Minutes of the 77th CCM Meeting
March 6, 2015

Ministry of Labor, Health and Social Affairs of Georgia

Participants:

	CCM Members	
1	**David Sergeenko**	Minister of Labor, Health and Social Affairs of Georgia CCM Chair Sector represented: Public; GOV
2	**Nino Kochishvili**	On behalf of **Janos Herman,** Ambassador, Head of EU Delegation to Georgia Sector represented: Public; ML/BL
3	**Zurab Vadachkoria**	Rector of Tbilisi State Medical University Sector represented: Public, EDU
4	**Tengiz Tsertsvadze**	Infectious Diseases, AIDS and Clinical Immunology Research Center General Director Sector represented: Public, EDU
5	**Khatuna Todadze**	Center for Mental Health and Prevention of Addiction, GFATM funded methadone substitution therapy program, Director Sector represented: Public, EDU
6	**Zaza Avaliani**	National Center of Tuberculosis and Lung Diseases Director Sector represented: Public, GOV
7	**Tamar Sirbiladze**	USAID/Caucasus USAID, Health and Social Development Office, Director Sector Represented: Public, ML/BL
8	**Lasha Tvaliashvili**	Real People-Real Vision

		Executive Director Sector represented: Non-public, NGO KAP, a representative of Prevention Task Force (PTF, big forum of NGOs active in HIV field)
9	**Giorgi Soselia**	On behalf of Konstantine Labartkava, New Vector, Board Chairman Sector represented: Non-public, NGO KAP, a representative of Prevention Task Force (PTF, big forum of NGOs active in HIV field)
10	**David Mikheil Shubladze**	LGBT Georgia Executive Director Sector represented: Non-public, NGO KAP, a representative of Prevention Task Force (PTF, big forum of NGOs active in HIV field)
11	**Rusudan Klimiashvili**	WHO Georgia, Head of Country Office Sector represented: Non-public, ML/BL
12	**Tamar Gabunia**	URC LLC USAID funded Georgia Tuberculosis Prevention Project Chief of Party, CCM Vice-Chair Sector represented: Non-public, NGO
13	**Salome Bakuradze**	On behalf of **Elguja Meladze** - Employers' Association of Georgia, President Sector represented: Non-public, PS
14	**David Ananiashvili**	NGO "Georgian Plus Group" Director Sector represented: Non-Public, PLWD
15	**Tamar Natriashvili**	Former TB Patient Sector represented: Non-public, PLWD

16	**Izoleta Bodokia**	NGO "HIV/AIDS Patients Support Foundation" Sector represented: Non-public, NGO, KAP
17	**Mariam Velijanashvili**	Georgian National Association for Palliative Care, Secretary General Sector represented: Non-public, NGO
18	**Tamaz Marsagishvili**	Deputy Minister of Education and Science Sector represented: Public, Gov
19	**Tornike Khonelidze**	On behalf of **Ketevan Tsikhelashvili,** First Deputy State Minister of Georgia for Reconciliation and Civic Equality Sector represented: Public, Gov
20	**Amiran Gamkrelidze**	NCDC&PH, General Director Sector represented: Public, Gov
21	**Lela Bakradze**	UNFPA, Assistant Representative Sector represented: Non-public, ML/BL
	Secretariat	
22	**Irina Grdzelidze**	Executive Secretary
23	**Natia Khonelidze**	Administrative Assistant
	Guests/Observers	
24	**Valeri Kvaratskhelia**	MoLHSA, Deputy Minister
25	**Irma Khonelidze**	NCDC, PIU, Projects director
26	**Irakli Katsitadze**	LFA, team leader
27	**Vyacheslav Kushakov**	FEI Expert
28	**Katerina Boyko**	FEI Expert
29	**Jeffrey Lazarus**	WHO, Expert
30	**Anders Sonneborg**	WHO, Expert
31	**Emilis Subata**	WHO, Expert
32	**Hernan Fuenzalida**	WHO, Expert

33	**Mariam Maglakelidze**	WHO mission assistant
34	**Nino Tsereteli**	NGO, Tanadgoma, Executive Director, HIV WG
35	**Tamar Germanishvili**	Georgian Harm Reduction Network Executive Director Sector represented: Non-public, NGO KAP, a representative of Prevention Task Force (PTF, big forum of NGOs active in HIV field)
36	**Maya Tsereteli**	NCDC, Head of HIV/AIDS, TB, Hepatitis and STI Division, HIV WG
37	**Natalia Zakareishvili**	UNFPA, National Programme Officer/HIV
38	**Mzia Tabatadze**	NGO, "Alternative Georgia"
39	**Nino Mamulashvili**	WHO, Program Coordinator
40	**Tamta Demurishvili**	Ministry of Corrections of Georgia, head of Healthcare Department
41	**Maka Gogia**	NGO GHRN, programs director

Agenda

13:00 – 13:10	**Opening speech /remarks** **Mr. David Sergeenko - CCM Chair, Minister of Labor, Health and Social Affairs of Georgia**
13:10 – 13:15	**Addressing the members with the request to declare the presence of the Conflict of Interest**
13:15- 13:45	**WHO mission on evaluation of HIV program review/ preliminary feedback Discussion** WHO experts **Mr. Jeffrey Lazarus**, Public Health expert, WHO CC on HIV and Viral Hepatitis, Denmark **Mr. Anders Sonneborg**, professor, clinical expert, Karolinska Instiutute, Sweden **Mr. Emilis Subata**, Harm Reduction Expert, WHO CC on Harm Reduction, Lithuania **Mr. Hernan Fuenzalida**, Health System Strengthening Expert, an independent consultant

13:45 – 13:50	**The issue of CCM membership of Mr. Archil Talakvadze, Deputy Minister of Internal Affairs**
13:50 – 14:10	**Introduction of HIV/AIDS NSP** **Mr. Vyacheslav Kushakov – FEI expert, International HIV/AIDS Alliance, Team Leader**
14:10 – 14:20	**Discussion/Agreement on HIV NSP**
14:20-14:35	**Global Fund Projects implementation status** **Ms. Irma Khonelidze** - NCDCPH, GFATM Project Director
14:35-15:00	**Report on the OC activities** **Level of compliance of existing GF grants Principal Recipient with Minimum Criteria** **David Ananiashvili- OC Chair**
15:00-15:10	**Discussion**
15:10-15:15	**Final agreement on PR selection/nomination**
15:15 – 15:55	**Secret ballot** **Counting of votes/ announcement and discussion of the results**
15:55 – 16:00	**AOB/announcements**

David Sergeenko – greeted the participants and thanked them for coming. The Chairperson addressed the members with the request to declare the presence of the Conflict of Interest (CoI) and filled out the Conflict of Interest declaration forms.

Comment: Presented at the meeting SR/SSRs, PR and a representative of the MoLHSA declared the presence of the CoI in connection with the PR selection/nomination. The filled out CoI forms are kept in the CCM Office.

David Sergeenko – briefly overviewed an agenda and gave the floor to the WHO experts for presenting preliminary feedback on evaluation of HIV program review.

Jeffrey Lazarus – presented the objectives of the mission (presentation attached). The following aspects were brought to the attention of the audience: HIV epidemiological data; concentration of HIV among key populations; reducing late HIV diagnosis was identified as a top priority; special emphasis was given to need for scaling up HIV testing. The following recommendations in connection of scaling up of testing were outlined: Develop more effective strategies for identifying the undiagnosed population and decrease proportion of late testers; Testing rates need to be improved, particularly at all TB and STI clinics (make it a universal offer, never obligatory); Continue and increase targeted testing of MARPs through community testing using friendly non-judging mobile teams and peer outreach workers; Consider how the coming scale up of HCV testing ; can benefit HIV testing, so-called tandem testing; The AIDS Centre should remain in its key role as the technical normative and clinical referral point for HIV and AIDS, e.g confirmatory HIV testing; Additionally, the AIDS Centre has a key role in the implementation of the NSP with healthcare staff training including family doctors and TB screeners.

Anders Sonneborg – presented to the audience the aspects of the Antiretroviral Therapy. He positively assessed the treatment care cascade especially 80% rate of viral suppression and other significant progress made. Mr. Sonneborg stated that most of the patients need ART at diagnosis and the estimated country need will increase substantially up to 2018 (n= 4095) compared to 2014 (n= 2204). The following recommendations were presented: Continue and establish firmly the cost-effective public health approach to use of ART; Optimaze the number of clinical visits to the AIDS Centre; Develop a comprehensive plan for ensuring healthcare capacity and ARV drugs for the PLHIV that remain undiagnosed; Improve the clinical management of TB/HIV co-infected patients, particularly outside of the capital.

Emilis Subata – outlined important aspects of PWID and Harm Reduction. Mr. Subata highly emphasized the significant developments in the Needle and syringe programmes, and HIV testing among PWID. Albeit there are some areas of concerns that need addressing. Accordingly the following recommendations to MoLHSA were presented: To develop and adopt legal acts on the prevention of HIV services among PWID which will define minimal standards of services including service package, requirements for staff, reporting, etc. to move these interventions to fully legal services for injecting drug users; To involve governmental medical institutions in service provision (e.g. stationery services); To develop a mechanism in the existing legal framework which would allow for funding from the governmental sources to NGOs for HIV

prevention services among PWID. Afterwards Mr. Subata presented the achievements and concerns in the sphere of OST services. The following recommendations were outlined: To increase OST coverage (to at least 4000 by 2018), improve geographical access; To make OST more attractive in the civil sector by: making OST in line with WHO Guidelines on OST (2009) – this may cause the need to review the existing legal acts; To offer both options of OST (maintenance & reduction) for inmates in penitentiary institutions (according WHO Guidelines on OST, 2009)

Hernan Fuenzalida – presented the current Health Care Situation. Mr. Fuenzalida stressed that Privatization of healthcare providers (95%) has weakened MoLHSA sector leadership & governance. Thus there is an imperative need to define a strong role for the public sector protecting public health and rights, care and safety of HIV and AIDS patients through funding and access to services. The following recommendations were outlined: Joint MOLHSA and NCDC effort for the definition of an HIV/Health System Action Plan in the context of the NSP and for the GF Concept Note, including role of the State and private sector in counseling, diagnostics and treatment (already in NSP 2011-2016), requiring STI providers to service PLHIV, role of laboratories, and the like; Develop and implement a national M&E framework to improve forecasting on a rolling basis. The latter is also included in the current NSP. Speaking of the financing Mr. Fuenzalida stressed that the necessity to ensure future financial sustainability of the state expenditure for medical services supported financially by international donor organizations specified as an important challenge for the healthcare system of the country by Governmental Ordinance # 724 of Dec, 2014. Based on afore-mentioned the following recommendations derived: include HIV in State Universal Health Care Programme for financial protection in access and coverage of services; Ensure budget allocations to the AIDS Centre beyond 2018 to maintain the level of treatment and other services; include performance based payments for PHC level counseling, testing and referrals. While speaking of the inter-institutional coordination in was recommended under leadership of the MoLHSA-NCDC and AIDS Center to strengthen the formal mechanisms of coordination with the following institutions: Ministry of Finance (budget allocations); Social Health Insurance (HIV and TB in package of services and financial protection); Ministry of Education and Science (sex education in schools and universities); Ministry of Interior/Police/Ministry of Justice (drug policy and training of law enforcement); Ministry of Corrections (HIV services in prisons).

Jeffrey Lazarus – brought the attention of the audience to some cross-cutting issues. Mr. Lazarus stressed the importance of ensuring human rights and combatting stigma. The following recommendations were presented: Need for national general population education (anti-stigma) campaign; Greater awareness training of health workforce, create "friendly non-judging champions" towards PLHIV, MSM, PWID and SW; Government leadership from all sectors is needed to ensure a truly enabling environment. Afterwards, Mr. Lazarus focused on draft HIV NSP and stated that the initial comments were already provided to the team during the meeting with NIV NSP WG on March 5. The main recommendations were structured around the following: To make NSP concise. Reduce the descriptive overview, organize the key discussion points around the care cascade; Set a hierarchy of priorities focusing on increased detection and prevention for key populations; Clearly delineate between the NSP and operational/action issues

so the strategic vision is clear. Mr. Lazarus identified the following issues to be further discussed: Inclusion of youth/adolescent friendly services into PHC; Increase capacity building of social workers in relation to HIV and AIDS outreach; Action plan to sensitize providers for counseling, testing, and referrals to HIV Centre; Confidentially guidelines revised and implemented to ensure anonymity incl with other sectors; Thorough review of legislative/regulatory framework to improve harmonization and implementation.

The rapporteur underlined that the presented afore is only preliminary feedback and furher discussion and work will be continued. The final report will follow within the shortest possible period of time taking into consideration the tight timelines.

The WHO experts expressed their gratitude to country stakeholders for support of the mission.

David Sergeenko – thanked the WHO experts for the presentation and for important recommendations and opened the floor for discussion.

