local/national government to encourage effective policies based on research; efforts to stimulate donor coordination and multi-sectoral approaches	

For example, in the Ukraine FHI/IMPACT is working with a local NGO that provides a wide range of harm reduction services to IDUs. With USAID funding, FHI is providing technical assistance to improve the NGO's communication and outreach methods. The same NGO has a separate needle exchange project funded by the Open Society Institute. In Vietnam, FHI/IMPACT is working with the Hai Phong AIDS Committee to implement a harm reduction project for IDUs, including a prevention component for youth at risk for drug use. USAID funds are supporting the training of counselors and for materials to sensitize policy-makers and local authorities to the program. FHI has leveraged funds from KfW, UNAIDS, UNDCP (UN Drug Control Program) and other donors to support the purchase of injecting equipment and condoms for the project.

Sex Workers

Sex workers are among the most vulnerable groups for HIV infection. Their large number and the very rapid change in sexual partners put sex workers at continuous risk of infection. Moreover, sex workers are often in a weak position to negotiate safe sex or condom use because of social, economic, cultural and legal factors. Clients of sex workers are considered a bridge population playing an important role in introducing HIV/STDs into the general population.²⁶ There is considerable global experience and evidence that targeted programs to reduce HIV transmission in sex workers and their clients are feasible and effective.^{18, 19, 26-31} While these programs' strategies and specific elements of the intervention package may differ, effective packages contain the following elements:

- Information and behavior change messages
- Condoms/other barrier methods
- Sexual health services
- Non-discriminatory practices and respect for human rights.

Strategies for delivering HIV prevention services to sex workers and their clients are similar to those for the IDU population described above and include: (1) use of informal contacts, key informants, "gatekeepers" to access the population, (2) peer health promotion and education, (3) outreach activities, (4) condom distribution and social marketing, (5) accessible sexual health services. The political and legal environment around prostitution has a major impact on HIV prevention programs. Decriminalizing sex work and encouraging safe work environments are important policy issues in HIV/STD prevention activities among sex workers.

2. *Institute/support comprehensive HIV prevention activities in the detention centers of Georgia.*

HIV/AIDS prevention interventions are critically needed in Georgian prisons. Prisons put people at great risk of HIV/AIDS and other diseases because of (1) overcrowding which contributes to the climate of violence and tension and the spread of HIV and TB; (2) continued drug use by individuals in prison because of drug offenses – the atmosphere and the availability

of drugs is not supportive in giving up drugs; (3) unsafe injecting practice because of the organization of Georgian prisons, the lack of fixing and injecting supplies and equipment and the lack of sterilizing equipment; (4) unprotected male-to-male sex and rape; (5) use of female prostitutes; (6) tattooing; skin piercing and blood brotherhood rites (frequency of skin piercing and blood brotherhood rites in Georgian prisons unknown). Most people who are in prison will be released back into the community and any infectious disease contracted in prison can and will be passed to the non-prison population once a prisoner is released. Based on the high frequency of IDU in Georgian prisons, the reported high level of male-to-male sex and the reported female prostitution involvement in the low security prisons a comprehensive HIV preventing intervention is warranted.

Optimally, whatever strategies are being used in the general community to prevent HIV infection in IDUs should be implemented in correctional facilities. However, the appearance of condoning illicit drug use or even admitting that it occurs in correctional facilities often limits the types of interventions possible in prisons. In Georgia for example, it appears that educational sessions with inmates are approved and that potentially condoms would be allowed. It is not clear whether, if the Georgian officials approve methadone maintenance, that it would be allowed in prisons. Changes in these policy and legal decisions can best be influenced through a concerted effort of interested parties. These parties in Georgia might include groups currently working with IDUs, groups interested in prisoner rights, the Georgian National AIDS Commission and possibly other groups.

3. *Support technically and materially the Georgian AIDS and Clinical Immunology Research Center of the Ministry of Health to develop a comprehensive behavioral and biologic monitoring plan (second generation surveillance) to monitor HIV/AIDS/STDs in Georgia and to implement the plan.*

The majority of HIV/AIDS data in Georgia has been obtained from blood screening and from HIV VCT centers. This data likely underestimates the true extent of the problem in Georgia and may have several biases. Recently the Georgian AIDS and Clinical Immunology Research Center has conducted a study of serial cross-sectional sero-prevalence studies with some behavioral information. This data clearly gives a better idea of the epidemic in Georgia and associated risk behaviors towards which interventions can be directed. Other than the single separately funded study conducted by the Georgian AIDS Research Center, there is not systematic behavioral and biologic data collection in high-risk groups with which to track risk behaviors and HIV/STD prevalence to monitor and adjust programming. New, strengthened surveillance systems, dubbed "second generation surveillance systems", aim to concentrate resources where they will yield information that is more useful.

