



# *HIV in Georgia:*

## *Where is it going?*

BACKGROUND DOCUMENT FOR THE DISSEMINATION OF THE  
BEHAVIORAL AND BIOMARKER SURVEILLANCE SURVEY IN  
TBILISI



**Infectious Diseases, AIDS and  
Clinical Immunology Research  
Center**

TBILISI, JULY 2003

# *HIV in Georgia: Where is it going?*

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DISSEMINATION OF THE  
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SURVEY IN TBILISI, 2002



**Infectious Diseases, AIDS and Clinical  
Immunology Research Center  
Ministry of Health  
Georgia**

Tbilisi, July 2003

## *Executive Summary*

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Since HIV first emerged 20 years ago, it has spread relentlessly around the globe. Georgia has been spared so far, but the sexual and drug-taking behaviors that carry a risk of HIV infection exist in this country just as they do in most others.

Information from this behavioral and biomarker survey in Georgia conducted in 2002 show that HIV infections rates are low, but it is now clear that this situation will not continue unless there are radical reductions in risk behavior. Sex workers in Georgia have high sexually transmitted infection rates, despite reported high condom use with paying clients. Over three quarters of injection drug users in Georgia shared injection equipment in the previous week.

Georgia is located in the region that has the unfortunate distinction of having the world's fastest-growing HIV/AIDS epidemic, the Commonwealth of Independent States (CIS). In 2002, an estimated 1 million people were living with HIV/AIDS in the CIS. As stated by the Executive Director of UNAIDS, Mr. Peter Piot, "Most of these new infections are among injecting drug users." In many of these countries, the fight against the epidemic is being waged against a backdrop of socio-economic turmoil. This instability fuels drug use and commercial sex, both of which increase the spread of HIV."

It is estimated that up to 1% of the population of countries in the CIS is injecting drugs, placing these people and their sexual partners at high risk of infection. The Russian Federation is experiencing an exceptionally steep rise in reported HIV infections. HIV epidemics have been discovered in 87 of the country's 89 regions. Another of Georgia's neighbors, Ukraine, has an estimated adult HIV prevalence rate of 1% and is the most affected country in the region (and in all of Europe). The example of the HIV explosion in Eastern Europe, including Russia and Ukraine, illustrates how quickly the HIV epidemic in injecting drug users (IDUs) can expand.

The information now available should set alarm bells ringing for Georgia. The good news is that, because HIV rates in the country are still low for now, we have a real opportunity to decrease high-risk behavior before the virus has a chance to take hold. Already, small-scale prevention programs working to reduce unprotected sex and needle sharing are having some success in our country. These programs need to be greatly expanded to cover a wider range of people engaging in risky behavior. Moreover, they need to address the background factors that make it so difficult to increase condom use in commercial sex encounters. Sex trade establishments and clients of sex workers must get involved; condom use with non-paying and regular partners is essential. In addition, they need to tackle those factors that make it dangerous for IDUs to get and carry new needles by involving law enforcement representatives.

The political, social and logistical challenges in promoting HIV prevention activity in our country may seem overwhelming. But if they are undertaken now, while HIV prevalence is still low, the HIV/AIDS epidemic may be averted. The leaders and people of Georgia have an opportunity to turn this country into a success story for HIV prevention.

## ***Introduction***

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Since HIV first emerged 20 years ago, it has spread relentlessly around the globe. Georgia has been spared so far, but the sexual and drug-taking behaviors that carry a risk of HIV infections exist in this country just as they do in most others.

The government of Georgia has been collecting HIV and AIDS data since the beginning of the epidemic in Georgia in 1989. The Government of Georgia, in partnership with Save the Children, Tanadgoma, the Research Institute on Addiction, Bemoni Public Union and other partners, has begun developing a more systematic surveillance system for HIV/AIDS. The system employs principals from second-generation surveillance whereby HIV-related behaviors are tracked over time in addition to other HIV and sexually transmitted infections (STI) data. This document summarizes data from the first behavioral and biomarker surveillance survey in Georgia conducted in Tbilisi in 2002 and supplements it with data collected by the Infectious Diseases, AIDS and Clinical Immunology Research Center (AIDS Center) in 1999.

