CCM Request for Renewal

February 15, 2012

CCM Request for Renewal Outline

SECTION 1: SUMMARY OF REQUEST

1.1 General Program Information

Applicant	**Country Coordination Mechanism**
Country	**Georgia**
Component	**HIV**
Component Implementation Period	**01 January 2013 – 31 December 2015**
Cut-off date	**31December 2011**
Renewal date	**15 February 2013**
Current Phase/Implementation Period Currency:	**EUR**
Next Phase/Implementation Period Currency:	**EUR**

Principal Recipient (PR) Name	Grant/SSF Number	Grant/SSF start date
Global Projects Implementation Center	GEO-H-GPIC	01 January, 2010

1.2 CCM Approval of Request for Renewal

Role	Title / Organization	Name	Signature
CCM Chair	"SOCO Foundation"- Charity NGO	Ms. Sandra Elisabeth Roelofs	
CCM Vice Chair	Minister of Labor, Health and Social Affairs of Georgia	Mr. David Sergeenko	
CCM member	Parliament of Georgia, Deputy Chairman of the Healthcare and Social Issues Committee	Mr. George Tsereteli	
CCM member	Patriarchate of Georgia Head of Public Health Department	Mr. Archimandrite Adam – Vakhtang	
CCM member	Ambassador, Head of EU Delegation to Georgia	Mr. Philip Dimitrov	
CCM member	Former TB Patient	Mr. KobaKhabazi	
CCM member	Rector of Tbilisi State Medical University	Mr. ZurabVadachkoria	
CCM member	Infectious Diseases, AIDS and Clinical Immunology Research Center , General Director	Mr. TengizTsertsvadze	
CCM member	Center for Mental Health and Prevention of Addiction, OST program director	Ms. KhatunaTodadze	
CCM member	National Center of Tuberculosis and Lung Diseases, Director	Mr. MamukaJaparidze	
CCM member	Global Projects Implementation Center (GPIC), Executive Director	Mr. AkakiLochoshvili	

CCM member	UNAIDS, Social Mobilization Advisor	Ms. LiaTavadze	
CCM member	USAID/Caucasus, Senior Health Advisor	Ms. Tamar Sirbiladze	
CCM member	The Union of Victims of the Conflict in Abkhazia "TANADGOMA", Executive Director	Mr. ZurabDanelia	
CCM member	Center for Information and Counseling on Reproductive Health TANADGOMA, Executive Director	Ms. Nino Tsereteli	
CCM member	GOPA /KFW, Project Coordinator	Ms. Maia Kavtaradze	
CCM member	WHO Georgia, Head of Country Office	Ms. RusudanKlimiashvili	
CCM member	USAID Georgia Tuberculosis Prevention Project, URC LLC, Chief of Party	Ms. Tamar Gabunia	
CCM member	Employers' Association of Georgia, President	Mr. ElgujaMeladze	
CCM member	HIV/AIDS Support Foundation, Director	Ms. IzoletaBodokia	
CCM member	"Georgian Plus Group", Director	Mr. David Ananiashvili	
CCM member	Georgian National Association for Palliative Care, Board Member	Ms. FatiDzotsenidze	
CCM member	Deputy Minister of Corrections and Legal Assistance	Mr. ArchilTalakvadze	
CCM member	Deputy Minister of Education and Science	Ms. KetevanNatriashvili	

1.3 Summary of CCM Request for Renewal

1.3.1 Summary of Request

Please provide a brief overview of the current progress toward goals and objectives of the proposal as well as main observations, the recommendations and the rationale for the Request for Renewal.

This application represents a Resubmission Request for Renewal of The Global Fund HIV Grant GEO-H-GPIC (Principal Recipient: Global Projects Implementation Center), which covers the next period from 01 January 2013 to 31 December 2015 (2nd Implementation Period). However, to avoid interruptions and allow CCM to revise and resubmit the request for the 2nd Implementation Period, the 1st semester 2013 is currently covered by the 1st Implementation Period no-cost extension approved by TGF separately on 03 December 2012.

The Grant Renewals Panel of TGF had a series of concerns, questions and clarifications to the Request for Renewal submitted on 30 April 2012 and recommended to address them in a Resubmission Request. In the current application, the CCM responded to the specific concerns and questions, provided additional contextual information and described all remedial actions that have been taken to address program weaknesses from the 1st Implementation Period of the grant (please see #1.3.2. – proposed programmatic, budgetary and implementation arrangements; #2.1.3. – program oversight; #2.1.5. – process description; #3.1. and 3.2. – epidemiological situation and country context; #4.2. – progress towards the goal and impact; 5.1.2. – grant risk management etc.)

The HIV Program evaluation commended by CCM determined the impact and outcome of the HIV program in Georgia to-date, assessed the quality of services based on available data and defined the most effective interventions to accelerate the impact on the epidemic. All the findings and recommendations of the evaluation determined the strategic approach and key programmatic interventions for the 2nd Implementation Period of the program and served as basis for the thorough analysis and justifications of the proposed implementation strategy and activities.

In particular, the HIV Program Evaluation report confirmed that Georgia is currently experiencing a national concentrated epidemic with demonstrated over 10% prevalence among MSM; prevalence among PWID is over 5% in two sites. The coverage with needle and syringe programs as well as by OST is unsatisfactory. Respectively, the report recommended establishing much ambitious targets for activities targeting MSM and increasing coverage of PWID with harm reduction services. Also, the report encourages continuation of VCT activities, ARV and hepatitis C treatment to further contribute to universal treatment coverage. All these recommendations were taken into consideration by the current application for renewal.

The Georgian Government is committed to fight the epidemic and increasingly allocates financial, human and infrastructural resources for this purpose. However, substantial financial and programmatic gaps exist, especially in regard to the complex and costly interventions in HIV/AIDS treatment and prevention activities among most-at-risk population groups. Taking the above into consideration, the CCM has therefore decided to re-submit the application for renewal and solicit support from the Global Fund in bridging the gap in the field and ensure continuation, consolidation and scaling up of activities initiated within the current SSF HIV program.

The overall Goal is to reduce transmission of HIV among most-at-risk populations (MARPs) and reduce mortality among PLHIV in Georgia. The goal is set in accordance with the international recommendations stipulated in the United Nations General Assembly Declaration on Scaling Up HIV Prevention, Treatment, Care and Support and other WHO and UNAIDS guiding documents calling for the ensuring of universal access for HIV prevention, treatment, care, and support.

The application complies with current TGF requirements, including mandatory budget reduction. As result of

the new epidemiological data analysis and HIV Program Evaluation recommendations, the activities implemented during the previous phase of the grant have been re-focused and prioritized, and were re-organized under the following four main ***Objectives***.

Objective 1. To establishsupportive environment for HIV/AIDS prevention, treatment, care and support

1.1. Developing and sustaining relevant HIV policies

[SDA: Policy development]

The current proposal intends to continue developing and sustaining further the relevant HIV policies, especially in view of newly elected Government (October 2012). The program will further focus on HIV/AIDS and drug abuse related issues by preparing necessary regulations and bylaws and their harmonization with other legal documents.

Late HIV diagnosis, often resulting from missed opportunities to diagnose HIV in healthcare settings constitutes one of the major causes of death among PLHIV. The current proposal will expand provider initiated HIV testing and counselling (PIHTC) in health sector, based on adjusted national guidelines (endorsed by WHO). The activity will support dissemination of national guidelines, training of healthcare professionals, including laboratory specialists, M&E and operation of the activity.