Khatunda Todadze – addressed Mr. Subata with the request to share with the audience WHO view on duration of the OST treatment

Emilis Subata – responded that the duration is based on individual needs and can substantially vary. The patients infected with HIV and other infectious diseases may require longer treatment. Thus sometimes in can be life-time treatment. The main strategy is not to focus on medication alone but provide concomitant interventions, such as pcysho-sociological support, change of behavior, integration into the society which will allow shorten the duration. The average duration recommended is 2,3,4 years. Quick end of treatment will result in relapse in 90% of cases.

Irma Khonelidze – addressed Mr. Subata with the question regarding final set of the targets and the mechanisms for making OST services more attractive for the beneficiaries.

Emilis Subata – focused on service delivery mode and the possible mechanisms for making them friendlier for beneficiaries; The possibility of taking methadone home was highlighted. This practice applied in all EU Countries. The rapporteur stressed the seriousness of this issue taking into account possible diversions. The regulations that do not allow this possibility interfere with social integration.

Tengiz Tsertsvadze – thanked WHO experts for excellent presentation and making such a comprehensive analysis during such short period of time. Prof. Tsertsvadze underlined two issues that one more time was revealed: high standards of care and treatment and problem existing in the field of testing and coverage of high risk groups and other prevention activities. He addressed the Minister, CCM, members of HIV Working Group with the request to endeavor to preserve the achievements and properly address the mentioned bottlenecks. Prof. Tsertsvadze expressed his hope that anticipated Hepatitis C elimination program will be very successful and mentioned possible linkages between HIV/AIDS response and the mentioned program.

Amiran Gamkrelidze – thanked WHO experts for excellent work. Prof. Gamkrelidze underlined the importance of the mission especially in terms of preparation of new NSP and CN. He agreed with the presented initial recommendations that one more time revealed the strength

of clinical management and treatment. Mentioned late diagnosis is directly linked with lack of prevention activities. Prof. Gamkrelidze underlined the weakness in the coverage of STIs as mentioned represent the big high risk group. The rapporteur underlined the importance of planned Hepatitis C elimination program that is the matter of high political commitment and support and expressed his hope that with launching of the program the coverage of high risk groups will be increased. Prof. Gamkrelidze emphasized the importance of the recommendations concerning Health System Strengthening especially in the primary health care level. Finally, he thanked the WHO experts one more time and expressed his hope that draft recommendations will be issued very soon which is very important in terms of tight timeline of NSP and CN development.

David Sergeenko – thanked WHO experts. The Chairperson put the issue of CCM membership of Mr. Archil Talakvadze, Deputy Minister of Internal Affairs to the vote. He extended to the audience his apologies for not being able to attend the meeting and his readiness to continue serving as CCM member in the new capacity of the Deputy Minister of Internal Affairs.

Mr. Archil Talakvadze, Deputy Minister of Internal Affairs was unanimously elected as CCM member.

David Sergeenko – gave the floor to Mr. Vyacheslav Kushakov.

Vyacheslav Kushakov – presented to the audience near to final version of the HIV NSP (the presentation attached). He thanked the WHO experts for initial recommendations and all parties engaged in the process. Mr. Kushakov presented to the audience ***strategic priorities*** noting that increased coverage with quality preventive interventions will be mostly targeting PWID and MSM. Improved treatment outcomes for IDUs was highlighted. The definition of ***overarching goal*** was presented as follows: "Turn the HIV epidemic in Georgia in the reversal phase through strengthened interventions targeting key affected populations (KAP), and significant improvement in health outcomes for PLHIV." Mr. Kushakov highlighted the factors of sustainability that are crucial for the program. The slightly revised (based on the consultations with country stakeholders) formulations of the ***strategic objectives*** were presented; Afterwards, Mr. Kushakov outlined strategic priorities under each strategic objective. He mentioned that in line the WHO recommendations the special paragraphs that preceded description of priority areas that set overall priority focus for each objective were included. Afterwards, Mr. Kushakov outlined the details of the most important areas of development. The rapporteur described the HIV prevention and detection among PWID. He explained that Strengthened communication protocols relate to all key populations; Special emphasis was given to more effective detection of HIV at primary outreach. The OST program was brought to the attention of the audience and explained in details. Current program capacity and targets were discussed. It is planned to increase current programme capacity and to decrease rotation rate. The steps for improved uptake and retention in OST were outlined. While speaking of Better collaboration with local law enforcement Mr. Kushakov emphasized the admittance to the CCM member of Deputy Minister of Internal Affairs. While speaking of conceptualization of OST approach the rapporteur stressed that OST is considered not only to be drug treatment strategy but also HIV

prevention strategy and a mechanism that helps people with history of drug use to access ART. The following benefits of substitution therapy were stressed: Reduced opioid use; reduced HIV risk behaviour and transmission; reduced criminal activity; reduced overdose and mortality; improved retention in treatment. The following aspects have big importance for successful implementation of OST: Accessibility; affordability; no dosage and duration restrictions (linked with disengagement in criminal activities); access to psychosocial support (effective collaboration of clinics with NGOs has a big importance). Afterwards, the rapporteur presented Implementation Approach & Assumptions for MSMs and SW. He noted that Greater involvement of community-based organisations is considered to be an effective tool for increased coverage. The creation of several new service delivery units run by CBOs is planned. While speaking of ART Mr. Kushakov one more time underlined significant achievements. The on-going rationalisation/optimisation of treatment schemes will bring significant savings in the treatment costs for 2016-2018; thus increase for funding for ART is relatively modest. The rapporteur presented Detection and treatment scale-up and the rationale for estimates. The figures are very close to AIDS Center's projections. Then the rapporteur focused on case management and stated that the key issue is to ensure linkage between that case management performed by the organizations working in outreach and case management performed by the clinicians, and engagement of organizations that provide peer support to the people living with HIV. The progression of patients from detection of HIV in the community to clinical settings and also to community based settings is planned. Mr. Kushakov highlighted that there is a specific target for the people who inject drugs. In the monitoring framework the particular indicator for this segment is inserted.

The rapporteur presented objective 3 in details, giving special focus to policy development that is linked to specific programmatic tasks. The tasks were presented. The greater involvement of Civil Society was underlined. Impact, Outcomes and Coverage targets were presented. The rapporteur brought to the attention of the audience coverage by essential prevention and testing; Treatment coverage targets. Finally, Mr Kushakov outlined funding prognosis in terms of gradual transition from donors' to governmental support and envisaged government's increased allocation. Funding dynamics for the year 2010-2018 and the graphics illustrating required funding by source and by interventions were presented.

David Sergeenko – thanked Mr. Kushakov and highlighted the importance of keeping the achievements and to try to improve the effectiveness of the program. The Chairperson opened the floor for discussion.

Amiran Gamkrelidze - thanked Mr. Kushakov and raised the following issues: Taking into account the importance of the finding issues especially in terms of transition to governmental support to continue consultations with relevant stakeholders (e.g MoLHSA) for more comprehensive review of all details and further detalization; The structure of the NSP versus its content needs further revision. It should be reshaped and make more appropriate for strategy document. At the end he reiterated the urgency of the work to be done taking into account tight timelines for submission of the HIV CN.

Vyasheslav Kushakov – thanked Mr. Gamkrelidze for remarks. He stated that the work undertaken for development of the NSP will be very helpful for CN development. From now on the work on CN and finalization/polishing of the NSP will be done in parallel.

The audience agreed with the main content of the NSP. It was decided that the work on finalization of the details and restructuring of the Strategy document will be continued. The HIV National Strategy will be submitted electronically to the CCM for final review and endorsement by the end of March.

David Sergeenko – gave the floor to Ms. Irma Khonelidze.

Irma Khonelidze – stated that the project implementation is happening without obstacles. Several important deadlines for submission to the GFATM the reports were observed. Currently the auditor company KPMG is undertaking programs audit. The details of the program will be presented in the dashboard diagram in one week and presented to the CCM.

Tamar Gabunia – raise the issue of budget split between TB and HIV programs. The Vice-Chair one more time presented the content of allocation letter received in March, 2014. Ms. Gabunia outline four main factors to be taken into consideration: willingness to pay; existing funding; absorptive capacity; cross-cutting health system strengthening. While speaking of health system strengthening component she noted that afore-mentioned may be addressed through TB CN. The Vice-Chair noted that existing financial analysis of TB and HIV programs will base as a ground for making a final decision. She underlined the importance for coming up with the final decision before HIV CN submission.

The audience discussed possible scenarios. Based on initial analyses of existing funding, absorptive capacity, willingness to pay, and cross-cutting health system strengthening a standpoint is to have the 60% of total allocation devoted to HIV and 40% to TB. The discussions leading to final decision will be continued within working groups.

The CCM discussed and agreed on appropriateness on sharing with the GFATM draft CNs. The approximate date for submission of the HIV CN was defined as of March 26 (will be further discussed). The date of the submission of TB CN will be defined later on after additional consultations with the TB WG.

In response to the GFATM offer the video-conference to discuss the CN development /country dialogue processes has been planned. The video-conference will be held in the format of the joint meeting of HIV and TB WGs and CCM members. The Secretariat will collect the questions from the participants by March 10 and will submit them to the GFATM prior to the video-conference. The precise date of the conference will be defined later on (preferably to be held no later than in the week of March 16).

Tamar Gabunia – gave the floor to Mr. **David Ananiashvili**

David Ananiashvili – presented to the audience the work undertaken by the Oversight Committee covering the period December 2014 – February 2015 (presentation attached). He presented to the audience the main objectives, conclusions and outcomes of the site visits to the TB Center, AIDS Center and HIV/AIDS Patients support foundation on December 25, December 26 and February 18 respectively. He briefly outlined the meetings the OC has participated during

the mentioned period. Dashboard for HIV and TB P3 will follow shortly. Apart from the site visits the daily work and frequent meeting with various organizations is taking place.

Tamar Gabunia – one more time presented to the audience the procedures agreed with the CCM on PR nomination/Selection. As per decision of the 76th CCM meeting the review of the compliance of the PR with the minimum criteria was done by the CCM Secretariat, Vice-Chair and the members of OC without CoI. The meeting dedicated to the defining the level of compliance was conducted on February 11, 2015. The attendees agreed that the current PR complies with the requirements for the GF grants Implementers. The conclusion of the meeting was agreed with the OC members without OC and notified to all CCM on March 3, 2015. Afterwards, the Vice-Chair gave the floor to Mr. David Ananiashvili to present to the audience the level of compliance of existing GF grants Principal Recipient with Minimum Criteria. The Vice-Chair noted that all members can attend the presentation. The PR will have the opportunity to answer any questions that may arise during the presentation.

David Ananiashvili – presented to the audience the review of the Compliance of the GF Grants principle Recipient with Minimum criteria (presentation attached). At the beginning the rapporteur presented GFATM requirements on PR Selection process under the New Funding Model. The decision to be made by the CCM is either to nominate the current PR or select a new PR. In case the the CCM members decide to initiate a new selection process for another PR, then the CCM will need to initiate a proper PR selection process. Mr Ananiashvili thoroughly discussed each minimum criteria presented by comparing with the performance status. Namely:

C1: Management structure and planning. PR Demonstrates effective management structure and planning (technical and procurement staff, organizational leadership).

The PR has sufficient number of skilled and experienced staff to manage the program

Compliance: For TB Grant out of 11 planned management positions 11 have been appointed (period P2); For HIV Grant out of planned 16 management positions 15 have been appointed from the beginning of the project. Due to an employee turnover selection is in place for one position.(Source: P2 Dashboards, job announcement on jobs.ge posted on February 7th , 2015).

Comment: it was noted by Mr Ananiashvili that selection process is in progress and will be completed early April.

PR shows effective organizational leadership, with a transparent decision making process

Compliance: Sub recipients are been selected through open competition process that is documented and transparent. PR regularly reports on key implementation development. CCM GA minutes and oversight committee meeting minutes clearly indicate transparency in PR decision making and effective organizational leadership (Source: CCM and OC meeting minutes)

Staff of key functions at the PR has relevant technical knowledge & health expertise for HIV/AIDS and tuberculosis

Procurement staff has relevant experience for procurement; warehouse staff is sufficient in number, and have appropriate skills to manage storage of health products.

Compliance: Staff was selected through open competitive selection process. After the first call the announcement was made repeatedly to attract highly qualified professionals (Source: CVs and Selection report)

C2: Program Oversight. The PR has the capacity and systems for effective management and oversight of sub-recipients (and SSRs)

PR exercises sufficient oversight over sub-recipients to safeguard both financial and physical assets

Compliance: PR has developed operations manual including procedures in respect of Financial management, Sub-recipient management (selection and contracting, reporting requirements, procedures for verification of sub-recipients financial and programmatic data, frequency and scope of monitoring visits, SR's audit arrangements-OM has been submitted to the GF on August 14th 2014

PR has the ability to provide or contract for capacity-building to ensure timely and quality program implementation

Compliance: PR regularly conducts workshops for SRs on the operational issues related to all aspects of implementation including logistics, financial, and data management. In addition, in collaboration with the USAID HICD plus project PR conducted specific training for SRs on Procurement and Supply Management (PSM) and logistics in October 2014. PR also effectively leverages external resources to build technical capacity of SRs (e.g. collaboration with the USAID TB Prevention).