The picture that emerges is worrying: while prevalence of HIV is low, risk behavior is common, at least in some groups. Experiences from other countries – described briefly in this document – highlight the dangers for Georgia. In Ukraine, for example, HIV prevalence was low in IDUs for a while and then exploded faster than a response could be mounted.

Will Georgia follow the same path? It depends on how the country responds to the information presented in this report. In the last decade, several countries whose governments and communities have acted strongly to prevent HIV through provision of means, services and skills have recorded sharp falls in risk behaviors, and a few have also measured falls in HIV prevalence.

This document draws lessons from the successes of those countries and makes suggestions about the actions we in Georgia can take to decrease risky behavior and prevent an HIV epidemic in Georgia.

### ***Where do the data come from?***

The data presented in this report come largely from the behavioral and biomarker surveillance survey for HIV in Tbilisi, Georgia that was conducted in November and December 2002. HIV surveillance systems aim to track changes over time in the prevalence of the virus and in the behaviors that can spread it. They concentrate on collecting information from populations likely to have behaviors that carry a substantial risk for HIV infection. In Georgia this survey was done among street-based female sex workers (FSWs) and IDUs. Biomarker surveillance entails collecting blood or other clinical specimens from participants to measure the prevalence of HIV and STIs among

**In Ukraine HIV prevalence was low in drugs users for a while and then exploded faster than a response could be mounted. Will Georgia follow the same path?**

the study population. These biomarkers – which are measured in the same groups as the behavioral indicators – confirm the high levels of risk reported by respondents and measure progress in prevention efforts.

In the biomarker surveillance portion of this study, IDUs were actively recruited through peers and encouraged to give blood for screening of HIV and syphilis. FSWs were actively encouraged by a local NGO to give a blood for HIV screening and urine sample for chlamydial and gonococcal infection. All the blood samples and urine specimens from different sites were marked with a study code number and tested by the AIDS Center in Tbilisi. All participating individuals were given the opportunity to learn their results and were given free treatment for any curable STI found.

While the behavioral surveillance tries to cover the same groups, it is not restricted to people attending clinics or involved in NGO interventions. Epidemiological approaches are used to try and give everyone an equal chance of being asked to participate. In some instances the population in questions is mapped, and a random selection of its members are asked questions about their sexual and drug injecting activity by trained interviewers. In very hidden populations that cannot be mapped, members of the group are asked to be recruiters and send potential participants in for questioning.

Because both the biomarker and behavioral surveillance activities were strictly anonymous – no names were recorded anywhere – it was not possible to do any sort of follow-up contact with the participants.

### ***What can surveillance data tell us?***

Biomarker surveillance, in combination with the behavioral surveillance, can build a picture of the national epidemic and response. The information can help to describe risky behaviors and quantify levels of risk in a population, providing an early warning for public health officials and demonstrating the need for prevention activities in different groups.

Surveillance data can also be used to plan prevention activities and, over time, to indicate whether the national response to HIV is effective or not.

## *Table of Key Indicators*

**Table 1: Key Indicators for the Behavioral and Biomarker Surveillance Survey, Tbilisi 2002.**

<b>INDICATOR</b>	<b>INJECTION DRUG USERS (%)</b>	<b>FEMALE SEX WORKERS (%)</b>
<b>HIV infection</b>	1.1	0.62*
<b>Syphilis infection</b>	1.4	27.8
<b>Gonorrhea</b>	—	17.1
<b>Chlamydial infection</b>	—	25.3
<b>Selling sex in the last week</b>	2	100
<b>Buying sex in the previous year</b>	48.4	—
<b>Condom use at last commercial sex</b>	83.5	94.9
<b>Consistent condom use in commercial sex last month (IDU last year)</b>	60.3	71.6
<b>Currently injecting drugs (FSW ever in last year)</b>	100	1.3
<b>Sharing injection equipment last week</b>		
needle/syringe	31.5	—
injection equipment	79.3	—
<b>With history of STIs in last year</b>		
discharge	21.4	70.3
ulcers	6.5	11.3
<b>Having HIV test ever</b>	20.1	51.6

\*Note: Of the 160 participants, two were male transvestites, one of whom was HIV positive.