During 1st Implementation Period, activities related to implementation of the HIV drug resistance (HIVDR) strategy have been piloted by the National AIDS Center. During the 2nd Implementation Period, the program aims to expand these initiatives at the regional facilities and improve it based on pilot lessons learned. It is intended to sustain the implementation of HIVDR strategy in order to prolong and maximize the quality of life for PLHIV by minimizing emergence of preventable HIVDR through supporting optimal ART program functioning.

1.2. Reducing stigma, advocacy, communication and social mobilization

[SDA: Stigma reduction in all settings]

The 2nd Implementation Period activities will be focused on implementing effective advocacy campaigns, conducting policy meetings with the participation of policymakers and law enforcement people, as well as NGO representatives in order to promote the proper execution of new laws by the adoption of bylaws and regulations. A series of reporting and advocacy workshops with the participation of key stakeholders, ombudsman office and mass media representatives will be organized. Different communication materials will be developed and distributed.

During next 3 years the program will support a series of trainingsfor health workers on stigma and discrimination, while helping them to understand their own attitudes about HIV/AIDS and PLHIV. The training will cover human rights aspects related to health care services, information about the use of standard precautions and proper infection prevention techniques to help minimize the risk of occupational exposure of HCWs to HIV. It is expected that about 2000 health care providers will be trained during the program life.

Objective 2. To increase coverage and quality of preventive interventions targeted at MARPs

2.1. Providing a comprehensive HIV prevention package to PWID

[SDA: Community based activities and services - delivery, use and quality]

The current application focuses on developing and delivering of a comprehensive package of HIV prevention services for MARPs. The program will further contribute to quality of services, will facilitate case management approach, will stimulate gender-specific interventions, and will expand new methods piloted during the 1st Implementation Period of the grant (e.g. Peer driven interventions for IDUs).

In particular,PWID will receive needles and other sterile injecting equipment, condoms, lubricants, IE

materials. The program will cover the existing 10 most affected regions: Tbilisi (2 sites), Gori, Zugdidi, Batumi, Sokhumi, Telavi, Kutaisi, Samtredia and Poti. Also, the activities are oriented to open four new centers– one additional in Tbilisi, one in Kvemokartli region and the third in SamtskeDjavakheti region.

During 2nd Implementation Period, the program will continue to support voluntary counselling and testing (VCT) to PWID from 11 cities of Georgia (13 harm reduction sites). The services will include rapid testing for HIV, HCV, HBV and TP-syphilis. In order to increase testing coverage, the program will support additional 6 mobile laboratories. The mobile units will distribute sterile equipment to PWID as well. Using this technology, it is expected that the program will rapidly scale-up this intervention and bring the total number of covered cities to 48.

The Global Fund supported program will contribute to strengthening participation of civil society and communities in HIV/AIDS control in Georgia. It is expected that a national network of PWID will be established starting from 2013. On-going technical assistance will be provided to self-support community based organizations; a series of capacity building activities will be provided to increase the role of communities in improving access and quality of services in Georgia, including training.

During the 2nd Implementation Period, the activities will be focused on scaling-up methadone maintenance therapy by development of capacities of existing centers, opening a new one and applying cost-efficient measures. It is expected that the program will support 6 OST centers in civilian sector and 2 centers in prison sector, and will cover more than 1000 beneficiaries; the overall costs will be decreased by 15% compare to 2012. In order to increase the outcome of OST treatment, the program will provide psycho-social support to beneficiaries and their families.

During the 2nd Implementation Period, the program will continue to support capacity building interventions, training of OST staff as well as involving peer educators. The program will support VCT unit to continue to serve OST beneficiaries. The beneficiaries of the OST centers will receive a minimum set of information and education materials. The special web-page on will be updated regularly.

2.2. Scaling-up prevention programs among MSM, FSWs and prisoners

[SDA: Community based activities and services - delivery, use and quality]

The coverage of FSWs during the 2nd Implementation Period will be increased up to 21%, 1 681 in 5 cities (size estimate 8,000). the coverage will be reached using the following techniques: Increasing the frequency of regular outreach; Mobile labs outreach; PDI model for FSWs. It is important to note that there is no reliable data on FSWs size estimation. There are many expert opinions on this including one that population size of street based and other most at risk FSWs is much lower in which case program coverage of 1681 FSWs will reach majority of this group.

The coverage of MSM will be gradually increased and will reach up to 18% (size estimation of 17000) or 3084 MSM in 3 cities through use of the following approaches: Increasing the frequency of regular outreach and recruiting MSM outreach workers for prevention programs; Peer education trainings and information-educational meetings; Popular opinion leaders program; In-office counseling and testing; Mobile labs outreach; Organizing special awareness rising events and social networking and internet based interventions

The size estimation of MSM conducted in 2010 by Tanadgoma suggests that there 7900 active MSM in Tbilisi and 1200 MSM with low socio-economic status. Given that most of coverage is planned in Tbilisi it is expected that the proposed program coverage will have visible impact on HIV epidemic in this group. At the same time it should be noted that given current level of stigma and marginalization of this group the target set for this program is very ambitious and could be achieved only with support of advocacy work directed on changing of social and policy environment.

The HIV counselling, testing, STIs treatment and other preventive measures will be conducted based on involvement of community outreach workers and mobile units. Special focus of the program will be made on MSM as one the main drivers of the epidemic in Georgia by peer-to-peer interventions, educational group community meetings, internet-based interventions, PDI, social events and Popular Opinion Leader program. Condoms, lubricants and IEC materials will be distributed by the program.

The activities targeting prisoners will include VCT capacity building, HIV and STIs awareness improvement,

capacity building of prison medical staff and ensuring access to basic diagnostic, treatment and care services for PLHIV. It is expected that all prisons of Georgia will be covered by testing and counselling services. The program will support extensive capacity building activities, including training of counsellors and laboratory technicians. During the 2nd Implementation Period, the prison inmates will be covered by a minimum set of preventive services, including condoms, lubricants, IEC materials, self-support groups etc. The program intends to reach about 12 000 inmates through VCT as well as other preventive services.

Objective 3. To sustain treatment, care and support for PLHIV including Abkhazia frozen conflict area

3.1. Improving access and quality of treatment

[SDA: Antiretroviral treatment (ARV) and monitoring]

During 2nd Implementation Period, the program will support provision of ARV drugs, overall administration of the program and monitoring of ART effectiveness. The activity will support implementation of new ART initiation criteria of CD4 count<500 cells/mm^3. The ART needs assessment and planning was based on epidemiological dynamics andART programmatic data, also taking into considerationestimated number of patients in need of treatment (based on UNAIDS Spectrum). The selection of ART regimens and drugs was based on 2012 revision of ART guidelines of the WHO Regional Office for Europe. It is expected the program will ensure more than 95% of eligible registeredPLHIV to receive treatment.

ART will be provided in 5 existing locations countrywide – National AIDS Center in capital city of Tbilisi, regional centers in Kutaisi, Batumi, Zugdidi, and Sokhumi regional center in breakaway region of Abkhazia. While all 4 regional centers operate in Western Georgia, National AIDS Center in the capital city is the only facility providing ART for patients living in Eastern parts of the country. Therefore, the program includes additional resources to support opening and operation of new facility in Eastern Georgia in the city of Telavi. The new centerwill provide treatment and care services to more than 300 PLHIV in Eastern Georgia (excluding Tbilisi).