C3.1.: Finance: The internal control system of the PR is effective to prevent and detect misuse or fraud

PR has an accounting system in place that can correctly and promptly record all transactions and balances making clear reference to the budget and work plan of the grant agreement

Compliance: The operational manual including details of the accounting and finance organizational structure of NCDC, all adequate policies and procedures to guide activities in financial management and accounting has been submitted to the GF on August 14th, 2014

The internal control system supports compliance effectively with the related grant agreement

Compliance: Based on the management letter as of December 16th 2014 there are no issues related to deficiencies related to internal control systems

External auditors and other third-party assurance providers are selected and assigned duties in accordance with Global Fund guidelines.

Compliance: PR has selected an external auditor and signed a contract with the provider on February 9th, 2015. (Source: a contract)

C3.2. Finance: The financial management system of the PR is effective and accurate

PR has an accounting system in place that can correctly and promptly record all transactions and balances making clear reference to the budget and work plan of the grant agreement.

Compliance: GF provided LFA assessment of at that time potential PR in late 2013. During the assessment the PRs' accounting system was evaluated. Compliance with the outstanding recommendations was conditionality for signing the grant. The TB and HIV grant agreement were signed in March and April 2014 respectively

PR manages all transactions and transfers to suppliers and sub-recipients in a transparent manner to safeguard financial and physical assets

Compliance: GF provided LFA assessment of at that time potential PR in late 2013. During the assessment the PRs' accounting system was evaluated. Compliance with the outstanding recommendations was conditionality for signing the grant. The TB and HIV grant agreement were signed in March and April 2014 respectively.

The PR monitors actual spending in comparison to budgets and work plan and investigates variances and takes prompt action

Compliance: In order to avoid frequent budget modifications, GF requires the PR to treat the approved budget as a plan and do not change it on an ongoing basis. Any variance between the originally approved and actual budgets will be reported as part of the Extended Financial Report (EFR). The EFR that is being currently prepared (to be submitted to GF by February 28, 2015) includes all such variances. In future, the reprogramming requests will be submitted for approval to GF fund prior to re-allocation of funds.

C4.1. PSM: Central warehousing and regional warehouses have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products

The storage capacity is appropriate in condition (including ventilation), equipment, and size for the type and quantity of products to be stored.

Compliance: Standard Operating Procedures (SOPs) were developed for receipt and storage for all levels-prior to grant signing

There is sufficient trained staff at central and regional level to manage stock

Compliance: There are five of staff at PR responsible for stock management

The facilities are properly secured against theft and damages.

Compliance: SOPs were developed for receipt and storage for all levels.

The facilities are equipped with a temperature monitoring and controlling mechanism

Compliance: SOPs were developed for receipt and storage for all levels

C.4.2. PSM: The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions

There is a distribution plan for supplies, dispatches and transportation

Compliance: Distribution plan for supplies, dispatches and transportation has been developed and is in use

The security measures for transportation are defined and the equipment and transportation conditions are adequate.

Compliance: Standard Operating Procedures (SOPs) for receipt and storage for all levels were developed

There is sufficient trained staff to manage distribution and delivery activities

Compliance: Five of staff are responsible for distribution management and delivery activities

There is a logistics-management information system (LMIS) with requisition and stock-reporting tools in place to anticipate and minimize risk of stock-outs (incl. accurate forecasting and timely ordering).

Compliance: The MIS has been finalized with USAID HSSP support and is fully functional. PR plans to extend the system to SRs.

The operations manual for procurement and supply management as well as Standard Operating Procedures (SOPs) for PSM for PR and SRs were approved by the GF on 30 June and 2 July 2014.

C4.3.PSM: Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain

There is qualified staff to manage/oversee quality assurance activities.

Compliance: There is a dedicated staff member within the PSM team responsible for quality oversight and assurance activities

There is a plan for quality monitoring activities throughout the in-country supply chain, including quality control.

Compliance: The plan for quality assurance and quality controls were submitted and approved by GF on July 11th, 2014

The World Health Organization "Model Quality Assurance System for Procurement Agencies (MQAS)" serves as guidance.

Compliance: SOP for "Procurement and Supply Management" was developed based on the GF Quality Assurance Policies which itself refers to "MQAS". PR follows SOP that includes applicable laws and regulations of the PSM SOP

The entity has Standard Operating Procedures (SOPs) for key processes in place and revises the SOPs when necessary.

Compliance: The operations manual for procurement and supply management as well as Standard Operating Procedures for PSM for PR and SRs were approved by the GF on 30 June and 2 July 2014

C5.1:M&E: Data-collection capacity and tools are in place to monitor program performance

The monitoring and evaluation (M&E) system defines relevant indicators for routine monitoring of activities/interventions that are aligned to the goals and objectives of the program in question.

Compliance: The PR organized the National Monitoring and Evaluation System Strengthening (MESS) workshops for TB and HIV grants in June 2014. As a result PR and SRs completed self-assessment tools and produced costed action plans to address M&E gaps in TB and HIV programs

Adequate mechanism and tools are in place to report accurate and quality assessed data from the sub-sub-recipient / sub-recipient to the PR level

Compliance: The PR developed detailed M&E plans for TB and HIV and corresponding M&E guidelines to be used by SRs and SSRs.

Program Reviews are planned during the implementation period and National program reviews are conducted with involvement of partners on a regular basis

Compliance: WHO TB program review conducted in November 2014. WHO HIV Program (treatment component) review in 2014

C5.2.M&E: A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately

The routine reporting system/ Health Management and Information System (HMIS) for facilities involved in TB and HIV program implementation has a coverage of at least 50 percent, and there is a costed plan to improve coverage to 80 percent.

Compliance: The routine reporting system for both TB and HIV covers almost 100% of health facilities. All participating facilities are covered with electronic health management information system developed in the country.

The relevant HIV and TB indicators have clear definitions, and are coded in the HMIS.

Compliance: Reflected in the performance framework approved by the GF

The routine reporting system / HMIS has a data-assurance mechanism in place that annually verifies data

Compliance: PR conducts regular monitoring activities in the HIV and TB project sites to produce corresponding reports and to share those with the GF, LFA, PR representatives, and with the CCM members.

The members did not have any additional questions with regard to the review and no objections with the level of compliance of the PR presented

Tamar Gabunia – summarized the presentation and specified the main sources of the review: The GF Management Letters as of December 16 2014; GF Feedback to NCDC provided in December 2013; Review of the progress made in accomplishing time bound actions and meeting condition precedents identified in December 2013 concerning PR's capacity and systems for effective SR management. After the thorough review of the material the group concluded that PR is compliant with the GFATM requirements for grant implementers. The Vice-Chair addressed the Secretariat with the request to present voting procedures.

Irina Grdzelidze – presented the procedure of the voting.

Description of the procedure.

Out of 25 CCM members 22 members were presented at the meeting. Thus the quorum (two/third) was observed. The following members declared the presence of the CoI and did not participate in the voting.

David Sergeenko – in his capacity of the Minister of Labor, Health and Social Affairs; **Tengiz Tsertsvadze** - Infectious Diseases, AIDS and Clinical Immunology Research Center, General Director, as SR of HIV grant; **Khatuna Todadze** - Center for Mental Health and Prevention of Addiction, GFATM funded methadone substitution therapy program, Director; as SR for HIV grant; **Zaza Avaliani** – National Center of Tuberculosis and Lung Diseases, Director; as SR for TB grant; **Lasha Tvaliashvili** – Real People-Real Vision, as potential SR for HIV grant; **Giorgi Soselia** – New Vector; as SR for HIV grant; **David Mikheil Shubladze** – LGBT Georgia, Executive Director; as potential SR for HIV grant; **Izoleta Bodokia** – HIV/AIDS Patients Support Foundation, Director; as SR for HIV grant; **Mariam Velijanashvili** - Georgian National Association for Palliative Care, Secretary General; as SR for HIV grant; **Amiran Gamkrelidze** – NCDCPH, General Director, as PR for HIV grants

Out of 15 members with voting rights 11 were presented at the meeting. The voting was done through secret ballot. The participants of the voting were handed the envelopes with bulletin. The bulletin attached as an example. The participants of the voting signed the ballot registration form (attached). They have put the filled out bulletins into the envelopes and sealed. The sealed envelopes were collected by the Secretariat and votes were calculated. The counting revealed that all 11 members participating in the ballot voted for nomination of the current PR, National Center of Disease Control and Public Health as a Principal Recipient of the GFATM HIV/AIDS and TB grants under NFM. The signed form of the results of voting attached. The LFA team leader has watched the process as an observer. The filled out bulletins are kept in the CCM office.

Irina Grdzelidze – announced the results of the voting

Comment: as per decision of the 76th CCM meeting the NCDCPH was notified by a letter on the results of the voting (the letter and English translation of the letter attached)

Tamar Gabunia – thanked the attendees and announced the meeting as closed.

Decisions:

1. **The comments made at the meeting, WHO experts' preliminary feedback on HIV/AIDS National Strategic Plan and further comments will be discussed at the meetings of the WGs The final version will be agreed with the CCM and presented to GoG for endorsement. In parallel the extensive work on HIV CN development will start.**
2. **To admit to CCM membership Mr. Archil Talakvadze, Deputy Minister of internal Affairs of Georgia**
3. **To continue discussion on HIV and TB programs split.**
4. **To share with the GFATM a draft HIV CN**
5. **To nominate the current PR, National Center of Disease Control and Public Health as a Principal Recipient of the GFATM HIV/AIDS and TB grants under NFM.**

David Sergeenko

Chairperson

Natia Khonelidze

N. Khonelidze

Administrative Assistant

Annexes:

Annex 1

HIV programme review in Georgia. WHO country mission, March 2015 (presentation)

Annex 2

Presentation of THE REVISED NATIONAL STRATEGIC PLAN ON HIV

Annex 3

Report of Oversight Committee

Annex 4

Presentation of the Compliance of the GF grants Principle recipient with minimum criteria

Annex 5

PR selection/nomination bulletin

Annex 6

Bulletin receipt registration form

Annex 7

Results of the secret ballot

Annex 8

Letter to Mr. Gamkrelidze

Annex 9

English translation of the letter to Mr. Gamkrelidze

HIV programme review in Georgia
WHO country mission, March 2015

Jeffrey Lazarus, WHO Collaborating Centre on HIV and Viral Hepatitis
Hernan Fuenzalida, The World Progress Center, WHO consultant
Anders Sönnerborg, Karolinska Institute, Sweden
Emilis Subata, WHO Collaborating Centre on Harm Reduction, Lithuania

chip

WHO Collaborating Centre on HIV and Viral Hepatitis

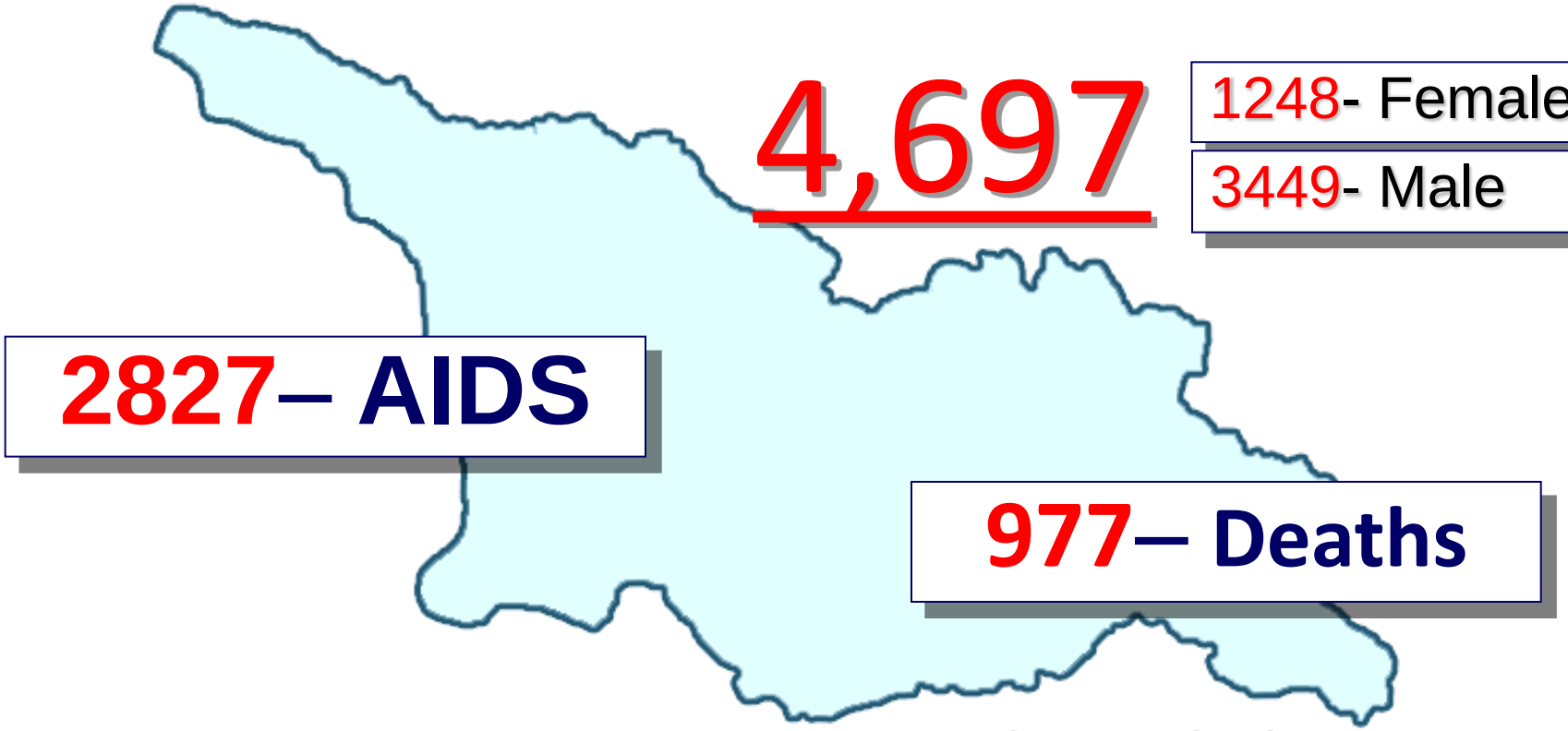
Objectives of mission

Programme review:

- HIV treatment and care along cascade of services
- HIV services for key populations
- Service delivery models for populations affected by the HIV epidemic from the perspective of the health system

+ Review of the National Strategic Plan (NSP) on HIV to be done as soon as the final draft is ready (might not be linked to the dates of the country mission).