## ***HIV in Georgia***

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### ***Where is it going?***

In the last two decades, we have learned a great deal about the way HIV works. It spreads in only a limited number of ways -mostly through unprotected sex or unsafe injection practices. It spreads fastest among those who have unprotected sex with a large number of sexual partners, especially if they have untreated sexual infections, among those who engage in especially risky practices, such as anal sex, and among those who share injecting equipment, such as syringes and needles, with other people.

These are behaviors that we can measure. Where substantial levels of risk exist, HIV will inevitably follow, even if it takes some time to appear. By looking at current levels of HIV, at levels of other diseases spread through the same behaviors, and at levels of risk behavior in a population, we can forecast what is likely to happen, if no action is taken to change the course of the epidemic.

### ***HIV prevalence is currently low***

In Georgia the HIV surveillance system has focused on testing of people with risky sexual or drug- taking behavior. To date the system reveals very low levels of HIV infection. However, systematic information from all parts of the country has been limited.

The first HIV diagnosis in Georgia was made in 1989. As of the end of April 2003, a total of 413 HIV cases have been registered, 353 of whom are males and 60 are females, ranging from 21 to 40 years of age. The estimated number of persons living with HIV in Georgia may be higher than 2,000 persons. IDUs account for 70% of the registered HIV cases, heterosexual contacts for 24% (a third of these heterosexual contacts were with known IDUs); homosexual contacts for 4%, and 2% were blood recipients.

Between 1997-1999, a study was conducted by the AIDS Center that followed persons from high-risk groups over time from Tbilisi, Poti and Batumi. The study found a rate of 1.4% prevalence of HIV among the 71 FSWs tested. In the same study HIV prevalence in 926 IDUs was found to be 0.54%.

These levels of HIV infection are extraordinarily low by the standards of the CIS, and indeed, the world. Does this mean that Georgia is safe from HIV?

A look at the behavioral data suggests not.

## ***Risky behavior is very common, at least among some Georgians***

Behavioral surveillance aims to track knowledge about HIV and attitudes towards it over time, concentrating especially on measuring changes in the sexual and drug-taking behaviors that can spread the virus.

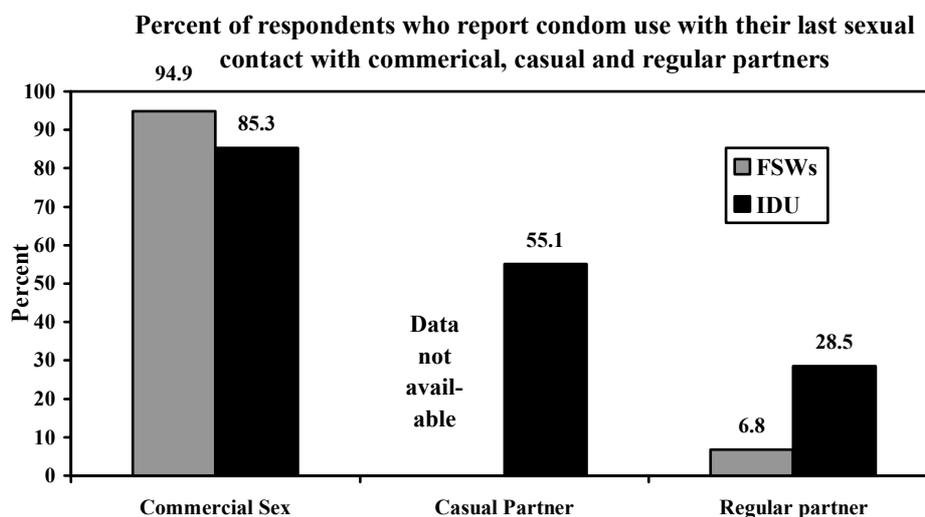
### ***Many people know they are at risk***

In Georgia, as in many countries throughout the world, the "knowledge" battle has been won. High proportions of men and women know about HIV and how to prevent it. Among people especially at risk of exposure to HIV – such as sex workers, their clients and IDUs – knowledge is virtually universal. While knowledge does not lead automatically to safer behavior, it is hard to see how people can act to protect themselves from HIV if they do not even know it exists.