The program will support antiretroviral drugs for the prevention of mother-to-child transmission of HIV. It is expected that 30 HIV positive pregnant women and their new-borns will undergo the course of ARV prophylaxis annually. Vaccines for common infections affecting HIV patients, such as hepatitis B and influenza will be provided.

The 2nd Implementation Period activities are also oriented to ART monitoring, including maintenance of AHIS (AIDS Health Information System), routine data management, implementation of data quality control and assurance and on-site data verification. The proposed M&E activities will be mainstreamed with the national M&E system. In parallel, the program will ensure tests to measure CD4 cell count and viral load based on national protocols endorsed by WHO. It also will sustain HIV drug resistance testing among patients to improve treatment outcomes.

The co-infection with hepatitis C virus (HCV) in PLHIV is one of the major problems in Georgia, influencing mortality high rates. About 50% of PLHIV have HCV antibodies in Georgia. The program will continue to support HCV therapy with pegilated interferon (IFN) and ribavirin (RBV), as well as monitoring of patients (including laboratory tests and elastography). Clinical management of HIV/HCV co-infection is provided based on the National Guidelines on Management of Hepatitis C and HIV Co-infection endorsed by WHO. It is expected 150 HIV/HCV co-infected persons to be treated annually.

3.2. Ensuring care and support, and capacity building

[SDA: Care and support for the chronically ill]

The 2nd Implementation Period activities aim at ensuring delivery of palliative care services to chronically ill people. Home-based and institutional (hospice) palliative care services were established within round 6 HIV project; starting from 2011 the institutional-based palliative care services to PLHIV are supported entirely by the state budget allocations. The Global Fund program will continue home-based palliative care service delivery and ensure coordination between TGF and state funded palliative care programs.

The network of four self-support centers of PLHIV established through TGF support will continue its operation,

providing telephone and face to face counselling and psychosocial assistance to HIV/AIDS patients and family members reaching more than 60% of registered PLHIV. The program will support remunerations of the staff with the majority being HIV positive, rent and operational costs. Along with psychological assistance, art-therapy, English language and computer lessons will be provided to PLHIV and family members to improve their integration and employment opportunities.

During 2nd Implementation Period, the program will continue support of PLHIV meetings at central and regional levels, exchange visits, training abroad and other events targeting both adults and children (e.g. summer camps). The events provide PLHIV with an opportunity to discuss the common problems and set the common goals to improve access to counselling, diagnostic, treatment, care and social assistance programs and employment opportunities. In addition, the Program will support PLHIV events on World AIDS Day and AIDS Commemorative day.

Objective 4. To generate evidences and document HIV program effectiveness

4.1. Conducting operational research to document program effectiveness

[SDA: HSS - Information system & Operational research]

To collect additional evidence, inform decisions and facilitate effective operational planning of HIV/AIDS control interventions, an operational research component is included in the proposal. The studies will address priority problems related to HIV/AIDS control in Georgia with special emphases on MARPs. The studies will be conducted by national and international organisations, which will be selected by the PR on a competitive basis taking into account technical and financial parts of the submitted proposals. The results of the studies will be published and publicly discussed, and relevant recommendations will be developed on the basis of the findings.

The total amount of funds requested for 2nd Implementation Period HIV program is EUR 24,429,620; it includes the TGF-mandated adjustment (10% reduction) vis-à-vis the initial TRP approved budget and other adjustments as result of TGF Secretariat and HIV Program Evaluation recommendations.

1.3.2 Proposed Changes in Programmatic, Budgetary and Implementation Arrangements

1. Are you proposing any changes in the Implementation Arrangements of the grant/program? No

If yes, please indicate the nature of the change.

Reallocationof funds between PRs	Changes in institutional arrangements	Budgetary changes
No	No	Yes

Please describe and provide rationale and justification for each proposed change.

The proposed budgetary changes represent 10% reduction from the total TRP clarified amount for years 2013-2015 (Round 2 RCC, Round 9 and Round 10) as currently mandated by TGF for renewals of grants in upper – low middle income countries. As result of the Program evaluation implemented in November – December 2012, a series of ordinary adjustments are proposed in order to increase the focus of program interventions and to uphold high priority interventions (i.e. MSM, NE and VCT among PWID etc).

No any re-programming actions are planned: all activities during 2nd Implementation Period are centered on the original program goal and objectives (see details in the working plan and the budget attached to this

document).

If you are adding new PR(s) to the grant/program, please provide name(s).

Not applicable

If you are discontinuing any PR(s) in the grant/program, please provide name(s).

Not applicable

2. Are you proposing any changes to the scope and/or scale of the performance framework of the grant/program? **Yes**

If yes, please describe and provide rationale and justification for the proposed change.

Based on the recommendations of the HIV Program evaluation implemented in November – December 2012, using the updated figures based on the most recent epidemiological data including the results of the 2012 Bio-BSS Survey, analyzed factors that contribute to the burden of HIV mortality and morbidity in MARPs in Georgia, the Performance Framework for 2nd Implementation Periodwas updated and adjusted accordingly.

Do the proposed changes entail material reprogramming compared to the original proposal(s)? **No**

If yes, please indicate and explain whether the changes affect the entire program or a specific PR.

Not applicable

1.3.3 CCM Request for Renewal

CCM Requested Budget for Renewal			
		PR 1[1]	**Total Program**
a	Adjusted TRP clarified amount for the next Phase/ Implementation Period	30,709,747	30,709,747
b	*Total budget requested (after cut-off date to the end of the next Phase/Implementation Period)*	*39,221,464*	*39,221,464*
c	- Undisbursed amount at cut-off date	12,714,135	12,714,135
d	- Cash at cut-off date	2,174,919.94	2,174,919.94
e	*= Incremental amount requested*	22,071,274.06	22,071,274.06
f	*% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)*	80%	80%

Has the CCM taken into account any Board-approved funding limitations? **Yes**
(Please refer to the CCM Invitation Letter for further details).

[1]Total amounts for each PR.

SECTION 2: CCM GOVERNANCE

2.1 CCM Governance Overview

Please refer to the CCM Requirements listed in the CCM Request Guidelines.

2.1.1 When was the last Round that the CCM/RCM/sub-CCM applied for funding? **Round 10, August 2010**

Was the CCM/RCM/sub-CCM determined compliant with the CCM requirements at this time? **Yes**

If the CCM/RCM/sub-CCM was not compliant when they last applied, please describe what remedial actions were taken by the CCM/RCM/sub-CCM?

Not applicable

CCMs/RCMs/sub-CCMs should answer questions 2.1.2 and 2.1.3, 2.1.4, and 2.1.5 (not 2.1.6)
Non-CCM applicants should proceed directly to question 2.1.6.

2.1.2 CCM Membership

a) When was the last time that changes were made in the CCM/RCM/sub-CCM membership of people living with HIV and people affected by tuberculosis and malaria? Please provide details for those changes, including the current membership of people living with and/or affected by the diseases.