All reported cases of HIV and AIDS in Georgia: 2014



Estimated number ≈ 6,400

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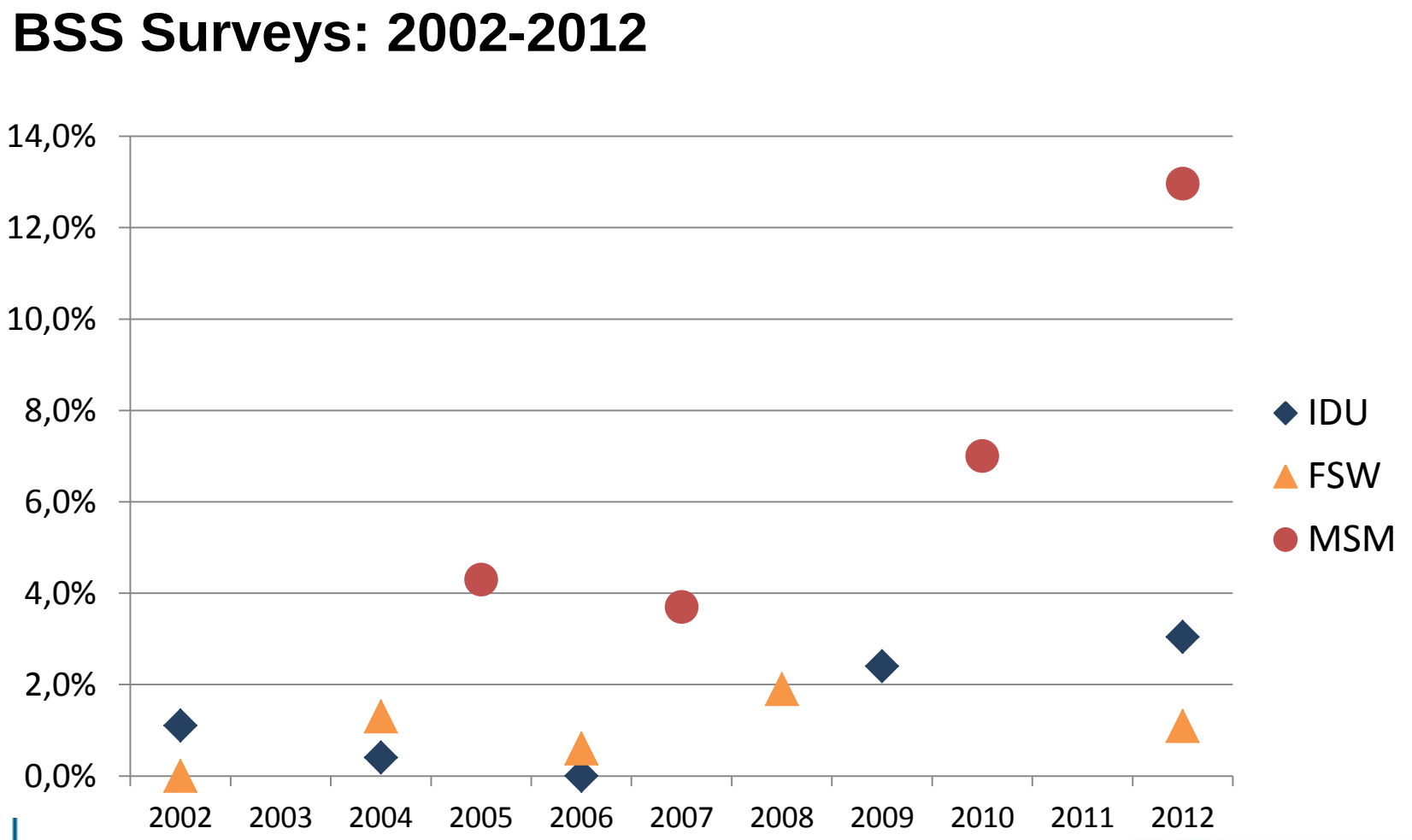
HIV prevalence *is* in key populations



Georgia Country reports for UNGASS and Global AIDS Progress Reporting: 2006-2014

Undiagnosed population and scaling up testing

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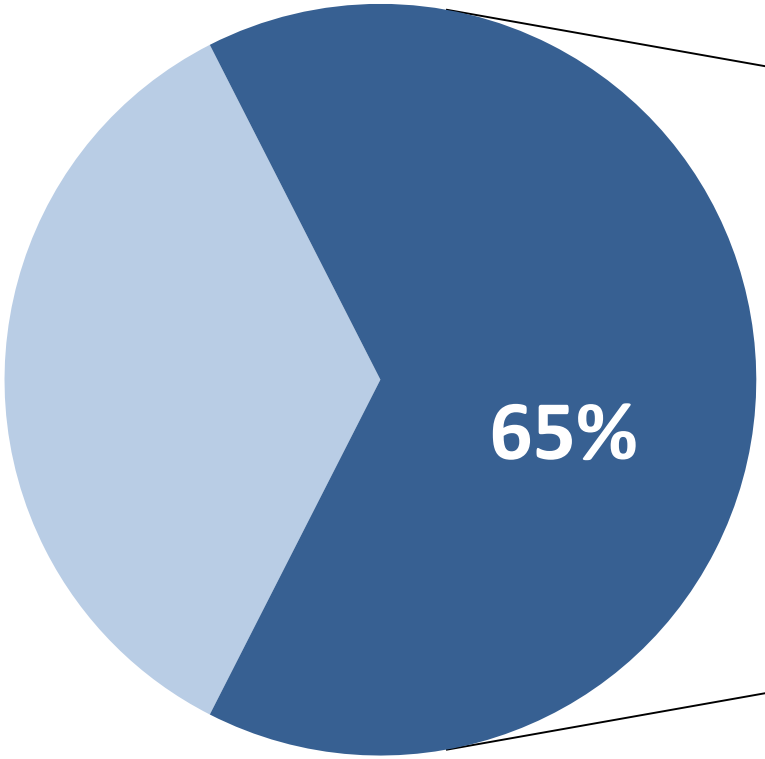
Reducing late HIV diagnosis is a top priority



- 65% of newly diagnosed HIV cases are identified at late stages
- Patient already has clinical manifestation of HIV/AIDS or CD4 <350

- **Increases early mortality rates**
- **Increases health expenditures**
- **Can lead to increased transmission**

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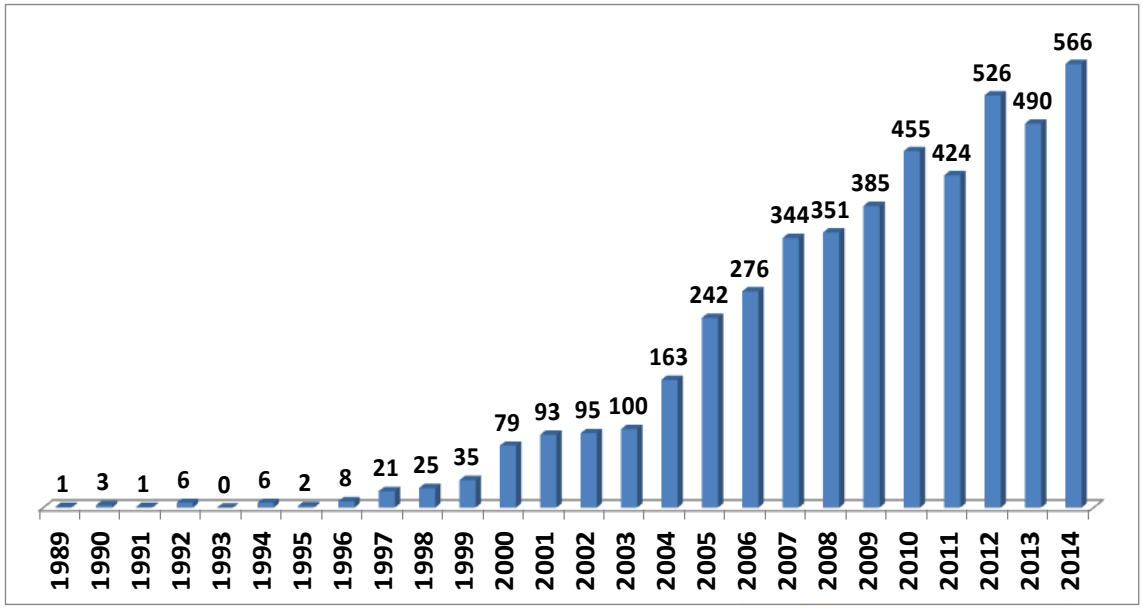
Undiagnosed and late presentation, need for scaling up testing

- HIV and AIDS diagnoses have increased markedly in recent years. This is *largely due to increases in testing rates*.
- However, at least 3200 people are unaware of their infection (~50% of PLHIV) and 65% of all diagnosed have a CD4 count <350 at baseline. Many present with AIDS symptoms

Recommendation:

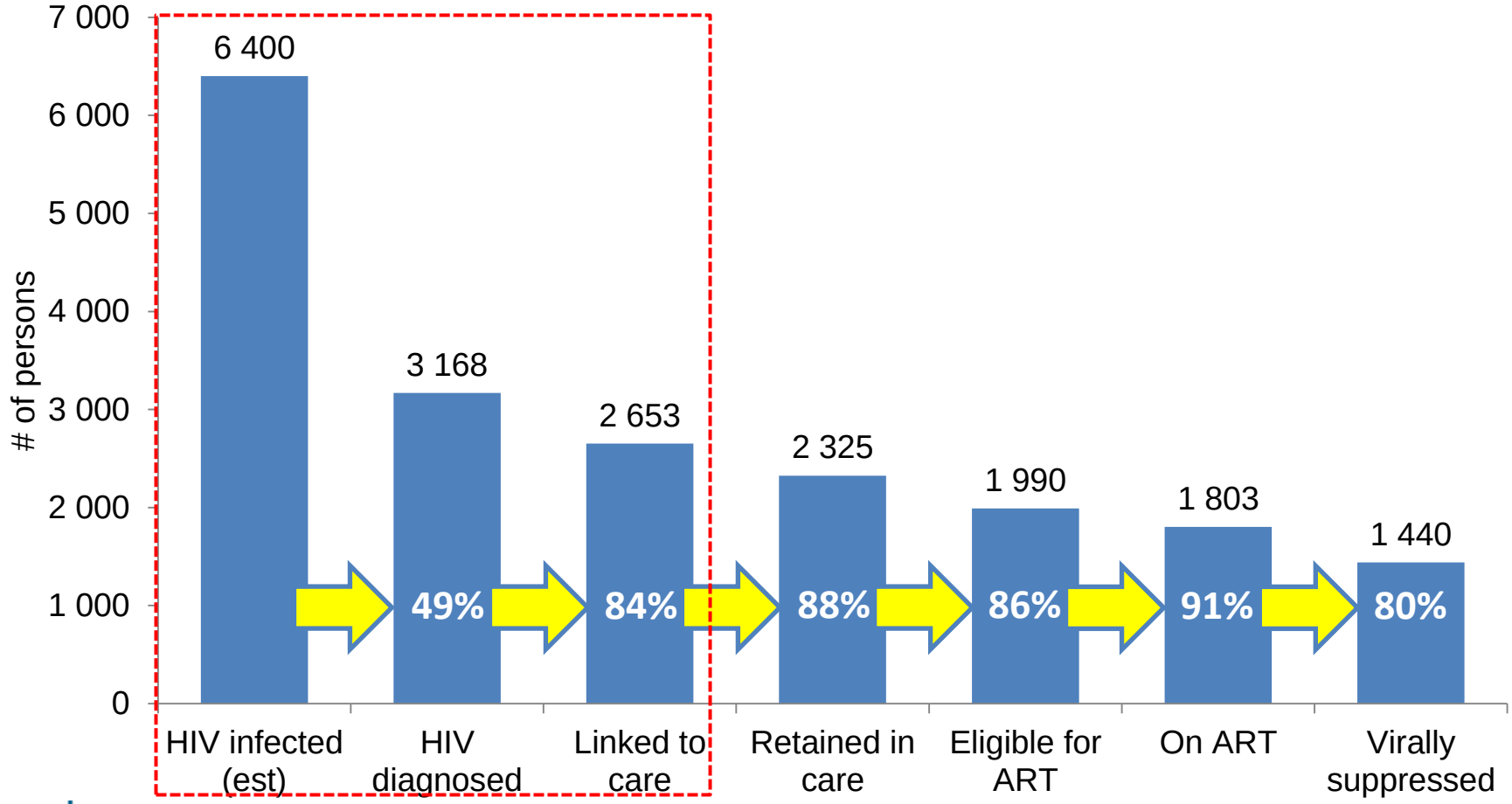
These findings

indicate a clear need for the scaling up of testing at a much faster pace than currently.