### ***Men who buy sex and women who sell it: many partners, many condoms and lots of sexually transmitted infections***

All over the world, men are prepared to pay women for sex, and where there is demand, there will always be supply. In Georgia, sex work has many faces. Women work in on the street, in saunas, in hotels, brothels and over cell phones.

Clients are equally diverse, although not fully studied in Georgia. They often range from the unemployed, laborers and transportation workers to students, civil servants and businessmen. Some are married, and many have very high numbers of sex partners, both paid and unpaid. IDUs in this survey reported on average four sexual partners per year.



**Figure 1: Condom use is high in commercial sex but not with regular partners**

Many of the men in this survey – and the women that serve their needs – have one thing in common: they report high condom use rates when buying or selling sex but much lower condom use rates with casual or regular partners. The low condom use rate with

non-paying clients or regular partners may explain the high STI level in these sex workers. It is important, because of the role that STIs play in HIV transmission, that effective STI treatment services be available to these women.

### ***Needle and drug equipment sharing is routine among drug injectors***

Sharing needles and syringes with an infected person is one of the most efficient ways of spreading HIV. Experience around the world – in countries as diverse as India, Scotland, Thailand and Russia -has shown that once HIV enters a drug injecting network, it can infect half of all injectors in two years or less, if needle sharing is common.

In Georgia, sharing of needles and of drug making equipment is more than common: it is the rule, at least in some parts of the country. In Tbilisi, a third of the 284 IDUs questioned said that they had shared needles or syringes in the past week, though nearly all said they could get or buy a needle if they needed one. Over three quarters of the same group said that they shared drug-mixing equipment. There appears to be some change in behaviors with the knowledge that sharing needles and syringes can be dangerous. The knowledge, however, does not extend to other injecting equipment. Regardless, sharing rates were still unacceptably high.

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### ***How many people engage in these behaviors?***

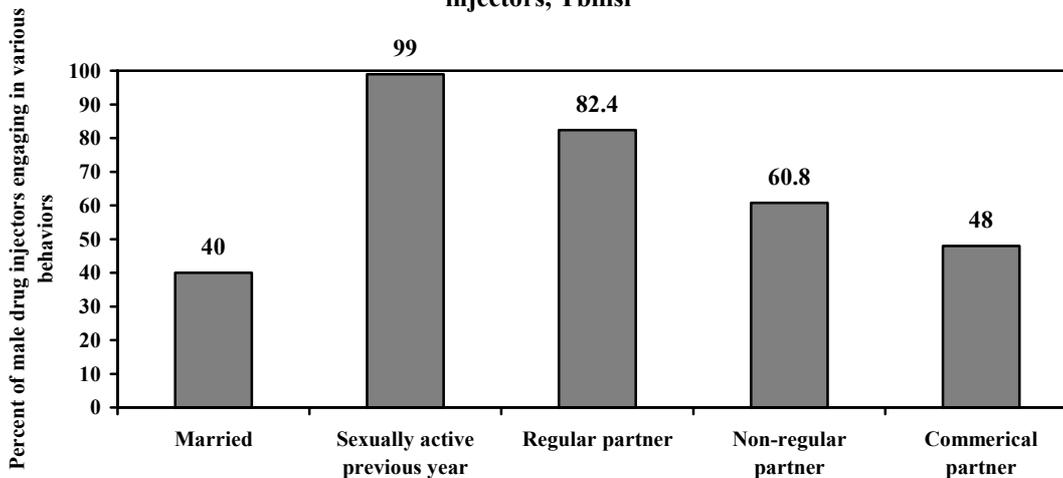
#### ***The risk may reach further than we assume***

It is important to stress that the groups included in the surveillance system were chosen precisely because it is believed they are likely to have high-risk behavior. FSWs are not any more representative of all women in Georgia or IDUs of all young people.