As with any disease surveillance system, the purpose of surveillance in the area of HIV/AIDS, STDs and related behaviors is to give support to public health activities. The specific roles of the Georgian surveillance systems for HIV/AIDS, STDs and related behaviors would be, for example,

- *Advocacy*: provide information that can be used to raise awareness of policy makers, funding bodies and other relevant organizations, as well as the media and the general public, about the public health importance of HIV/AIDS and STDs.
- *Situation assessment*: provide ongoing estimated of the past and current trends of behavior, transmission of HIV and other STDs, to guide the development and implementation of intervention programs.
- *Planning*: inform the planning of health services for both prevention and care, by providing estimates and projections of numbers of people at risk of infection and numbers of people requiring clinical treatment.
- *Evaluation*: provide the basis for assessing the overall impact of intervention programs in reducing the transmission rates of HIV and other STDs and in reducing the burden of illness resulting from these infections.

In order to carry out the roles described above, a surveillance system should produce a number of products. They are described here under the heading of HIV/AIDS, other STDs, and behavior.

HIV/AIDS (HIV surveillance systems -- HSS)

1. *The prevalence of HIV infection in selected sentinel population groups, by location and year.* This produce will indicated the main characteristics of the HIV epidemic in each location and allow an assessment of changes in transmission patterns over time. It will also indicate the stage of the epidemic in each location.
2. *The prevalence of HIV infection in selected young populations as a surrogate for incidence.*
3. *The number of people living with HIV infection and the estimated number becoming newly infected.*
4. *The number of people developing advanced HIV-related illness (AIDS and other manifestations).* This figure, and its future projection, is required for planning clinical care services.

Behavior (Behavioral surveillance system – BSS)

1. *Patterns of risk behavior (including the number and types of partners) among sentinel groups and the general population.* These behavioral data help identify subsets of the population at risk locally, and suggest pathways of spread. They also suggest levels of sexual intercourse between the general population and higher-risk groups.
2. *Trends in behavioral risk behaviors in selected sentinel groups:* These data are used to inform effective program design and implementation, to track changes in risky behavior, to provide evidence for success of interventions, to help explain changes in HIV prevalence, and explain geographic variations in prevalence.

Other STDs

1. *Prevalence of common STD syndromes in clinic attendees at public and NGO facilities by age and sex.* Used in the management and planning of service provision and evaluation of interventions in client populations.
2. *Prevalence of selected etiologic agents for STDs:* Used to monitor trends and effectiveness of interventions as well as for targeting interventions.

3. *Patterns of STD care provision:* Used to assess the quality of STD care and for monitoring the application of treatment guidelines. (Requires special surveys).
4. *Prevalence of antibiotic sensitivity:* Used to develop and update treatment guidelines for management of gonococcal infection.

It is recommended that several underlying principles be respected in the design and implementation of an HIV/AIDS and STD surveillance system.

- *Support for national program:* All activities should be carried out under the guidance of the National AIDS Center to ensure maximum support of the program.
- *Scientific validity:* The activities should be based on the best available scientific methodologies over time.
- *Capacity building:* Appropriate training should be provided at all levels so the surveillance can be conducted by national institutions as autonomously as possible.
- *Consistency:* The activities should be standardized over time as far as possible, to allow for valid assessment of time trends and geographic patterns.
- *Confidentiality and informed consent:* All activities should respect individual rights and ensure confidentiality regarding health and medical status. Informed consent for participation in surveillance activities should be assured unless using some forms of unlinked anonymous methods are used (e.g. stripping identifiers off of already collected specimens).
- *Acceptability:* Activities must be acceptable to all people involved in the surveillance, including the subjects.
- *Coordination:* integration of all agencies involved in HIV/AIDS activities is necessary to assure collection of the maximum amount of data.

Recommendations for surveillance in Georgia, a low-level epidemic

- Cross-sectional surveys of behavior in sub-populations with risk behavior (IDUs, sex workers, MSM, high risk men?).
- Surveillance of STDs and other biologic markers of risk.
- HIV surveillance in sub-populations at risk.
- HIV and AIDS case reporting.
- Tracking of HIV in donated blood.
- Cross sectional surveys of behavior in general population, especially youth

4. *Support programmes to improve the commercial private sector delivery of HIV/AIDS prevention information, products and services for Georgian youth, as well as high-risk groups such as IDUs and FSWs.*

Existing HIV/AIDS prevention activities in Georgia have extremely limited reach in the distribution of information, products and services to risk groups. IEC efforts consist mainly of traditional awareness-raising activities, lack good organization and coordination, and fail to strategically target groups at risk. Outreach activities are overly “medicalized” and neglect the critical need for systematic involvement of risk group members themselves in designing and

implementing outreach strategies. Condoms are generally not available in outlets where risk groups can get them conveniently and discreetly, especially outside Tblisi, and are inadequately promoted. No organization is making strategic use of media, peer outreach and product distribution to shift behavioural norms among risk groups towards healthy behaviors.