Continuum of care cascade for Georgia:

Need to scale up testing and improve retention in care



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Scaling up HIV testing

Early diagnosis and treatment is imperative for improved public health outcomes and reducing HIV transmission

- A large reported increase in testing in 2014 but low incidence of identified HIV infections
- Testing of newly diagnosed TB patients is far too low (62%)
- Degree of testing at STI clinics is not well documented

Scaling up of HIV testing

Recommendations

- Develop more effective strategies for identifying the undiagnosed population and decrease proportion of late testers
- Testing rates need to be improved, particularly ***at all TB and STI clinics***. Make it a universal offer, never obligatory.
- Continue and increase targeted testing of MARPs through community testing using friendly non-judging mobile teams and peer outreach workers
- Consider how the coming scale up of HCV testing can benefit HIV testing, so-called tandem testing.

Recommendations (cont'd)

- The "AIDS centre" would remain in its key role as the technical normative and clinical referral point for HIV and AIDS, e.g confirmatory HIV testing.
- Additionally, the AIDS centre has a key role in the implementation of the NSP with healthcare staff training including family doctors and TB screeners

Antiretroviral Therapy

chip

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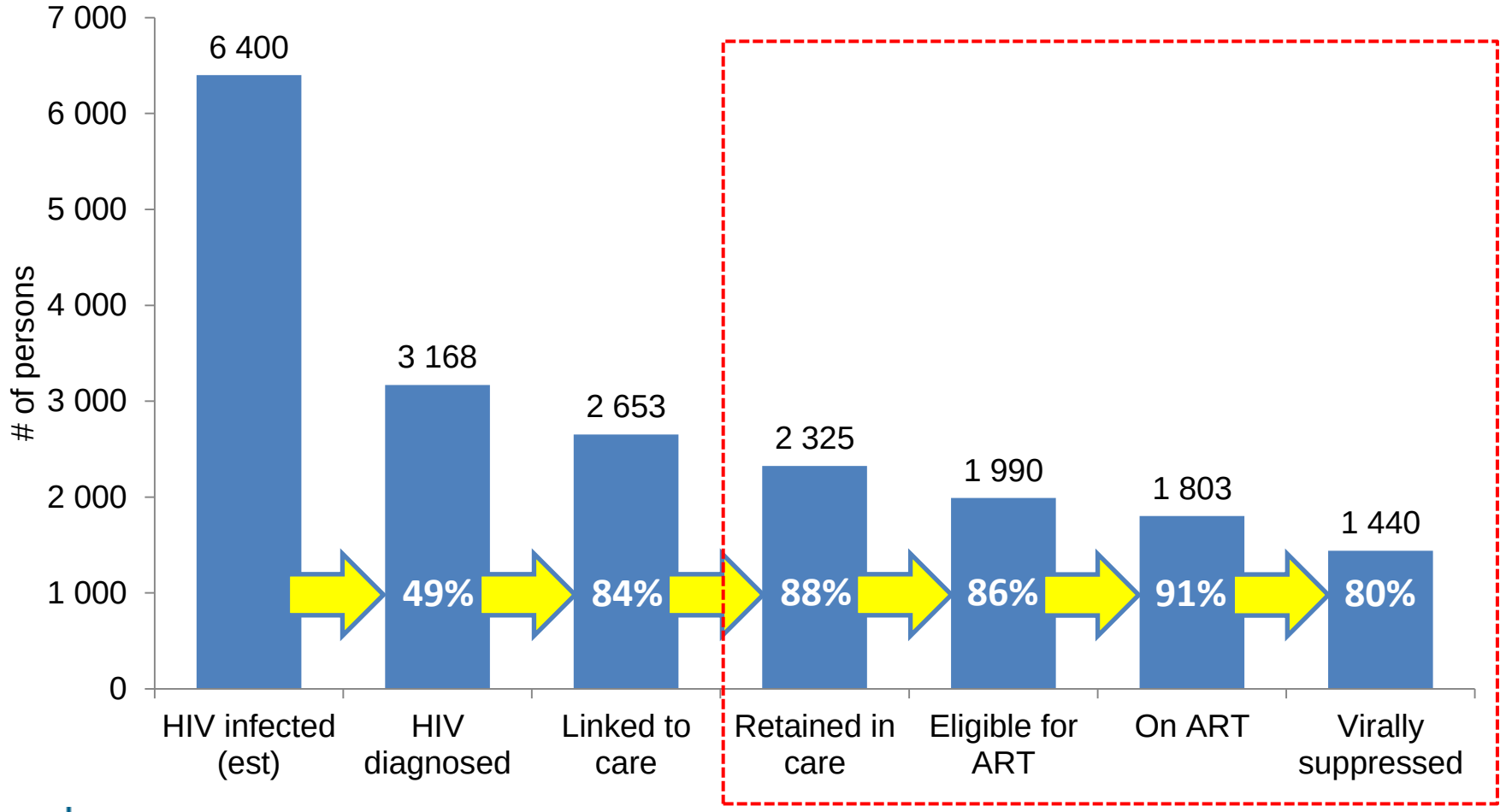
Treatment cascade for Georgia



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WHO Collaborating Centre on HIV and Viral Hepatitis

Use and monitoring of ART

- The implementation of a public health approach to ART has been initiated in line with the 2013 WHO Consolidated Guidelines and 2014 WHO CC recommendations
- The high quality of HIV care and efficacy of ART has been sustained
- Monitoring (viral load / CD4+ cell count) is well balanced
- It is possible for the AIDS C entre lab to reduce costs for viral load/resistance testing by using ”in-house/home-brewed” assays – current legislation does not permit this
- Number of clinical visits can be substantially reduced in stable patients – currently being addressed

Use and monitoring of ART

- A high rate of late positive testers (<350 CD4 cell count) and patients with CD4 <500 at diagnosis:
  - **most of the patients need ART at diagnosis** and the estimated country need will increase substantially up to 2018 (n= 4095) compared to 2014 (n= 2204)

Recommendations

- Continue and establish firmly the cost-effective public health approach to use of ART
- Decrease the number of clinical visits to the AIDS centre
- Develop a comprehensive plan for ensuring healthcare capacity and ARV drugs for the PLHIV that remain undiagnosed.
- Ensure the clinical management of TB/HIV coinfected patients, particularly outside of the capital.

PWID and Harm Reduction

chip

WHO Collaborating Centre on HIV and Viral Hepatitis

Needle and syringe programmes, HIV testing among PWID – significant developments

- Increasing coverage with preventive interventions over the last years
- Increasing amount of community HIV testing
- Anonymous testing has been re-introduced
- 2015-16 mobile units will be acquired to reach PWID in other cities and also serve for community HIV testing (for a total of 8)
- Targets in NSP are in line with WHO/UNODC/UNAIDS Technical Guide recommendations

Ref: WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012.

Needle - syringe programmes – concerns

- Implemented by NGOs, which are reliant on external funding
- There is no legal acts from the MoH regulating HIV prevention among PWID
- Governmental institutions are not involved in providing this service
- Uncertainty of the mechanism in the existing legal framework for the govt to buy HIV prevention services directly from NGOs

Recommendations MoH:

1. To develop and adopt legal acts on the prevention of HIV services among PWID which will define minimal standards of services (service package, requirements for staff, reporting, etc.) and end arrests when in possession of a needle and syringe
2. To involve governmental medical institutions in service provision (e.g. stationery services)
3. To develop a mechanism in the existing legal framework which would allow for funding from the government sources to NGOs HIV prevention services among PWID

Opioid substitution therapy (OST) achievements

- Well established, sites in many geographical areas
- Funded partially by the government
- Existing links with HIV and TB sectors
- Methadone well introduced in the penitentiary system

OST - concerns

- Coverage very low
- Not accessible in some cities where needed
- Not attractive for many PWID, because of:
  - Restricted medication “take-homes”
  - Substantial payment from patients
  - Daily travel/opportunity costs
  - OST opening hours - conflicting with a job
- Mandatory reduction of medication dose and termination of treatment in penitentiary institutions

OST - recommendations

1. To increase of OST coverage (to at least 4000 by 2018), improve geographical access
2. To make OST more attractive in the civil sector by:
   - making OST in line with WHO Guidelines on OST (2009)
   - allowing methadone “take-homes”, etc.

3. To offer both options of OST (maintenance & reduction) for inmates in penitentiary institutions (according WHO Guidelines on OST, 2009)

Health System

chip

WHO Collaborating Centre on HIV and Viral Hepatitis

Health System Situation

- Privatization of healthcare providers (95%) has weakened MLHSP sector leadership & governance.
- Need to define a strong role for the public sector protecting public health and rights, care and safety of HIV and AIDS patients through funding and access to services

Health System - Recommendations

- Joint MOLHSP and NCDC effort for the definition of an HIV/Health System Action Plan in the context of the NSP and for the GF Concept Note, including role of the State and private sector in counselling, diagnostics and treatment (already in NSP 2011-2016), requiring STI providers to service PLHIV, role of laboratories, and the like.
- Develop and implement a national M&E framework to improve forecasting on a rolling basis.

Financing

The necessity to ensure future financial sustainability of the state expenditure for medical services supported financially by international donor organizations (incl. Global Fund, Global Alliance of Vaccines and Immunization, USAID) is an important challenge for the healthcare system of the country) Ord. 724, Dec, 2014).

- Include HIV in State Universal Health Care Programme for financial protection in access and coverage of services
- Ensure budget allocations to the AIDS Centre beyond 2018 to maintain the level of treatment and other services
- Include performance payments for PHC level counselling, testing and referrals

Inter-Institutional Coordination

Under leadership of the MLHSP-NCDC and AIDS Center strengthen the formal mechanisms of coordination with:

- Ministry of Finance (budget allocations)
- Social Health Insurance (HIV and TB in package of services and financial protection)
- Ministry of Education (sex education in schools and universities)
- Ministry of Interior/Police/Ministry of Justice (drug policy and training of law enforcement)
- Ministry of Corrections (HIV services in prisons)

Cross-Cutting

Stigma and ensuring human rights remain very high and impedes the public health response

Recommendations

- Need for national general population education (anti-stigma) campaign – HIV is no longer a death sentence – anyone can get HIV. It can be prevented and treated.
- Greater awareness training of health workforce, create “friendly non-judging champions” towards PLHIV, MSM, PWID and SW
- Government leadership from all sectors is needed to ensure a truly enabling environment

Cross-Cutting – NSP draft comments

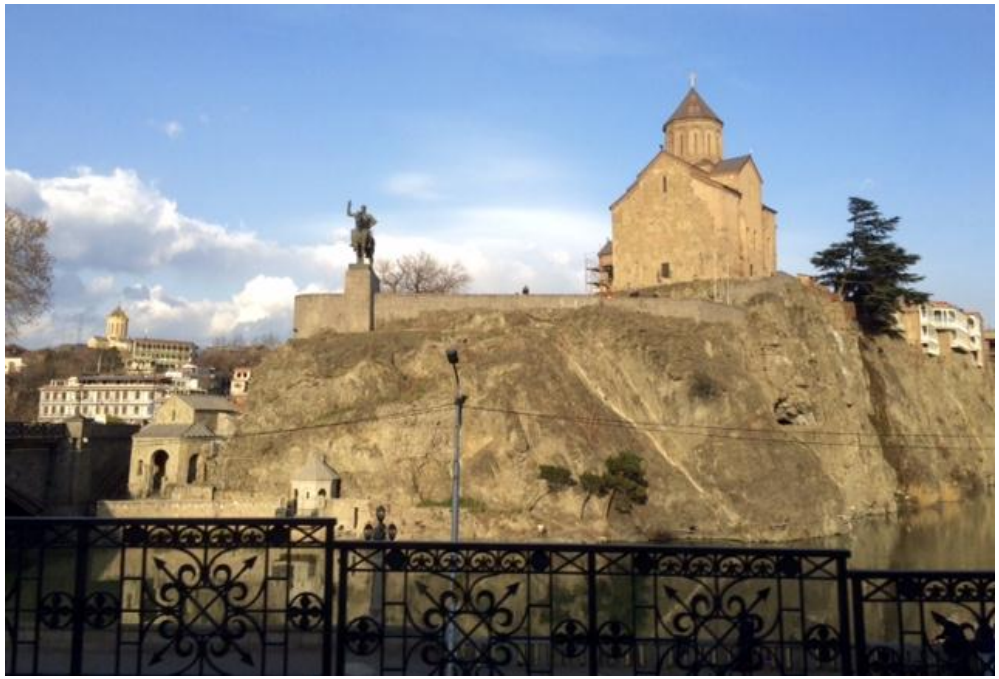
Recommendations

- Reduce the descriptive overview to <2 pages, keeping the treatment cascade (Fig 8). The NSP should be concise.
- Set a hierarchy of priorities focusing on increased detection and prevention for key populations
- Clearly delineate between the NSP and operational/action issues so the strategic vision is clear.