At the moment, it is not possible to estimate what proportion of the total population engages in one or more of the risks described in this summary. What is clear, however, is that many people may be exposed to high-risk behavior even when they themselves do not engage in it.

The wives and regular partners of men who visit sex workers are only the most obvious example. Other examples come from drug injectors and from sex workers, both male and female. Most people don't think about the risks associated with drug injection because they don't inject drugs and don't know anyone who does. But drug injectors are part of the fabric of our society: they buy sex from the same sex workers, and sometimes sell sex and blood, too. Male injectors are often married to women who don't inject, and many have other girlfriends. Figure 2 gives an idea of the extent of behaviors potentially linking non-injectors to injectors: these are all channels through which HIV can pass.

**Channels through which HIV may pass between drug injectors and non-injectors, Tbilisi**



Although drug injection in Georgia remains overwhelmingly male dominated, a few FSWs – particularly those working on the streets – reported that they injected drugs. In some countries in the NIS, notably in Ukraine, and in some countries in Asia, notably Vietnam and China, injecting drug use among FSWs has fuelled the heterosexual epidemic.

***Are people really telling the truth about all this risk?***

Many people believe that the data must somehow be flawed. Perhaps people are boasting about their number of sexual partners, or understating condom use. If there really were so much risky behavior, how come there is no HIV epidemic?

Risk behavior existed for many years in many populations around the world before HIV appeared. For generations, it has left signs and symptoms other than the virus that causes AIDS. If risky sexual behavior really is taking place in a population, we can expect to see high levels of "classic" sexually transmitted diseases, such as syphilis. Drug injectors sharing needles are also vulnerable to other blood-borne infections, such as Hepatitis B and Hepatitis C.

Positive Hepatitis B and Hepatitis C serologic markers in IDUs confirm the reported behavior of sharing drug-injecting equipment. In a 1999 study by the AIDS Center, 52% of IDUs were Hepatitis B positive and 58% were Hepatitis C positive. This is in contrast to the blood donor groups, where the prevalence of Hepatitis B and Hepatitis C was about 7%.

Female respondents in the behavioral and biomarker survey had very high levels of sexual infections. The high rates of syphilis and other STIs are worrying for three reasons. Firstly, STIs are health problems in their own right, causing sickness and congenital disorders. Secondly, the prevalence rates confirm that unprotected sex with multiple partners is indeed a norm, at least for some sections of the Georgian population.

And thirdly, infection with STIs greatly increases the efficiency of HIV transmission. High sexual infections rates means HIV is likely to spread more quickly when it does enter the population.

***The evidence suggests that unless risk changes, it's just a matter of time before HIV rises significantly in Georgia***

For years, many countries that have seen no HIV epidemic have thought that they were somehow "protected" by their culture or other physiological factors. This has been true even where behavioral surveillance has shown consistently high levels of risky behavior. There are, indeed, some cultural/physiological factors, such as widespread male circumcision, that can slow the onset of an epidemic. One by one, however, the "low HIV" countries of the CIS are falling to the virus: Estonia, Russia, Kazakhstan are all examples of countries that have registered sharp increases in HIV infection in some groups. It turns out that these countries were not protected by their culture, their traditions or their geography. They only had a false sense of protection—time—and time has now run out.

The lesson that low prevalence in the past does not mean low prevalence in the future is universal. Although HIV is currently low in Georgia, risk behavior and other biological markers of risk are high. All the available data suggest that time again is providing a false sense of protection in Georgia. We must use that time wisely if we are to change the course of the epidemic.

**Low HIV  
prevalence in the  
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in the future**

## Learning from experience

### Building on the lessons of the past

If the likely course of the HIV epidemic in Georgia is clear, so are the paths that can help turn the nation away from that course. Several countries have begun actively to confront the HIV epidemic, and valuable lessons have been learned. In Georgia, we can benefit from one of the most important of these lessons: the earlier prevention programs are instituted, the more effective they are likely to be.