The Country Coordination Mechanism (CCM) in Georgia was formed in 2002 as a Coordinating Authority in order to coordinate and provide monitoring of implementation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and other Programmes. On 01 May 2007 Ministry of Labour, Health and Social Affairs (MoLHSA) of Georgia approved (Order # 144) Country Coordinating Mechanism Membership and Charter for Projects of the Global Fund in Georgia and other Programmes in Relation with AIDS and Tuberculosis within the Country (based on resolution N249 of 31/12/2005 of the Government of Georgia). On 18 June 2012 the CCM and its regulation was approved by the Resolution (#220) of the Cabinet of Ministers of Georgia – hereinafter CCM Regulation. The CCM is a standing advisory and consultative body under the Cabinet of Ministers of Georgia, engaged in inter - sectoral and multi - sectoral coordination of the national response to epidemics of HIV/AIDS, TB and Malaria. The membership of the NationalHIV/AIDS, TB and Malaria Council is multi - sectoral and includes representatives of governmental, non-governmental and private organizations as well as other civil society representatives.

Since Georgia submitted its Round 10 Proposal to the GF, the CCM membership has not been changed. The Parliamentary elections in 2012 and subsequent changes in the Government did not affect the composition of the CCM as well as the civil society constituency in CCM. In addition to two representatives of people living with the diseases (one member representing PLHIV and one former TB patient), the CCM membership includes NGOs working to provide care and support to PLHIV, MARPs (FSWs, IDUs, MSM, Prisoners, TB patients). Based on OIG recommendations, the representation of two NGOs is rotation based and was prolonged for the current year as well.

b) When was the last time that changes were made in the representation of non-government constituencies (e.g. community based organizations, faith based organizations, private sector, private academic institutions, people living with and/or affected by the diseases, key affected populations) on the CCM/RCM/sub-CCM? Please describe how new members were selected by their own constituencies based on a documented, transparent process developed within each constituency.

The election of CCM members on behalf of non-government constituencies is made in accordance with the CCM Regulations. According to the Regulations, the government agencies delegate their representatives in CCM by written notification, while international and national non-governmental organization ensure an open and transparent process of electing their representative from among those organizations that expressed their

desire and commitment to coordinate joint activities in TB and HIV/AIDS areas. Documentary evidence of transparent decision to delegate the authority to the representative of the group of stakeholders is submitted to the CCM Secretariat.

On 3 February 2012, the NGO constituencies changed their representation: Mrs. Tamar Gabunia, URC Chief of Party was elected as a CCM member. URC is implementing USAID funded TB Prevention Program. Along with GFATM funded TB grant this project represents a major assistance to the National TB program for the next four years.NGO representation at the CCM regarding of HIV/AIDS is on rotational basis and HIV/AIDS Prevention Task Force (PTF) that includes all NGOs active in this field selects two NGOs that represent the PTF at the CCM through transparent voting. In case of TB programs, URC is the only one NGO that works in this area in Georgia implementing very important project and CCM took in the account importance of having international expertise on TB.

Based on the current membership, the civil society has a 37.5% representation on the CCM.

2.1.3. Program Oversight

Does your CCM have an oversight plan which has been approved by the CCM?**Yes**

If no, explain the reasons.

Not applicable

If yes, describe the oversight activities which are detailed in the plan.How has the CCM been implementing this plan?How does the CCM engage program stakeholders in oversight, including the CCM members and non-members, in particular non-government constituencies and people living with and/or affected by the diseases.

The draft of the CCM oversight plan has been updated by the CCM secretariat during December 2012 – January 2013 based on GFATM recommendations and as agreed during the CCM meeting from 31 January 2013 it has been circulated and approved by the members via e-mail on 12 February 2013.

The Plan is aimed at improving the TGF aid effectiveness through oversight of the performance of the Principal and Sub-Recipients and assesses the outcomes and impact of the TGF Grant Programmes on the epidemics. The key areas of oversight for the CCM are defined as follows: Proposal Development, Grant Negotiations, Grant Implementation, Donor Coordination and Alignment with Health Systems, Grant Closure. The CCM could nominate the Oversight Committee (OC) with the task of gathering, reviewing and condensing information into briefs that can be presented to the CCM. The OC should be chaired by a CCM member and comprised of maximum six members, from CCM, secretariat and non-CCM members, respectively three, one and two.

Each of the OC members should have specific management, financial, procurement or other technical skills to assist with the task of information review and analysis. The OC may from time to time delegate or refer specific tasks, questions or areas of inquiry beyond its capacity to address to other groups including Technical Working Groups, individuals with specific expertise, or individuals or groups within the national programs for HIV/AIDS, TB and Malaria. The OC will meet quarterly. The OC debrief of grant progress and findings will be a regular feature on the agenda of all CCM meetings. The OC, with input from the CCM, will decide what information it will track in executing an appropriate oversight role.

The following areas of inquiry will be addressed: Finance; Procurement; Implementation; Result; Reporting; Technical Assistance. The CCM and the OC will have at its disposal a variety of information sources, both formal and informal (Work plans; Budgets; Monitoring&Evaluation Plan; Procurement and Supply Management Plan and other relevant documents; Grant Score Card (GSC) Any survey or operational research reports- Grant Performance Report (GPR); Informal reports Progress Update/ Disbursement Request (PU/DR)

etc).

The CCM should conduct site visits to places where services are being delivered or other grant activities are taken place. The CCM and/or OC may need technical support to carry out its oversight activities. It may be possible for the CCM to obtain these kinds of technical support from partner organizations such as UNAIDS, WHO and bilateral donors. The plan describes key communication/functions related to oversight: GFATM's management letters; PUDRs; PR's should annual work and visiting plan; PR grant's calendar of milestones. In the process of problems' identification they can be classified into one of several categories. The plan gives the resolution models for the problems according to the category they lie within.

The copy of the plan is attached to the renewal request.

2.1.4 Managing Conflicts of Interest and Constituency Engagement

How does your CCM manage conflict of interest among its members and/or grant implementers who sit on the CCM?What measures are in place to ensure the CCM's conflict of interest section from your CCM governance documents is applied?How is the management of conflict of interest documented by the CCM?

The conflict of interest is mitigated based on conflict of interest policy, as approved by the CCM regulation on 18 June 2012.The policy highlights the importance of the issue and defines the responsibilities of the CCM and its members regarding the disclosure of the conflict of interest and its management.

Before voting for his or her CCM membership each potential member shall declare in writing in the Conflict of Interest Register maintained by the CCM Secretariat the interests that such person or the organization that he or she represents may have in any activity of CCM.

In any situation that may give rise to a conflict of interest or a potential conflict of interest, the member concerned shall declare the same to the CCM Secretariat before vote and the Secretariat shall notify the same to all CCM members, or the Chair CCM during a meeting of the CCM.

If the conflict of interest is likely to undermine or raise questions about the decision or action of CCM, the Chair (with the approval of CCM members) should take appropriate action to avoid or minimize that impact. Depending on the seriousness of the conflict of interest, ideally the member concerned should step down from any involvement in the particular decision or action of CCM. This may be done by not participating in the relevant meeting of CCM or not taking part in discussion concerning the decision or action in question and not participating in the relevant votes.

Where this is not possible because the member concerned is the most suitable for taking part in the discussion, or the only member with the relevant expertise, the Chair with the approval of CCM members should explore ways in which actual or potential bias can be overcome (e.g. seeking referees or outside expert opinion, or documenting the conflict of interest etc.). Wider consultation with non-Member experts may also be considered to minimize the impact of any actual or perceived bias.

CCM asks the members if there is any conflict of interest regarding the issue to be discussed at each meeting. Where any conflict of interest is disclosed in a meeting it is recorded in the minutes together with the decision of the CCM in respect thereof. In case of a failure to do disclose the serious conflict of interest, the CCM may choose to disqualify the individual or the organization concerned from its' membership.