Issues to be discussed

- Inclusion of youth/adolescent friendly services into PHC.
- Increase capacity building of social workers in relation to HIV and AIDS outreach.
- Action plan to sensitize providers for counselling, testing, and referrals to HIV centre.
- Confidentially guidelines revised and implemented to ensure anonymity incl with other sectors.
- Thorough review of legislative/regulatory framework to improve harmonization and implementation.

Didi madloba



INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

THE REVISED NATIONAL STRATEGIC PLAN ON HIV

Consultation with CCM members
6 March 2015

STRATEGIC PRIORITIES

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Increased coverage of quality prevention interventions targeting KAPs (PWID and MSM, OST);
- Improved detection of HIV;
- Timely presentation for treatment;
- Improved treatment outcomes (including IDU);
- Improved programme monitoring;
- Better regulatory environment;
- Effective stigma reduction efforts

OVERARCHING GOAL

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

Turn the HIV epidemic in Georgia in the reversal phase through strengthened interventions targeting key affected populations (KAP), and significant improvement in health outcomes for PLHIV.

SUSTAINABILITY FACTORS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Strengthened commitment of the government,
- Greater involvement of civil society, and
- Optimal integration of various branches of the prevention and care continuum

STRATEGIC OBJECTIVES

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

HIV Prevention and Detection: Improve the effectiveness of outreach and prevention and ensure timely detection of HIV and progression to care;

HIV Care and Treatment: Improve HIV health outcomes through ensuring universal access to quality treatment, care and support;

Leadership and Policy Development: Ensure sustainably strong response to the epidemic through enhanced government commitment, enabling legislative and operational environment, and greater involvement of civil society.

OBJECTIVE 1: HIV PREVENTION AND DETECTION

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Priority area 1.1. Prevent HIV transmission, detect HIV, and ensure timely progression to care and treatment among the key affected populations
- Priority area 1.2. Prevention and detection of HIV within healthcare settings

OBJECTIVE 2: HIV CARE AND TREATMENT

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Strategic priority 2.1. Ensure uninterrupted delivery of high quality treatment and care
- Strategic priority 2.2. Reduce morbidity and mortality due to TB and HCV co-infections and injecting drug use
- Strategic priority 2.3. Ensure provision of care and support services for PLHIV

OBJECTIVE 3: LEADERSHIP AND POLICY DEVELOPMENT

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Priority area 3.1. Ensure adequacy of state budget allocations for HIV prevention and treatment to sustain and scale-up the national response
- Priority area 3.2. Improved policy environment and stakeholder coordination
- Priority area 3.3. Generate evidence for informed decision making

IMPLEMENTATION APPROACH & ASSUMPTIONS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

PWID

- Further coverage expansion (variety of outreach techniques);
- Outreach and service delivery standards (revision and endorsement);
- Strengthened communication protocols;
- Tailoring distributed commodities;
- More effective detection of HIV at primary outreach;
- Detection of HIV among people with history f IDU;
- Involvement of sexual partners (bridges, detection, links to care, services to attract);
- Universal questionnaire-based TB screening of clients;
- Case management to facilitate progression to care and treatment (links to PLHIV support organisations and clinical facilities)

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

OST as Drug Treatment, HIV Prevention and Care

Current programme capacity - 2,800 patients (2015).

Targets:

2016: **3,000** capacity, **4,350** patients (rotation 45%),

2017: **3,500** capacity, **4,900** patients (rotation 40%),

2018: **4,000** capacity, **5,400** patients - 34% of the estimated number of dependent opioid users (rotation 35%).

45,000 estimated number if PWID

22,500 estimated number of opioid users (50%)

15,750 estimated number of dependent opioid users (70%)

OST: UPTAKE AND RETENTION

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Promotion through BCC protocols and awareness raising among patients;
- Strengthening social support in collaboration with needle and syringe programmes;
- Supporting OST patients' associations/councils;
- Improved access for disadvantaged;
- Tailoring for women;
- Revision of protocols (incl. dosing, take-home policies, use of illicit substances);
- Better collaboration with local law enforcement;
- OST option in penitentiary institutions

OST: THE APPROACH

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Drug treatment, HIV prevention, ART support;
- Reduced opioid use;
- Reduced HIV risk behaviour and transmission;
- Reduced criminal activity;
- Reduced overdose and mortality;
- Improves retention in treatment;
- Accessibility;
- Affordability;
- No dosage and duration restrictions;
- Access to psychosocial support

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

MSM and SW

- Segmentation and tailored service combinations, by age and income level;
- Target setting for specific segments;
- Greater involvement of community-based organisations;
- Internet-based communication for MSM and higher-income sex workers;
- Strengthened BCC: protocol development and implementation monitoring;
- Detection of HIV and other diseases and facilitated progression to care and treatment;
- Better promotion through BCC protocols, collaboration between providers

IMPLEMENTATION APPROACH & ASSUMPTIONS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

ART

- The on-going rationalisation/optimisation of treatment schemes will be completed;
- This brings significant savings in the treatment costs for 2016-2018;
- Projections of the ART coverage are in line with expected detection rates;
- Clinical care is part of case management continuum involving clinical staff, community counsellors, and social workers of KAP outreach and prevention programmes;
- Psychosocial aspects of case management and community support and monitoring of treatment;
- Specific treatment targets for PWID

DETECTION AND TREATMENT SCALE-UP

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

	2016	2017	2018
Tested PWID	11542.5	12555	13567.5
Tested MSM	2720	3400	4250
Tested SW	1566	1825	2437.5
Tested prisoners	1750	2000	2250
Tested blood donors	58000	59000	60000
Detected PWID	**277**	**226**	**163**
Detected MSM	**283**	**265**	**221**
Detected SW	**9**	**8**	**7**
Detected prisoners	6	7	8
Detected blood donors	23	24	24
Detected pregnant	50	50	50
Total	**648**	**579**	**473**
80%	**518**	**464**	**378**
Treatment scale-up		**4318**	**4764**
AIDS Centre Projections	**3800**	**4300**	**4800**

HIV prevalence PWID	3
HIV prevalence MSM	13
HIV prevalence SW	0.7
HIV prevalence prisoners	0.35
HIV prevalence other	0.04

IMPLEMENTATION APPROACH & ASSUMPTIONS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

Policy development work focuses on specific programmatic tasks:

- Regulations affecting service delivery, access and retention;
- Relations between service providers and law enforcement and healthcare workers;
- Collaboration with outreach, VCT and peer support: Quality assurance and monitoring, Involvement in personnel capacity development;
- Participation of KAPs in official delegations and specific task forces;
- Collaboration on national conferences;

Access to quality services is primary and community development is secondary, complementary task from public health perspective.

IMPACT, OUTCOMES AND COVERAGE TARGETS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

- Increased funding of HIV response from state budget from 32% (2013) to 70% (2018);
- By 2018 HIV prevalence among PWID, SW and prisoners is contained under 5% each;
- By 2018 HIV prevalence among MSM is contained under 15%;
- Rate of late HIV detection is reduced from 70% to 35% by 2018;
- AIDS related mortality is reduced below 2.0 deaths per 100,000 population

COVERAGE BY ESSENTIAL PREVENTION AND TESTING

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

	2016	2017	2018
PWID coverage	25650 (57%)	27900 (62%)	30150 (67%)
PWID testing	23085 (51%)	25110 (56%)	27135 (60%)
PWID on OST			4500 (10%)
MSM coverage	6800 (40%)	8500 (50%)	10200 (60%)
MSM testing	5440 (32%)	6800 (40%)	8500 (50%)
FSW coverage	3915 (60%)	4560 (70%)	5220 (80%)
FSWs testing	3132 (48%)	3650 (60%)	4875 (75%)
Prison coverage	4000 (40%)	5000 (50%)	5500 (55%)
Prison testing	3500 (35%)	4000 (40%)	4500 (45%)

TREATMENT COVERAGE TARGETS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

Percentage of adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy	90%
Percentage of newly diagnosed persons who are enrolled in care	>90%
Percentage of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy	85%
Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol at the end of the reporting period	4800 (59%[1])

FUNDING ISSUES

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

Government to gradually increase allocation;

Government to support:

- ART,
- OST,
- Laboratory testing for treatment monitoring,
- Testing in the community settings?
- OST for disadvantaged clients?

FUNDING DYNAMICS

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME

in mln USD

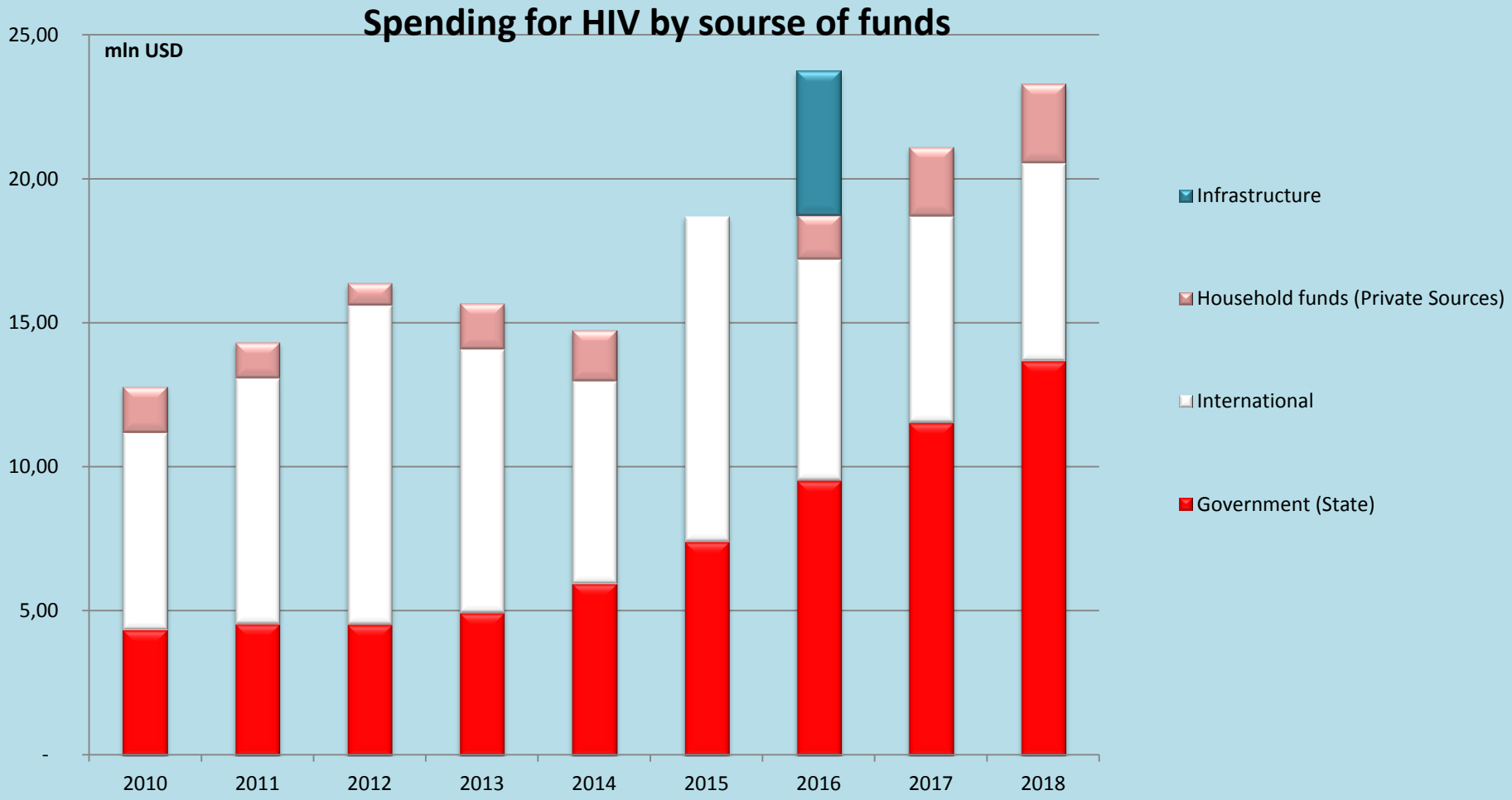
By Source	2010	2011	2012	2013	2014	2015	2016	2017	2018
Government (State)	4.36	4.56	4.55	4.95	5.96	7.41	9.07	11.4	13.6
International	6.83	8.52	11.06	9.14	7.02	11.28	8.13	7.29	6.93
Household funds (Private Sources)	1.61	1.26	0.78	1.60	1.77	-	1.56	2.41	2.77
Infrastructure	-	-	-	-	-	-	5.00	-	-
TOTAL	**12.80**	**14.34**	**16.39**	**15.69**	**14.76**	**18.69**	**23.76**	**21.10**	**23.29**

in mln USD

By Programme Area	2010	2011	2012	2013	2014	2015	2016	2017	2018
Prevention and Detection	7.22	7.87	7.19	6.49	8.47	7.79	10.31	12.07	13.56
Care and Treatment	3.11	3.76	6.20	6.12	4.78	8.88	6.10	6.95	7.92
Leadership and Policy Development, program management	2.47	2.71	3.00	3.08	1.51	2.03	2.35	2.08	1.81
Infrastructure	-	-	-	-	-	-	5.00	-	-
TOTAL	**12.80**	**14.34**	**16.39**	**15.69**	**14.76**	**18.69**	**23.76**	**21.10**	**23.29**