#### Lesson one: effective early action is essential

The government of Georgia recognized that it is easier to keep HIV prevalence low than to try to reverse the course of the epidemic once it has taken hold. Based on this understanding, it acted early by establishing a National Program on HIV/AIDS Prevention and a Governmental Commission on HIV/AIDS in 1996. In 2002 the Strategic Plan on HIV/AIDS for 2003-2007 was initiated. More recently, it applied for and was awarded support through the Global Fund to Fight AIDS, Tuberculosis and Malaria to mount a truly comprehensive, nationwide HIV prevention and care effort.

Another example of a country that acted early is Laos. Laos is locked in by nations with already high or rapidly rising HIV epidemics: Thailand, Cambodia and Vietnam. The HIV situation is not dissimilar to Georgia. While there was no active HIV surveillance system in the 1990s, case reports registered only a tiny handful of infections, mostly in migrant workers returning from neighboring Thailand.

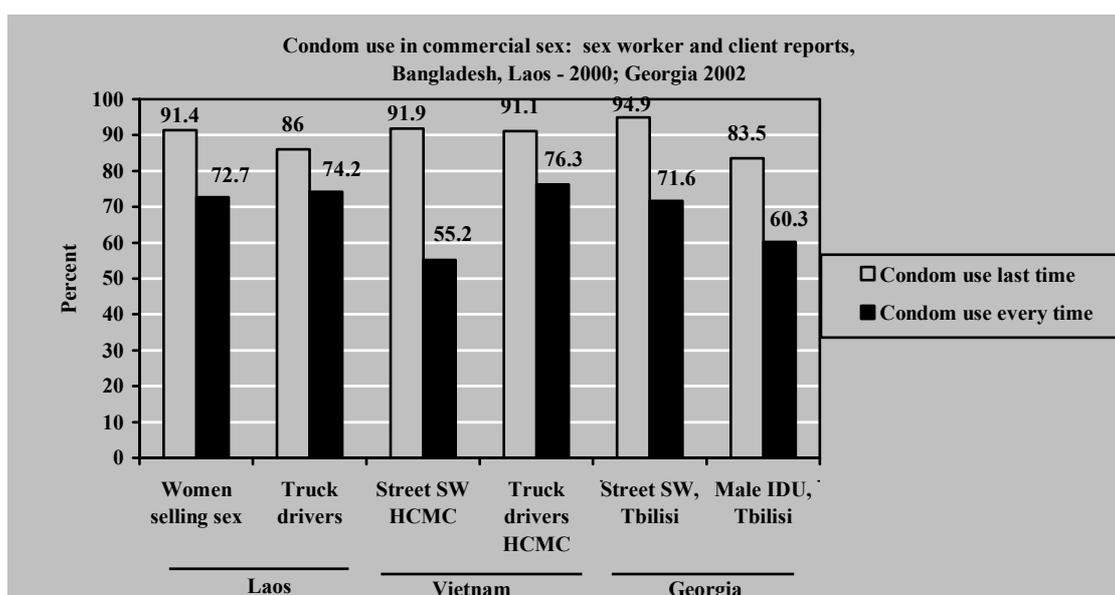


Figure 3: Condom use has reached very high levels in other countries, including countries like Laos with very low HIV prevalence  
(Source: National surveillance data, Vietnam and PDR Laos)

The Laotian government backed an aggressive condom marketing campaign. By the time the first round of integrated surveillance took place in 2000, men buying sex and women selling it both reported extraordinarily high rates of condom use, as Figure 3 illustrates. Active HIV surveillance conducted in 2000 found virtually no HIV in these groups. If the reported rates of condom use reflect the truth, and if those rates can be sustained over time, it is likely that the heterosexual spread of HIV will have been permanently averted in Laos.

Figure 3 shows similar success in increasing condom use in commercial sex in Ho Chi Minh City in Vietnam; however, Vietnam did not begin effective HIV prevention efforts until much later. Surveillance data show that one sex worker in five in the city is already infected with HIV. This late start has important implications for the epidemic: even though roughly the same levels of condom use have been achieved in these neighboring Southeast Asian countries, sex workers and their clients are over 20 times as likely to have unprotected sex with an infected partner in southern Vietnam as they are in Laos simply because a pool of infection was allowed to build up *before* condom use reached high levels.