2.1.5 In case of any proposed changes in Programmatic, Budgetary and Implementation arrangements (1.3.2), please describe the documented and transparent processes followed to ensure participation of all constituencies represented on the CCM/RCM/sub-CCM (including members and non-members) in the development and approval of these changes. Please describe the process that was used to ensure effective management of any potential conflict of interest that might have affected this process.

One of the CCM functions is to evaluate and recommend to the Government solutions regarding budget estimations and identification of financial resources needed for the implementation of TB and HIV/AIDS national programs.If specific changes need to be made in programmatic, budgetary and/or implementation arrangements with respect to TB or HIV responses, then the initiative is preliminarily discussed amongst stakeholders active in the field. Based on an open, transparent and participatory process, the CCM of Georgia submitted a request for renewals on 30 April 2012.

After conducting a thorough review of the performance of the HIV program as described in the CCM Request for Renewal submitted to the Global Fund Secretariat on 30 April 2012, the Grant Renewals Panel of TGF has decided that it cannot recommend the programs for continued funding at this time. Instead, the Panel has recommended a resubmission request. The following concerns were addressed by the CCM during the resubmission process.

1. The CCM request did not address progress towards proposal goals and impact to demonstrate that the grant service delivery areas are adequately addressing the HIV epidemic.

The CCM in collaboration with the Secretariat and technical partners conducted an external and independent evaluation of the HIV program. A team of four members was commissioned to conduct the evaluation and report onthe findings and recommendations. The evaluation took place during 28 November - 10 December 2012. The evaluation team has conducted series of meetings with main stakeholders. Finally, the team conducted a debriefingwith the CCM members. The evaluation determined the impact and outcome of the HIV program in Georgia to-date, assessed the quality of services based on available data and defined the most effective interventions to accelerate the impact on the epidemic. All the findings and recommendations of the evaluation determined the strategic approach and key programmatic interventions for the 2nd Implementation Period of the program and served as basis for the thorough analysis and justifications of the proposed implementation strategy and activities described in details in the Section 6: Programmatic proposal.

2. The current grant implementation arrangements are unsatisfactory with significant issues identified in all functional areas of grant management.

The CCM has taken necessary measures to address the weaknesses in the areas of program management, sub-recipient management, financial management, procurement and supply management, and monitoring and evaluation. On 01 September at its 59th meeting the CCM discussed PR modalities, strengthening Global Fund grants implementation oversight and specifically GEO-H-GPIC grant, renewal re-submission and it was decided to re-submit Renewal of the GEO-H-GPIC grant through open voting.

Concerning the PR-ship, the CCM updated the oversight plan (OP), which envisages enhanced monitoring of the GFATM program implementation. The OP was developed to improve the donor aid effectiveness through oversight of Principal Recipient and Sub-Recipients performance and assess the outcomes and impact of TGF grant programs on the three diseases.

Decision-making model was used with respect to the CCM decision to apply to TGF renewals of HIV grant. As it was recommended in the Grant Renewal resubmission request, the CCM considered external evaluation results in shaping the strategy for the next implementation period and therefore key programmatic interventions are determined accordingly for the next period. After receipt of HIV program evaluation report on 04 January 2013, the report was distributed among CCM members to meet final agreement on key findings. The relevant comments were collected, compiled and communicated to the evaluation team. The evaluation team took into consideration all the comments and submitted the final version of the report on 18 January 2013. Following the report, all Grant Renewal documentation was disseminated to stakeholders by GPIC on 21 January 2013 with the request to submit proposals on activities and budget by 29 January 2013.

PR nomination process. On 31 January 2013, the CCM during its meeting discussed the PR nomination issues

as well as HIV Periodic review procedures. CCM selected PR for the 2nd Implementation Period through an open public competition. Two organizations applied: GPIC and NNLE "Maternal and Child Care Union". The evaluation process was anonymous (21 out of 24 CCM members were presented at the CCM meeting; 17 out of 21 presented were not in conflict of interest and subsequently voted). Following this process, the CCM nominated the Global Projects Implementation Center as PR for the 2nd Implementation Period of the grant (14 votes pro out of 17 total votes).

On 08 February 2013 a stakeholder meeting was organized to finalize the renewal process. As a result, based on programmatic and budgetary information presented by the PR on the HIV program, the workgroup members assessed the relevance of all activities conducted during the 1st Implementation Period of the program implementation, agreed on the need to exclude in the 2nd Implementation Period those activities that do not add vivid value for money, and recommended to the CCM to apply for the renewal of a TGF grant for the national HIV response.

The formal/documented recommendations of the working group meetings were considered and supported by the CCM, which adopted the final application to apply for GF grant renewal through electronic correspondence on 14 February 2013. All the decisions and minutes of the CCM meetings are made public and placed on the website of the CCM Secretariat (http://www.georgia-ccm.ge).

Non-CCM applicants only

2.1.6 Please refer to the original proposal(s) and provide a brief update on the status of exceptional conditions for which you were last approved as a non-CCM applicant (maximum 1/2 page.

Not applicable

SECTION 3: COUNTRY CONTEXT

3.1 Epidemiological situation

Please describe any changes to the disease epidemiological situation that is likely to affect program implementation or strategies. (Please indicate sources of information)

It took almost two decades for Georgia population to improve health status thatdeteriorated dramatically after the collapse of Soviet Union in 1990. Life expectancyincreased from 71.6 years in 2001 to 74.4 in 20106, exceeding the average in formersoviet republics. The fertility rate increased from 1.41 in 2003 to 1.83 in 2010 but it isstill below the replacement value necessary for population growth.[2] The share of theelderly above 60 years increased from 15% in 1990 to 18.6% in 2011.The absolute number of deaths has not been reduced to around 47,000annually over the past decade. Progress has been made in reducing infant andunder-five mortality from 41.6 to 14.1 per 1000 live births for infants, and from 45.3 to16.4 for children under-five from 2000 to 2010.[3] The Maternal Mortality Ratio hasdecreased from 48 in 2000 to 14.3 in 2008, jumped up to 52.1 in 2009, anddecreased to 19.2 in 2010. It should be noted that there is a difference in ratesreported by official statistics & population-based studies, and those published ininternational sources.

Georgia has a low HIV prevalence of 0.05% in adults but is a high-risk country for anexpanding epidemic. There is widespread injecting drug use and populationmovement between Georgia and neighboring higher prevalence countries such asUkraine and Russia.The number of people living with HIV (PLHIV) in the country was estimated to be 4,950 in2012.[4] As of December 31, 2011, there were 3,033 cases of HIV infection

[2]Statistical Yearbook of Georgia; 2011. National Statistics Office of Georgia; Tbilisi; 2012

[3]Serbanescu F, Egnatashvili V., Ruiz A., Suchdev D., Goodwin M. 2011.Reproductive Health SurveyGeorgia 2010.Summary Report.Georgian Center for Disease Control and Centers for Disease Controland Prevention. Atlanta, GA, USA.