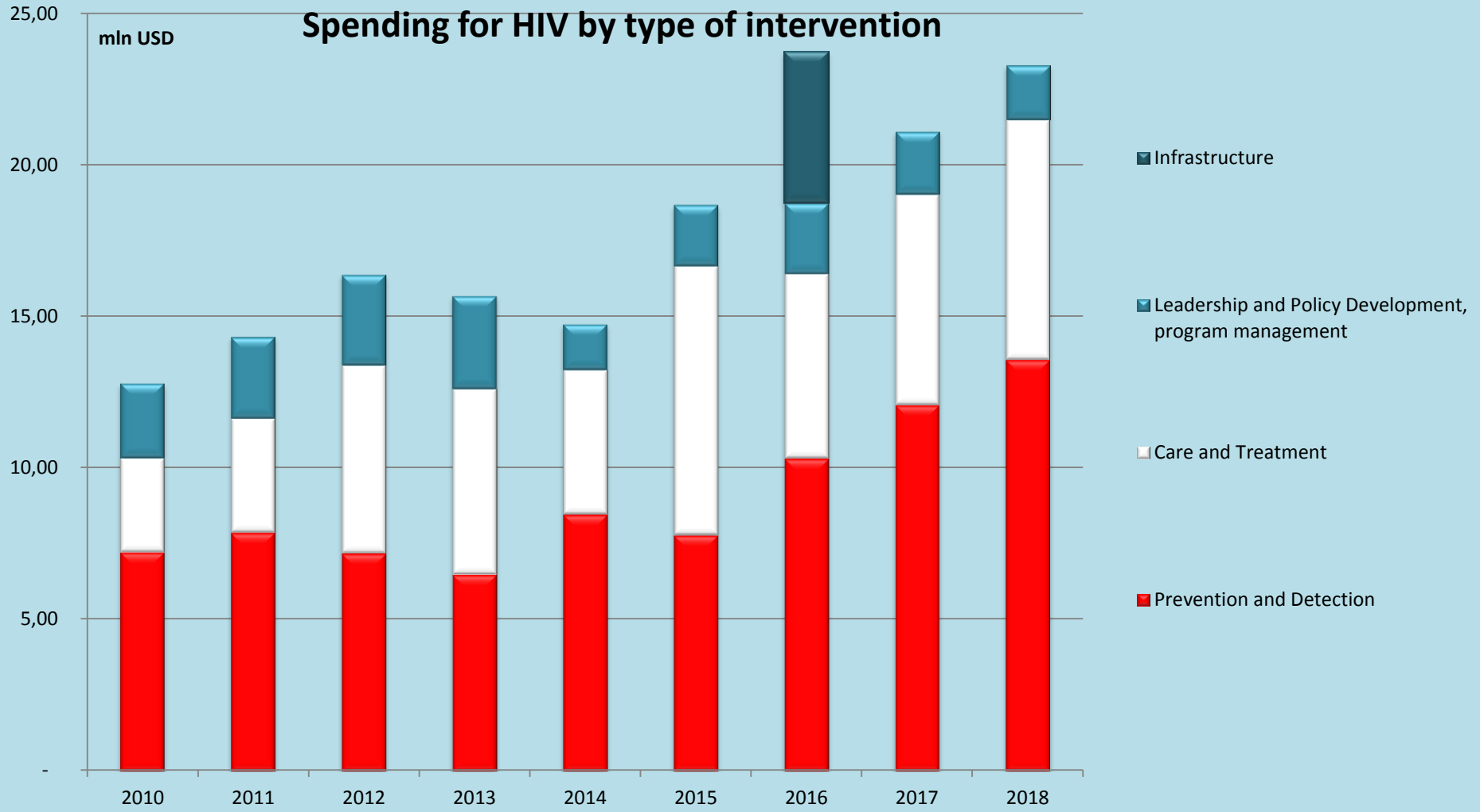
REQUIRED FUNDING BY SOURCE

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME



REQUIRED FUNDING BY INTERVENTION

INITIATIVE 5%
SIDA, TUBERCULOSE, PALUDISME



Report of Oversight Committee

December 2014 – February 2015

Site Visit to TB Center

25 დეკემბერი, 2014ბ

December 25, 2014

- Delay in receipt of information on new cases of TB

- Data delay for the indicator: Percentage of TB patients who had an HIV test result recorded in the TB register
- Out of 110 patients starting treatment for MDR-TB, 7 (6.36%) were lost to follow-up during first six months of treatment

The objectives of the visit

- Review of the recording-reporting system of TB cases; analysis of the problem with the staff
- Review of information on Cash Incentive Scheme
- Discussion on procurement mechanism of drugs
- Mode of cooperation with the PR
- Mode of cooperation with the CCM/facilitation of the determining the most optimal format of cooperation

Conclusion

- Sharing the experience of HIV rapid testing on the regional level and introducing at district level
- Inclusion in the existing form (TB 10/12) the status of HIV testing (without showing test result) which will display the coverage of the beneficiaries. Training of health care personnel on new reporting and recording forms will be supported by the USAID Georgia TB Prevention Project.
- Introduction of USAID/URC e-module for prompt exchange of the information

Site Visit to AIDS Center, December 26, 2014

- Study the reasons for decreased number of HIV patients receiving Hepatitis C treatment
- Discussion on the mechanisms for procurement of 1st line drugs
- Mode of the cooperation with PR
- Mode of cooperation with the CCM; facilitation of the determining the most optimal format of cooperation

Site visit to HIV/AIDS Patient Support Foundation February 18, 2015

- Review of the of the GFATM grant implementation
- Review of the problems existing for people living with HIV and finding the ways for solution
- Mode of cooperation with PR
- Mode of cooperation with the CCM; facilitation of the determining the most optimal format of cooperation

Meetings

- Gender responsive workshop for CCM members and Secretariat – February 13, 2015
- New CCM members orientation training – February 18, 2015

COMPLIANCE OF THE GF GRANTS PRINCIPLE RECIPIENT WITH MINIMUM CRITERIA

February 2015

Background

- CCM Georgia is preparing the country concept notes to apply for support with the Global Fund New Funding Model
- CCM can nominate the current well performing PR (A1, A2, B1) as a main implementer of the GF grants or initiate a proper selection process to identify the new PR
- The decision to nominate the current PR should be made based on review of the compliance of the PR with the minimum criteria
- A set of minimum criteria is derived from the GF standard concept note instructions (10 March 2014)

Minimum criteria for PR assessment: Key Blocks

1. PR Demonstrates effective management structure and planning (technical and procurement staff, organizational leadership)
2. Program oversight: PR has the capacity and systems for effective management and oversight of sub- recipients (an relevant sub-sub-recipients)
3. Finance: The internal control system of the PR is effective to prevent and detect misuse or fraud
4. PSM
5. Monitoring and Evaluation

C1: Management structure and planning

PR Demonstrates effective management structures and planning	Compliance
• The PR has sufficient number of skilled and experienced staff to manage the program	For TB Grant out of 11 planned management positions 11 have been appointed (period P2); For HIV Grant out of planned 16 management positions 15 have been appointed from the beginning of the project. Due to an employee turnover selection is in place for one position.(Source: P2 Dashboards, job announcement on jobs.ge posted on February 7th , 2015)
• PR shows effective organizational leadership, with a transparent decision making process	Sub recipients are been selected through open competition process that is documented and transparent. PR regularly reports on key implementation development. CCM GA minutes and oversight committee meeting minutes clearly indicate transparency in PR decision making and effective organizational leadership (Source: CCM and OC meeting minutes)
• Staff of key functions at the PR has relevant technical knowledge & health expertise for HIV/AIDS and tuberculosis • Procurement staff has relevant experience for procurement; warehouse staff is sufficient in number, and have appropriate skills to manage storage of health products.	Staff was selected through open competitive selection process. After the first call the announcement was made repeatedly to attract highly qualified professionals (Source: CVs and Selection report)

C2: The PR has the capacity and systems for effective management and oversight of sub-recipients (and SSRs)

SR Oversight	Compliance
• PR exercises sufficient oversight over sub-recipients to safeguard both financial and physical assets	PR has developed operations manual including procedures in respect of Financial management, Sub-recipient management (selection and contracting, reporting requirements, procedures for verification of sub-recipients financial and programmatic data, frequency and scope of monitoring visits, SR's audit arrangements-OM has been submitted to the GF on August 14th 2014.
• PR has the ability to provide or contract for capacity-building to ensure timely and quality program implementation	PR regularly conducts workshops for SRs on the operational issues related to all aspects of implementation including logistics, financial, and data management. In addition, in collaboration with the USAID HICD plus project PR conducted specific training for SRs on Procurement and Supply Management(PSM) and logistics in October 2014. PR also effectively leverages external resources to build technical capacity of SRs (e.g. collaboration wit the USAID TB Prevention).

C3.1.: Finance: The internal control system of the PR is effective to prevent and detect misuse or fraud

Internal Control System	Compliance
• The internal control system ensures that the PR adheres to policies and procedures consistently.	The operational manual including details of the accounting and finance organizational structure of NCDC, all adequate policies and procedures to guide activities in financial management and accounting has been submitted to the GF on August 14th, 2014
• The internal control system supports compliance effectively with the related grant agreement	Based on the management letter as of December 16th 2014 there are no issues related to deficiencies related to internal control systems.
• External auditors and other third-party assurance providers are selected and assigned duties in accordance with Global Fund guidelines.	PR has selected an external auditor and signed a contract with the provider on February 9th , 2015. (Source: a contract)

C3.2. Finance: The financial management system of the PR is effective and accurate

Financial management system	Compliance
• PR has an accounting system in place that can correctly and promptly record all transactions and balances making clear reference to the budget and work plan of the grant agreement.	GF provided LFA assessment of at that time potential PR in late 2013. During the assessment the PRs' accounting system was evaluated. Compliance with the outstanding recommendations was conditionality for signing the grant. The TB and HIV grant agreement were signed in March and April 2014 respectively.
• PR manages all transactions and transfers to suppliers and sub-recipients in a transparent manner to safeguard financial and physical assets	GF provided LFA assessment of at that time potential PR in late 2013. During the assessment the PRs' accounting system was evaluated. Compliance with the outstanding recommendations was conditionality for signing the grant. The TB and HIV grant agreement were signed in March and April 2014 respectively.
• The PR monitors actual spending in comparison to budgets and work plan and investigates variances and takes prompt action	In order to avoid frequent budget modifications, GF requires the PR to treat the approved budget as a plan and do not change it on an ongoing basis. Any variance between the originally approved and actual budgets will be reported as part of the Extended Financial Report(EFR). The EFR that is being currently prepared (to be submitted to GF by February 28, 2015) includes all such variances. In future, the reprogramming requests will be submitted for approval to GF fund prior to re-allocation of funds. .

C4.1. PSM: Central warehousing and regional warehouses have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products

Storage capacity	Compliance
• The storage capacity is appropriate in condition (including ventilation), equipment, and size for the type and quantity of products to be stored.	Standard Operating Procedures (SOPs) were developed for receipt and storage for all levels-prior to grant signing
• There is sufficient trained staff at central and regional level to manage stock.	There are five of staff at PR responsible for stock management
• The facilities are properly secured against theft and damages.	SOPs were developed for receipt and storage for all levels.
• The facilities are equipped with a temperature monitoring and controlling mechanism	SOPs were developed for receipt and storage for all levels.

C.4.2. PSM: The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions

Distribution systems	Compliance
• There is a distribution plan for supplies, dispatches and transportation.	Has been developed and is in use.
• The security measures for transportation are defined and the equipment and transportation conditions are adequate.	Standard Operating Procedures (SOPs) for receipt and storage for all levels were developed
• There is sufficient trained staff to manage distribution and delivery activities	Five of staff are responsible for distribution management and delivery activities
• There is a logistics-management information system (LMIS) with requisition and stock-reporting tools in place to anticipate and minimize risk of stock-outs (incl. accurate forecasting and timely ordering).	The MIS has been finalized with USAID HSSP support and is fully functional. PR plans to extend the system to SRs.