Data from the survey in Georgia are also shown in Figure 3. It is clear that a high percentage of FSWs and IDUs in Tbilisi are using condoms in commercial sex. However, STI rates are very high in sex workers, and they report low condom use with non-paying clients and regular partners. Therefore, it is imperative that condom use rates with non-paying partners and access to good reproductive health services increase dramatically to prevent HIV from spreading.

Many in Georgia would be forgiven for questioning the data. Don't we have NGOs working on condom promotion and harm reduction just as they do in other countries? Here lies the second lesson of the past.

### ***Lesson two: effective prevention targets the context, not just the group***

Many of the early HIV prevention activities in Georgia have focused on urging sex workers to use condoms with their clients. And indeed, sex workers are far more likely to ask their clients to use condoms now than ever before. Women are also more likely to have a condom on hand and to use them. However, there is significant violence reported by sex workers often in the context of condom negotiation.

The implications are clear: sex workers are not the ones who always decide whether or not they use condoms. Sometimes, the decision is left to the client and regular partners, and pimps and sauna-owners sometimes have a say, too.

It is important that sex workers have the knowledge and the skills to negotiate condom use, but it is not enough. Short-term prevention efforts need to target both sides of the commercial sex equation, as well as its context. That means working with clients, sauna-owners, pimps and the police as well as with sex workers. It also means reducing the climate of violence that is a norm for sex professionals in Georgia. About one in five female street-based sex workers report violence from police and clients.

Similarly, it is important that IDUs have knowledge and skills to not reuse drug-injecting equipment. However, in order to act on that knowledge, a drug user must not be penalized for carrying clean needles. In the short term this would mean a more pragmatic and flexible application of law and regulations, including a decrease in harassment and the risk of arrest for those found carrying a needle and providing "free passage" for outreach workers and peer educators. In parallel and in the medium to longer-term, prevention efforts need to target the legal and social context of drug use. It must be examined and reformed to make prevention possible, including in prisons. That means working with drug users, health officials working in and outside prisons, prison authorities, policy makers, and police enforcement agencies.

Longer-term prevention efforts should work on changing the social landscape that accepts violence as a norm and which deprives people – especially women – of choices in their working lives as well as their sexual and reproductive lives. Furthermore, all prevention efforts need a multi-sectoral approach, recognizing that targeting risk behaviors only, neglecting vulnerability, does not work.

### ***Lesson three: effective prevention is possible, but programs must reach large proportions of people at risk***

There is clear evidence from Georgia itself that HIV prevention programs can make a difference – reported condom use by sex workers was high. The problem is, however, that interventions for sex workers currently exist in Tbilisi only.

As we saw earlier in this document, the networks of risk in Georgia are both complex and extensive. Effective prevention in just a small corner of the network may delay the takeoff of the epidemic, but the virus will eventually circumvent the "protected" group and take hold anyway.

This was powerfully illustrated in Nepal, where a needle exchange program for drug users was started as early as 1991. For years, no rise in HIV prevalence was registered, and it appeared that the needle exchange program had effectively prevented an HIV epidemic among drug injectors. Indeed in 1995, a paper was published in a scientific journal declaring that harm reduction programs had scored a victory and effectively prevented an HIV epidemic among drug injectors in Nepal.<sup>1</sup> Between 1995 and 1997, approximately half of all injectors tested in the capital were infected with HIV.<sup>2</sup> After much analysis, researchers and public health officials concluded that this was because the needle exchange program was too small and too localized to make a permanent difference. Once HIV found its way into sharing networks, it just took off. Nepal's prevention efforts were on too small a scale and didn't keep up with the rising number of drug users. This points to another lesson for effective HIV-prevention:

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<sup>1</sup> Peak et al, 1995. AIDS 9:1067.

<sup>2</sup> Oelrichs et al, 2000. AIDS 74:1149.