[4]Infectious Disease, AIDS and Clinical Immunology Research Centre, Georgia, December 2012

registeredin the country.[5]Over a third of PLHIV live in the capital Tbilisi, with another 31% in theBlack Sea coastal regions of Adjara and Samegrelo. In 2010 the highest rates ofcase detection were found in Tbilisi, Samegrelo, and Adjara, having 14.1, 13.5 and9.1 case detections per 100,000 populationrespectively.[6]The epidemiological distribution of case detection by gender and age indicates apeak among the 25-40 age group. The biggest difference between the number of HIV positive men and women was also detected in those over 25 years old, while the genderdifference is minimal among people between 15 - 24 years old.[7]

The number of newly reported cases has been risen each year, but the rates remain significantly lower compared to Eastern European average.[8]The annual number of detected cases grew from around a hundredduring 2000-2003 to over 250 in 2005-2006, and over 400 since 2010; with estimatedincidence rates in 2011 varying from 5.5 to 9.5 per 100,000 population.HIV surveillance data indicates that annually, on average 45% of newly reported cases are diagnosed at advanced stages of disease, adversely affecting survival. Two major reasons underlying this problem is the missed opportunities to diagnose HIV earlier in healthcare settings and low HIV testing uptake among key populations at risk.[9]As shown in last Bio-BSS HIV testing and counseling coverage is low among all most-at-risk populations (MARPs): 28% among female sex workers (FSWs), 16% among men who have sex with men (MSM) and 3-8% (depending on geographic location) among people who inject drugs (PWID).

HIV infection is primarily restricted to the key populations at higher risk: MSM, PWID, FSW and prisoners. The Behavioral Surveillance Surveys with Biomarker Component (Bio-BSS) conducted among MSM in Tbilisi in 2007 found an HIV prevalence of 3.7% and in 2010 - 6.4%. Provisional data fromthe ongoing sentinel surveillance exercise found HIV prevalence among MSM at 13%.[10]This is likely to be the highest prevalence in the country as it is the largest city. As Tbilisi is the only Bio-BSS sampling site, there is alack of data from other cities. However, the epidemic among MSM appears to be the most severe among four most at risk populations.

Another key population at risk is PWID. About 40,000 PWID are estimated in Georgia: 27,000 live in Tbilisi and 13,000 in the rest of the country. In 2012, preliminary data notes that reporteddrug use was: desomorphine 36%; heroin 35.9%; ephedrine 31%; buprenorphine13.4%; and morphine 7.2%.According to the preliminaryresults of the 2012 Bio-BSS, an aggregated HIV prevalence among PWID in five cities in Georgia is 3.0%. This appears to be stable as may be compared to the aggregate figureof 2.5% in 2008.Thesexual partners of PWID are also affected. The proportions of male and female detections were 75% and 25%respectively until 2011. After 2011, the proportion changed, with males accounting for 70% of casedetections and females for 30%. This shift might be explained by the spread of HIVamong sexual partners of PWID.

The epidemic among FSW is of lower magnitude. The HIV prevalence among FSW in two sentinel surveillance sites was about 1.9% in Tbilisi and 1.3% in Batumi in 2009; the 2012 data shows stabilization of these figures (1.1%). The proportion of sex workers who report consistent condom use declined slightly in both sites since the last round of sentinel surveillance. Self reported condom use with the last client is still very high at 94.4% in Tbilisi and 85.8% in Batumi.

With about 20,000 prisoners in December 2012, Georgia has the sixth highest rate ofincarceration in the world (about 514/100,000).Many prisons have been built in Georgia in the last decade. The consensus is thatvirtually no drugs are now found in prisons in Georgia. This is usually attributed tostringent measures taken by

[5]UNAIDS

[6]NCDCPH Statistics Yearbook, 2010

[7]UNAIDS

[8]World Health Organization Regional Office for Europe, European Centre for Disease Prevention and Control. 2010. HIV/AIDS surveillance in Europe 2010: surveillance report. Stockholm: European Centre for Disease Prevention and Control (ECDC).

[9]Chkhartishvili N, Rukhadze N, Sharvadze L, et al.. Factors associated with late HIV diagnosis in Georgia. Tbilisi: Infectious Diseases, AIDS and Clinical Immunology Research Center, WHO Country Office in Georgia.

[10]Final results will be available in December 2012

Georgian correctional authorities and the design of thenewer prisons. However, similar measures even in new prisons in most othercountries have failed to stem the flow of drugs into prisons. Although, a large prison population represents a high risk of drug-related HIV infection. The results of 2012 Bio-BSS showed HIV prevalence at 0.3% vs. BSS result conducted in 2008 (1.4%).

In addition, the prevalence of HIV infection remains very low among pregnant women. In 2011, HIV testing coverage among pregnant women was 82.3% and theprevalence of infection was 0.03%. In this respect, the data show that HIV epidemic has not established in general population and remains concentrated around MARPs, emphasizing the need for interventions targeting most-at-risk and bridging populations.

There are an estimated 5,000 people living with HIV in Georgia. About 2,700 have been diagnosed, 1,500 are eligible for antiretroviraltreatment at a CD4 threshold of 350, and 1,640 are currentlytaking treatment (1,537 treatment naive and 103 – treatment experienced). This is a remarkable "shallow or gradual treatment cascade" andrepresents a leading achievement of the treatment program in the country and theregion. Basically 2004-2012, the number of patientsreceiving antiretroviral therapy grew-up 22 fold. The HCV prevalence in general population is about 6% and 50% is among PWID. Up to date, about 120 people began HCV treatment with TGF support. Currently, all patients with TB/HIV co-infection received free care, includingtreatment for both diseases.

Georgia has implemented HIV prevention and care activities since 1994, prioritizingvoluntary counseling and testing, reaching key populations for prevention, providingfree prevention of mother to child transmission services, providing antiretroviraltreatment, building capacity, and raising awareness through media campaigns.The National Strategic Plan of Action 2011–2016 is focused on prevention for keypopulations and improving health outcomes for people living with HIV. A newHIV/AIDS Surveillance System was introduced countrywide in January 2010.HIV prevention and care activities have been categorized into state programscalled the HIV/AIDS Prevention and Treatment Programme; the Safe BloodProgramme; and the Prevention of Mother to Child Transmission Programme.

3.2 Country Context

Please describe the relevant key changes in the national or program context (political environment, economic situation, social situation and legal context) and the effect of these on program implementation. Elaborate on the changes adversely influencing the program performance and any strategies put in place to mitigate the negative effect on the program. (Please indicate sources of information).

Georgia continues to view EU membership as a long-term objective. It will not be considered a candidate for membership any time soon. Georgia will have to be content, at least for the foreseeable future, with the Georgia-EU association agenda and in negotiations of the Association Agreement. The new government has maintained the main priorities in foreign policy however it has delayed certain significant processes and decisions (source: http://georgiaonline.ge/articles/1360021430.php).

Leading party pledged to reduce the level of confrontation with Russia without sacrificing Georgia's overall path toward EU integration, close relations with USA, and NATO membership ambitions (source: http://www.europeanforum.net/country/georgia#elections_and_political_situation). The new Government coming into power after the parliamentary election of October2012 made a call for achieving higher coverage, equality and fairness in health and social protection. Respectively, it is expected that there will be a continuesincrease in allocation of theState budget to health and social protection for 2013. This sets the scene for moreresources for addressing the HIV epidemic in the next few years.