The operations manual for procurement and supply management as well as Standard Operating Procedures (SOPs) for PSM for PR and SRs were approved by the GF on 30 June and 2 July 2014.

C4.3.PSM: Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain.

Product quality	Compliance
• There is qualified staff to manage/oversee quality assurance activities.	There is a dedicated staff member within the PSM team responsible for quality oversight and assurance activities.
• There is a plan for quality monitoring activities throughout the in-country supply chain, including quality control.	The plan for quality assurance and quality controls were submitted and approved by GF on July 11th, 2014.
• The World Health Organization "Model Quality Assurance System for Procurement Agencies (MQAS)" serves as guidance.	SOP for "Procurement and Supply Management" was developed based on the GF Quality Assurance Policies which itself refers to "MQAS". PR follows SOP that includes applicable laws and regulations of the PSM SOP
• The entity has Standard Operating Procedures (SOPs) for key processes in place and revises the SOPs when necessary.	The operations manual for procurement and supply management as well as Standard Operating Procedures for PSM for PR and SRs were approved by the GF on 30 June and 2 July 2014.

C5.1:M&E: Data-collection capacity and tools are in place to monitor program performance

M&E: Data Collection capacity	Compliance
• The monitoring and evaluation (M&E) system defines relevant indicators for routine monitoring of activities/interventions that are aligned to the goals and objectives of the program in question.	The PR organized the National Monitoring and Evaluation System Strengthening (MESS) workshops for TB and HIV grants in June 2014. As a result PR and SRs completed self-assessment tools and produced costed action plans to address M&E gaps in TB and HIV programs.
• Adequate mechanism and tools are in place to report accurate and quality assessed data from the sub-sub-recipient / sub-recipient to the PR level.	The PR developed detailed M&E plans for TB and HIV and corresponding M&E guidelines to be used by SRs and SSRs.
• Program Reviews are planned during the implementation period and National program reviews are conducted with involvement of partners on a regular basis	WHO TB program review conducted in November 2014 WHO HIV Program (treatment component) review in 2014

C5.2.M&E: A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately

M&E: Routine reporting	Compliance
• The routine reporting system/ Health Management and Information System (HMIS) for facilities involved in TB and HIV program implementation has a coverage of at least 50 percent, and there is a costed plan to improve coverage to 80 percent.	The routine reporting system for both TB and HIV covers almost 100% of health facilities. All participating facilities are covered with electronic health management information system developed in the country.
• The relevant HIV and TB indicators have clear definitions, and are coded in the HMIS.	Yes (Reflected in the performance framework approved by the GF).
• The routine reporting system / HMIS has a data-assurance mechanism in place that annually verifies data.	PR conducts regular monitoring activities in the HIV and TB project sites to produce corresponding reports and to share those with the GF, LFA, PR representatives, and with the CCM members.

Summary

- Based on
  - The GF Management Letters as of December 16 2014
  - GF Feedback to NCDC provided in December 2013
  - Review of the progress made in accomplishing time bound actions and meeting condition precedents identified in December 2013 concerning PR's capacity and systems for effective SR management

The oversight committee concluded that the current PR complies with the requirements for the GF grants implementers.

ხმის მიცემის ბიულეტინი

Ballot bulletin

ქვეყნის საკოორდინაციო საბჭოს 77-ე სხდომა

2015 წლის 6 მარტი

თბილისი

შიდსთან, ტუბერკულოზსა და მალარიასთან ბრძოლის გლობალური ფონდის დაფინანსების ახალი მოდელის ფარგლებში

აივ/შიდსის და ტუბერკულოზის გრანტების ძირითადი მიმღები ორგანიზაციის არჩევა/ნომინირება

Georgia Country Coordinating Mechanism

77th Meeting

March 6, 2015

Tbilisi

Nomination/Selection of the Principal Recipient for the HIV/AIDS and TB grants under the Global Fund New Funding Model

გთხოვთ შემოხაზოთ თქვენი არჩევანი

Please circle your choice

1. მხარს ვუჭერ აივ/შიდსის და ტუბერკულოზის გლობალური ფონდის გრანტების არსებული ***ძირითადი მიმღები-ორგანიზაციის- დაავადებათა კონტროლისა და საზოგადოებრივი ჯანმრთელობის ეროვნული ცენტრის,*** აივ/შიდსის და ტუბერკულოზის გრანტების ძირითად მიმღებად ნომინირებას
   I support the nomination of ***the current Principal Recipient of the Global Fund HIV/AIDS and TB grants - National Center of Disease Control and Public Health*** as a Principal Recipient of the GFATM HIV/AIDS and TB grants

2. მხარს ვუჭერ გლობალური ფონდის აივ/შიდსის და ტუბერკულოზის გრანტების ***ახალი ძირითადი მიმღების შერჩევას***
   I support ***the selection of a new Principal Recipient*** of the Global Fund HIV/AIDS and TB grants

ქვეყნის საკოორდინაციო საბჭოს 77-ე სხდომა

2015 წლის 6 მარტი

თბილისი

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Georgia Country Coordinating Mechanism

77th Meeting

Nomination/Selection of the Principal Recipient for the HIV/AIDS and TB grants under the Global Fund New Funding Model

Secret ballot bulletin receipt form

#	სახელი, გვარი Name, surname	ორგანიზაცია Organization	უფლებამოსილი წარმომადგენელი/ სახელი, გვარი **Authorized representative/name, surname**	ბიულეტინის რაოდენობა **Number of bulletins**	ხელმოწერა Signature
1	დიმიტრი ხუნდაძე **Dimitri Khundadze**	საქართველოს პარლამენტის ჯანმრთელობის დაცვისა და სოციალურ საკითხთა კომიტეტის თავმჯდომარე Parliament of Georgia,Chairman of the Healthcare and Social Issues Committe		1	

2	გიორგი ხეჩინაშვილი **Giorgi Khechinashvili**	საქართველოს პარლამენტის ჯანმრთელობის დაცვისა და სოციალურ საკითხთა კომიტეტის წევრი Parliament of Georgia, Member of the Healthcare and Social Issues Committee		1	
3	არქიმანდრიტი ადამი - ვახტანგ ახალაძე **Archimandrite Adam – Vakhtang Akhaladze**	საქართველოს საპატრიარქოს ჯანმრთელობის დაცვის დეპარტამენტის თავმჯდომარე Patriarchate of Georgia Head of Public Health Department		1	
4	იანოშ ჰერმანი **Janos Herman**	საქართველოში ევროკავშირის წარმომა დგენლობის ხელმძღვანელი, ელჩი Ambassador, Head of EU Delegation to Georgia	p.o.	1	
5	ზურაბ ვადაჭკორია **Zurab Vadachkoria**	სახელმწიფო სამედიცინო უნივერსიტეტის რექტორი Rector of Tbilisi State Medical University		1	

6	თამარ სირბილაძე Tamar Sirbiladze	აშშ საერთაშორისო განვითარების სააგენტოს ჯანმრთელობისა და სოციალური დახმარების დეპარტამენტის დირექტორი USAID, Health and Social Development Office, Director		1	
7	რუსუდან კლიმიაშვილი **Rusudan Klimiashvili**	ჯანდაცვის მსოფლიო ორგანიზაციის საქართველოს ოფისის ხელმძღვანელი WHO Georgia, Head of Country Office		1	
8	თამარ გაბუნია **Tamar Gabunia**	უნივერსითი რისერჩ კო" (URC) ამერიკის შეერთებული შტატების საერთაშორისო განვითარების სააგენტოს მიერ დაფინანსებული საქართველოში ტუბერკულოზის პრევენციის პროექტის დირექტორი საბჭოს თავმჯდომარის მოადგილე URC LLC USAID funded Georgia Tuberculosis Prevention Project Chief of Party CCM Vice-Chair	—	1	
9	ელგუჯა მელაძე **Elguja Meladze**	საქართველოს დამსაქმებელთა ასოციაციის პრეზიდენტი Employers' Association of Georgia, President	Salome Balkuradze	1	

10	დავით ანანიაშვილი **David Ananiashvili**	„საქართველოს პლიუს ჯგუფი“ – ს დირექტორი "Georgian Plus Group" Director		1	
11	თამარ ნატრიაშვილი **Tamar Natriashvili**	ტუბერკულოზით დაავადებული ყოფილი პაციენტი Former TB Patient		1	
12	არჩილ თალაკვაძე **Archil Talakvadze**	საქართველოს შინაგან საქმეთა მინისტრის მოადგილე Deputy Minister of Internal Affairs of Georgia		1	
13	თამაზ მარსაგიშვილი **Tamaz Marsagishvili**	საქართველოს განათლებისა და მეცნიერების მინისტრის მოადგილე Deputy Minister of Education and Science of Georgia		1	
14	ქეთევან ციხელაშვილი **Ketevan Tsikhelashvili**	შერიგებისა და სამოქალაქო თანასწორობის საკითხებში სახელმწიფო მინისტრის პირველი მოადგილე First Deputy State Minister of Georgia for Reconciliation and Civic Equality		1	
15	ლელა ბაქრაძე **Lela Bakradze**	გაეროს მოსახლეობის ფონდის საქართველოს ოფისის ხელმძღვანელი UNFPA, Assistant Representative		1	

ქვეყნის საკოორდინაციო საბჭოს 77-ე სხდომა

2015 წლის 6 მარტი

თბილისი

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Georgia Country Coordinating Mechanism

77th Meeting

The results of the Secret ballot on the Nomination/Selection of the Principal Recipient for the HIV/AIDS and TB grants under the Global Fund New Funding Model

Total number of bulletins 11 (Eleven)

	Number of votes
The nomination of the current Principal Recipient of the Global Fund HIV/AIDS and TB grants - National Center of Disease Control and Public Health as a Principal Recipient of the GFATM HIV/AIDS and TB grants	11 (Eleven)
The selection of a new Principal Recipient of the Global Fund HIV/AIDS and TB grants	0

Signatures:

Irina Gsdzelidze – [signature]

Natia Khonelidze – N. Khonelidze

შიდსთან, ტუბერკულოზსა და მალარიასთან
ბრძოლის გლობალური ფონდის პროექტების
ქვეყნის საკოორდინაციო საბჭო
- შიდსის პროგრამების ერთიანი სახელმწიფო საკოორდინაციო საბჭო -
- ტუბერკულოზის პროგრამების ერთიანი სახელმწიფო საკოორდინაციო საბჭო -

Country Coordinating Mechanism
for Projects of the Global Fund to Fight
AIDS, Tuberculosis and Malaria in Georgia
- One National AIDS Coordinating Authority -
- One National Tuberculosis Coordinating Authority -

01-01/470 9 მაისი 2015

დაავადებათა კონტროლისა და საზოგადოებრივი ჯანმრთელობის ეროვნული ცენტრის
გენერალური დირექტორს

ბატონ ამირან გამყრელიძეს

ბატონო ამირან,

როგორც მოგეხსენებათ, 2015 წლის 6 მარტს საქართველოში აივ ინფექციის/შიდსის, ტუბერკულოზისა და მალარიის წინააღმდეგ მიმართულ ღონისძიებათა ქვეყნის ერთიანი საკოორდინაციო საბჭოს რიგით 77-ე სხდომის მსვლელობისას გაიმართა შიდსთან, ტუბერკულოზსა და მალარიასთან ბრძოლის გლობალური ფონდის დაფინანსების ახალი მოდელის ფარგლებში აივ/შიდსის და ტუბერკულოზის გრანტების ძირითადი მიმღები ორგანიზაციის არჩევა/ნომინირების ფარული კენჭისყრა.

წინამდებარე წერილის მეშვეობით საბჭოს სამდივნოს აქვს პატივი გაცნობოთ კენჭისყრის შედეგები.

კენჭისყრაში მონაწილე ყველა სუბიექტის მიერ აივ/შიდსის და ტუბერკულოზის გლობალური ფონდის გრანტების არსებული ძირითადი მიმღები-ორგანიზაცია, დაავადებათა კონტროლისა და საზოგადოებრივი ჯანმრთელობის ეროვნული ცენტრი, ნომინირებულ იქნა აივ/შიდსის და ტუბერკულოზის გრანტების ძირითად მიმღებად.

პატივისცემით,

ი. ქრძელიძე

ირინა გრძელიძე

ქვეყნის საკოორდინაციო საბჭო

აღმასრულებელი მდივანი

01-01/470

March 9, 2015

To Mr. Amiran Gamkrlelidze

National Center for Disease Control and Public Health

General Director

Dear Mr. Gamkrelidze

As you are aware on March 6, 2015 at the 77th CCM meeting the voting on nomination/selection of the of the Principal Recipient for the HIV/AIDS and TB grants under the Global Fund New Funding Model through secret ballot was held

Herewith we are presenting the results of the voting.

The current PR, National Center of Disease Control and Public Health was nominated as a Principal Recipient of the GFATM HIV/AIDS and TB grants by all participants of the voting.

Respectfully,

Irina Grdzelidze

CCM

Executive Secretary