### ***Lesson four: HIV prevention needs to be adapted and continued over the long haul***

Even countries and communities that have registered major victories in cutting down on unsafe sexual and drug-taking behaviors have seen those victories reversed as soon as their prevention efforts slackened. Probably the best-known example comes from gay communities in industrialized countries. Here, prevention efforts were so successful that safe sexual behavior became the new norm; subsequently, prevention programs tailed off. The result of this, together with the availability of medicine to treat HIV (although not to cure it), has been a sharp upturn in risky sexual behavior. New generations of young men – generations who don't remember the worst of the epidemic and who have not been exposed to aggressive HIV prevention campaigns – are resuming the risky behaviors of the past. The consequence: new HIV infections are rising again, after more than a decade of decreasing consistently.

### ***Lesson five: political leadership is key***

The concerted effort of a number of social, cultural and economic groups is important in ensuring success in the fight to keep HIV at bay. Realistically, however, we have to face the fact that these different groups rarely come together without the strong personal commitment of senior figures in society.

It is impossible to overstate the importance of political leadership in successful responses to HIV. The seeds of all of the "success stories" that are so much touted around the world – Uganda, Thailand, Senegal, Cambodia – can be found in the dedication and commitment of political leaders: President Yoweri Museveni in Uganda, Prime Ministers Anan Panyarachun of Thailand and Hun Sen of Cambodia, and the leaders of the Islamic faith in Senegal.

These leaders had the vision and the courage to acknowledge the realities of risk behavior in their countries. They also had the ability to mobilize and disperse funds adequately and in a sustained way. Furthermore, they had the leadership skills to create a network into which they pulled a large number of partners, each with a contribution to make in preventing the spread of HIV and reducing its impact on those affected.

## ***Opportunities for action***

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### ***Towards a safer future for Georgia***

The information presented in this document tells us several things:

- ◆ Behavior that carries a risk for HIV is common in Georgia.
- ◆ Networks of risk mean that epidemics will not be contained for long in any given sub-population.
- ◆ Prevention efforts have shown some success in Georgia, but to date they have been insufficient to deal with the threat.
- ◆ “Time” is not a prevention strategy. While the prevalence rate is presently low, this may not be the case for long.

Together, this adds up to a single, central message:

***Georgia has an unparalleled opportunity to avert a potentially serious HIV epidemic, if action is taken now.***

What must happen to turn that opportunity into a reality? Again, the data presented in this document point to several things:

- ◆ Prevention programs are needed to reduce the dangers of injecting drugs and of buying and selling sex.
- ◆ These programs must work to change the context in which these risks take place, rather than focusing on "risk groups" alone.
- ◆ Prevention must happen on a large scale.
- ◆ Comprehensive programs must be designed and sustained over the long term.
- ◆ The longer we wait to initiate effective, large-scale HIV prevention, the more difficult the task will be.

Comprehensive HIV prevention is no small task, and it cannot fall to the Ministry of Health alone, much less to NGOs. Successfully reducing the risk associated with the sex industry and with drug taking requires the active cooperation of many different groups. Government bodies in the health sector may take the lead, but they will need 1) the support of government bodies working in drug interdiction and the justice system; 2) the support of communities engaging in risk behaviors and the organizations that represent them; and 3) the support of the educational and business sectors, the police force and religious leaders.

Strong political leadership and quick action will help Georgia take advantage of an opportunity to become one of the few success stories in HIV prevention.

## *Acknowledgements*

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The work presented here is the contribution of many people. Large numbers of people have been involved at different stages of data collection over the years. We have had policy makers, people from the community, researchers, NGO workers, academics, private sector, all involved in this data collection. The Infectious Diseases, AIDS and Clinical Immunology Research Center has been the focal point of HIV/AIDS data collection in Georgia. This work was done in collaboration with many partners – NGOs, government clinics, private organizations, PVOs and they include: Research Institute on Addiction, Bemoni Public Union, Tanadgoma, Save the Children, the Healthy Cabinet, and Institute for Polling and Marketing.



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