Georgia has made remarkable progress in improving its economic status during thelast two decades despite the conflicts that have occurred.Gross Domestic Product grew at a rate of 11.1% in 2003 and 12.7% in 2007. Itdropped to minus 3.8% in 2009 due to conflict. Georgia managed to recover with6.3% and 7% growth in

2010-2011 and International Monetary Fund Projections for2012-2013 show a positive trend in growth with 6.5% and 5.5% respectively.[11]

The country can demonstrate a more than three-fold increase of a total healthspending over the past decade and the share of resources dedicated for healthincreased from 7.8% of Gross Domestic Product in 2001 to 10.14% of GDP in 2010[12],putting Georgia on par with more economically developed countries.From 2007 through 2012, 37.9% of the population, mainly the socially vulnerable,became enrolled in health insurance pools funded by the State, with some privatecontributions. Despite these positive trends, out of pocket payments remained in arange of 70% of total health expenditure over the last decade, leaving the majority ofthe population unprotected from health financial risk. In 2010 2.6% of household fellbelow the poverty threshold because of high health costs, and 8.5% of householdswere bearing catastrophic health costs.[13]

In 2011, the GoG endorsed the National Health Care Strategy 2011-2015 (NHCS), which identifies control of HIV/AIDS as one of the public health priorities, thus reaffirming country's commitment to fighting the epidemic.[14]In 2009 Parliament of Georgia adopted new law on HIV/AIDS, which improves overall legal environment for national response and along with several other laws guarantees basic civil liberty, antidiscrimination, and patient rights of those affected by HIV. However, current anti-narcotic regulations, which apply administrative and criminal penalties for personal use and possession of illicit drugs, impede implementation of effective prevention interventions in IDUs.

The CCM of Georgia in collaboration with partners has been directing efforts towards reducing legal and regulatory barriers for drug users. In 2011, USAID funded Georgia HIV Prevention Project (GHPP) assisted the Parliamentary Committee on Health and Social Affairs to assess the national drug policy and existing legal framework within the context of international drug policy and UN conventions.[15] Currently newly elected Parliament of Georgia reviews amendments to the legislation adopted in May 2012. Also, establishment of the new Interagency Drug Council (Presidential decree #751, November 22, 2011) could be reflecting a will for creating adequate momentum and environment towards future improvements, in close collaboration with the CCM of Georgia.

Stigma and discrimination of PLHIV, as well as negative societal attitudes and low public awareness have been identified in 2011-2016 National HIV/AIDS Strategic Plan (NSP) as important barriers to HIV prevention and service utilization.

3.3 Health Systems Analysis

Please comment on the status of the HSS (Health System Strengthening) actions undertaken with the Global Fund and/or other domestic or partnersupport and how the identified health system constraints have been addressed.

The Georgian health care system is dominated by direct out ofpocket payments - 68.35% of total health expenditure in 2010 - for services andpharmaceuticals, with budgetary revenues funding state programs. Thegovernment share in total health expenditure varied from 17.02% in 2001 to 23.4% in2010[16], remaining at

[11]International Monetary Fund; Georgia and the IMF; Projections for 2012-2013; http://www.imf.org/external/country/GEO/index.htm (Accessed 8 December 2012)
[12]WHO-EURO Health For All Database 2012. http://data.euro.who.int/hfadb/profile/profile(Accessed 8 December 2012).
[13]MoLHSA, December 2012
[14]Georgia – National Health Care Strategy 2011-2015: Access to Quality Health Care. 2011. Tbilisi: Ministry of Labour, Health and Social Affairs of Georgia
[15]Georgia HIV Prevention Project.Mapping the Future: Options for Drug Policy in Georgia. 2011. Tbilisi: RTI International, USAID/Georgia.
[16]WHO-EURO Health For All Database 2012. http://data.euro.who.int/hfadb/profile/profile

2.4% of Gross Domestic Product and 6.5% of the state budget.In 2009, drugs purchased through retail outlets consumed 42% of total healthexpenditure, being much higher than in any other OECD country.[17]A small percentage of the generalpopulation purchases private insurance.

Up to 2007, publicly funded services were purchased througha single state purchaser. Private insurance was operating with about 1% of totalhealth expenditure. During 2006-2007 the government initiated bold health care financing reforms by purchasing private insurance coverage for the poor population and for certain public sector employees, and also promoting private self-insurance for the rest. As a result of these efforts, up to 1.66 million people (37.9% of total population) had health insurance by the end of 2010. This contributed to encouraging developmentof an institutional setup, with the hope that this would decrease out of pocketpayments through the development of voluntary health insurance. Although privateinsurance infrastructure has developed, voluntary health insurance has not increasedto the level anticipated.

Long-term goal is to achieve universal insurance coverage through state subsidization and generally through the development of health insurance market. Currently benefit packages do not include HIV/AIDS related services, but are financed through state budget allocations and support from the Global Fund (TGF). GoG significantly increased public expenditures over the last five years. However, continued support from TGF remains critical for sustaining progress and further accelerating national response. TGF significantly contributed to health system strengthening. Considerable investments in physical infrastructure and diagnostic capacities, along with covering significant share of treatment costs, made it possible to improve quality of and access to HIV/AIDS preventive and curative services.

Georgia has been undertaking sweeping changes in healthcare delivery system. Healthcare reform priorities have been outlined in NHCS aiming to improve health of the nation through better health system performance and stronger intersectoral collaboration. Within the strategic objective of increasing geographic and financial access to quality healthcare GoG launched hospital restructuring initiative. Up to 2007 services were delivered mainly bypublicly owned institutions. In 2007 the government introduced a hospital master plancalling for the complete replacement of the existing hospital infrastructure within 3year period by transferring full ownership rights from the State to the private sector.With the help of private investors and public investments up to 50 modernly-equipped hospitals have started functioning by the end of 2011. GoG plans to have a total of 150 newly constructed/renovated medical facilities by the end of 2013. The new facilities are expected to emerge on the principles of a referral network and will offer inpatient, outpatient and pre-hospital (ambulance) services. In line with this reform project for reconstructing National AIDS Center's facility (which is the country's referral institution for HIV treatment and care) is underway within the current SSF grant.

Reforms initiated in 2007 weakened the role and capacity of the primary care sectorin Georgia. Public health initiatives have been selectively strengthened during thelast few years. Efforts were made to improve immunization, preventive services forcancer screening, escalating cross-sectoral efforts to reduce road-traffic accidentrelated deaths, escalating interventions against illegal drug use, and improving livingconditions in penitentiary system.

Enhancing coordination and governance of the national response has been identified as one of the strategic areas of 2011-2016 National HIV Strategic Plan (NSP). New CCM regulations strengthen its multisectorial mandate for coordinating the national response. Considerable progress has been made towards the development of the national monitoring and evaluation (M&E) system, which is the cornerstone for effective coordination and governance. Under the auspices of the CCM and with financial and technical support from the UNAIDS national HIV M&E Framework was elaborated and endorsed by the CCM of Georgia in June 2011. The M&E Framework document outlines M&E system design, and also provides operations manual and the

[17]OECD Health database, 2011. www.oecd.org

operationalization plan.

Please answer the following question if you are submitting the CCM Request for a HSS grant/program. Otherwise proceed to the next HSS question.

In the context of the national health system strategic plan, goals and objectives, please elaborate on how the HSS grant/program has contributed to the progress towards MDGs 4, 5 and 6. Please also describe if the HSS grant/program has resulted in any demonstrable improvements in access (addressing geographic and gender inequalities), coverage and quality of services.

Not applicable

Please elaborate on any lessons learned and what health system gaps remain in scaling up the disease program.

Competent health-care providers and managers are critical for the effective performance of the health system. The grant is used for capacity building activities conducted by external and local experts. Training component started in 1st Implementation Period will be continued in the 2nd Implementation Period. Training on various aspects of HIV control will cover not only the medical specialists but also civil society and community layers.