Social marketing would offer an innovative and integrated approach to addressing these key knowledge, normative and “market” barriers to healthy behavior. Social marketing uses commercial marketing strategies, on a not-for-profit basis, to assure the wide dissemination of information to target populations, client-centered outreach and services, and the widespread distribution of quality, affordable commodities. The success of USAID-supported social marketing interventions in other CEE/NIS contexts (e.g. Russia, Romania) suggests that social marketing could make a notable contribution to HIV/AIDS prevention in Georgia.

Support activities

5. ***Increase communication/coordination among donors supporting HIV/AIDS interventions.***
5. ***Support Georgian National AIDS Committee and other key stakeholders (including health, legal and regulatory bodies) to develop a national HIV/AIDS strategic plan of action.***

An unfortunate lesson from HIV/AIDS programs around the world is that government officials and other key influentials often fail to act – and act effectively – at the early stages of the epidemic when the opportunities for averting a larger problem are strong. This happens for numerous reasons including the modern-day penchant for crisis management versus early and effective intervention, the lack of appreciation of how quickly epidemics can flare, the lack of information on effective strategies, and importantly, an unwillingness to address culturally-sensitive matters particularly for politically invisible and marginalized populations.

While the UNICEF meeting in June provides an opportunity for consciousness-raising and networking, given the range of expected participants it is unlikely that an effective regional strategy can be developed within the confines of the meeting. It is likely that follow on efforts will be necessary for Georgians to develop a country strategy (and for a Caucasus-wide regional strategy). The design for a national strategic planning effort would ideally be developed jointly with the Georgians with others drawn from a broad participation of various stakeholders across the nation. One approach could be to utilize, as appropriate, current participatory, rapid planning models that involve situation analysis, response analysis, strategic planning and resource mobilization. A working group comprised of returnees from the Odessa meeting could be formed to support the process. Assistance could be provided in the form of technical experts and to commission work on estimates and projections of the epidemic, modeling and creation of policy presentations tailored to the Georgian context. This process could be extended for the design of a regional strategy.

7. *Foster linkages between nascent Georgian HIV/AIDS NGOs and regional and international groups already engaged and experienced in the proposed intervention activities.*
8. *Facilitate communication, planning, and information sharing among government, private sector, NGO sector and beneficiary communities to harness the resources of each sector for integrated HIV/AIDS activities.*

VII. Results and Performance Indicators

Results of the proposed HIV/AIDS/STD prevention interventions and activities will contribute to the Mission's Strategic Objective (SO) 3.1 "Reduced Human Suffering in Targeted Communities" and specifically to Intermediate Result 3.1.2.1 "Increased Capacity to Deliver Health and Other Services".

It would be beyond the resources of any prevention program to directly measure changes in HIV incidence that result from interventions directed at unsafe injecting practices and adoption of safer sexual practices including increased condom use. Depending on the package of HIV/AIDS/STD prevention services the USAID mission decides to support the following are potential illustrative indicators recommended for low-level countries.^{32, 33} Words in brackets indicate the level of the indicator (e.g. context, input, process, output, outcome, impact) and words in parentheses indicate the potential source of the data. Once a specific program is designed other indicators and targets can be determined tailored to the specific interventions.

Policy:

1. AIDS Program Effort Index (special survey) [Context indicator]

Condom accessibility and quality

1. Condoms available nationwide
2. Condoms available retail (retail audit) [Output]
3. Condom quality (intermittent quality tests) [Input]

Knowledge (target groups and general population) [All output indicators]

1. Knowledge of HIV prevention (Behavioral Surveillance Survey (BSS))
2. No incorrect beliefs about AIDS (BSS)
3. Comprehensive knowledge about AIDS (BSS)
4. Knowledge of HIV prevention among MSM (BSS)
5. Knowledge of HIV prevention among IDUs (BSS)
6. Knowledge of prevention of MTCT (BSS)

Sexual behavior [All Outcome]

1. Risky sex in the last year (BSS)
2. Condom use at last risky sex (BSS)

3. Commercial sex in the last year (BSS)
4. Condom use by clients at last commercial sex (BSS)
5. Condom use by sex workers with last client (BSS)
6. Risky male-male sex in the last year (BSS)
7. Condom use at last male-male anal sex (BSS)

Young people's sexual behavior [All Outcome]

1. Median age at first sex (BSS)
2. Young people having premarital sex in the last year (BSS)
3. Condom use with premarital sex (BSS)
4. Young people with multiple partners in the last year (BSS)
5. Condom use at last risky sex (BSS)

Injecting drug use [All Outcome]

1. Drug injectors sharing equipment (BSS)
2. Drug injectors using condom at last sex (BSS)

STI Care and Prevention

Depending on formative research and the ultimate project design these indicators will be modified or supplemented and targets can be realistically set. For example, the globally recommended IDU indicators do not take into account the risk of using specific drugs. Other indicators might include percentage of IDUs using methadone.....

VII. Opportunities for Linkages and Leverage of Resources

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