Participation of a civil society including those living with the disease is a key success factor. Like many already implemented and on-going projects, next period of SSF program considers NGO sector as one of the key implementers of the activities. Previous experience shows that TGF and other donor financing have had positive impact on NGO development in terms of their capacity building, improving staff motivation and increasing availability of trainings. Continuing support through SSF will allow NGOs to sustain activities in priority areas and strengthen their capacity for delivering client-oriented services with adequate technical excellence and human rights perspective, to all those most at risk populations in need.

TGF and USAID financing made it possible to support community-based system through capacity building initiatives, establishing social networks of PLHIV, establishing VCT services, and increasing opportunities for research and community outreach activities. Recent initiative by European Commission (EC) on capacity building for non-state actors will undoubtedly further strengthen community-based systems.

*Strengthening monitoring and evaluation system.*The development and maintenance of electronic data management systems, standardization of data collection and reporting tools and human capacity building are the core elements of success. Development of the national HIV M&E framework was preceded by successful launch of new HIV/AIDS surveillance system with TGF support. The new system features standard data collection forms, a methodological manual for data analysis and is equipped with electronic HIV/AIDS surveillance database, which will also serve as warehouse for M&E data. National Center for Disease Control and Public Health (NCDCPH) has been identified as a key national agency responsible for coordinating HIV/AIDS surveillance; the role is harmonized with the agency's leading role as a technical arm for the CCM to operationalize the new M&E system.

Another important development to strengthen national M&E capacity is the launch of a web-based AIDS health information system (AHIS). Operated by the National AIDS Center, AHIS networks all HIV/AIDS clinical facilities countrywide and captures essential case-based treatment and care related data. During the operationalization of national M&E system AHIS will also become integral part of the system, as well as National Health Management Information System (HMIS) being developed by Ministry of Labour, Health and Social Affairs as one integrated system.

Additional efforts are already undertaken to address weaknesses identified by recent OIG diagnostic review and data quality audit. All activities will follow the national M&E documents to ensure that all stakeholders share the same arrangements. Many of the proposed activities will be supported by the state, USAID and other donors; the current request for renewal seeks funds to conduct Bio-BSS surveys, operational research and

maintenance of AHIS (HIV/AIDS clinical database).

Sustainable financing for HIV/AIDS is the issue of primary importance. The CCM has continuously been advocating for increasing the state share of national HIV/AIDS funding to gradually decrease reliance on donor resources and make HIV/AIDS interventions sustainable. Owing to these efforts GoG significantly increased HIV budget allocations. HIV related medical services are provided by publicly owned National AIDS Center and affiliated regional facilities. State program on HIV/AIDS treatment covers outpatient and inpatient services, while TGF program ensures procurement of antiretrovirals and other pharmaceutical product, which are dispensed at central and regional facilities. However concerns remain regarding sustainability TGF support curative and preventive services after the end of the TGF grants. Given the GoG plans regarding health insurance coverage it is reasonable to explore opportunities for integrating HIV/AIDS preventive and curative activities under insurance schemes in a medium to long-term perspective and support this integration as appropriate.

While HIV/AIDS and related medical services (TB, viral hepatitis) are provided free of charge through state and TGF funded programs, PLHIV experience financial barriers for accessing clinical care (including dental care) outside the AIDS service. In a given context it becomes important to assure that gradually PLHIV will be covered under insurance program and such coverage will not only provide free ART and TB treatment, but will also finance other medical services, which patients often require. Although TGF and other donor support significantly increase expertise and experience community-based organizations for quality service provision, unsustainable financing often limit their capability to ensure continuity of their activities. This in turn prevents establishment of effective partnerships with PLHIV and most at risk groups and may result in program implementation failure.

The main lessons learned during implementation of TGF support are about the need to place more emphasis on community involvement, which requires the introduction of multidisciplinary patient-centered approaches, which often extend beyond the traditional health system's boundaries and involve rigorous actions by other public services (such as social services) and non-state and community actors. In this regard, implementation experience during 1st Implementation Period showed that the direction chosen and priorities are correct, but that they require further streamlining and maintaining and expanding the efforts which, in the near future, will not be possible to manage by domestic resources and therefore necessitate additional TGF support.

The content of the 2nd Implementation Period application takes into account these lessons learned and focuses on bridging the health system gaps in regard to HIV control. Besides staff training, which will be reconfigured taking into account the emerging needs of placing emphasis on HIV case management, and enabling health care providers to provide effective work at community level, the application also foresees upgrading of HIV information, monitoring and evaluation system, to be aligned with the revised international strategies for HIV prevention and treatment and the resulting new WHO recommendations in the countries.

SECTION 4: PROGRAM OVERVIEW

4.1 Financial Gap Analysis, Counterpart Financing and Additionality

This section is not applicable for G20 UMICs that are no longer eligible for Renewals. Please continue to section 4.2 'Progress Towards Proposal Goals and Impact/Outcome'.

Please provide an update of the financial needs, actual and planned sources of funding, and financial gap of the disease/HSS program.

CCMs must use the 'Financial Gap Analysis and Counterpart Financing' table to provide financial information pertaining to the national program that implements the national disease strategy. Detailed instructions on how to complete the Financial Gap Analysis and Counterpart Financing table are provided is in the Financial template provided with the CCM Invitation package: **Renewals_Financial Template_ FinancialRequest_ResourcesAvailable.**

4.1.1 Overview of Government Financing of the National Program

Please specify the levels of government (central, regional, local) that incur spending on the disease programs and the major agencies through which government funds are spent. Elaborate on the availability of earmarked budget line items to capture government disease spending and the extent to which these budget line items capture total government spending on the disease program.

According to the latest WHO estimates (source: Health For All Database, WHO/EURO), total expenditures on health in Georgia in 2010 constituted 10.14% of GDP which is higher compared to the region (CIS countries - 5.74%) and EU average (9.88%). The share of health spending in the total government expenditure (6.88%) is below the region average (CIS average: 8.52%) and is much less than European Union countries (EU average: 15.23%). At the same time, due to the low level of national income, in absolute terms total health expenditure remained as low as 522 PPP$ per capita in 2010 (EU: 3,230 PPP$ per capita).

GoG has committed to the UNAIDS "Three Ones" principle and prioritized attainment of all three targets within the National HIV/AIDS response. Country endorsed the first one agreed HIV/AIDS National Strategic Framework for 2006-2010 (revised and modified in 2007). The new NSP was developed in 2010 for the period of 2011-2016 (mid-term review envisaged by NSP is planned in May 2013 by UNAIDS technical support) that set the main strategies for the national response for coming years and provided estimation of the NSP budget and projected financial gaps. The CCM renewal request budget is based on the financial analysis completed during the NSP development, on the new information regarding their financial commitments collected from the MoLHSA, private sector, bi and multilateral donor organizations active in the field of HIV/AIDS in Georgia and addresses the identified gaps.

Budget figures of the National Programs on HIV/AIDS starting from 2012 are as following (EUR):

National Programs	2012	2013
HIV/AIDS Program	1465596	1538220
Safe Blood Program	456422	444450
Maternal and Child health program (testing of pregnant women on HIV and viral hepatitis)	2206400	2320000
Epidemiological surveillance	642202	705000
Drug Addiction Prevention and Treatment Program	2156400	2561300
Palliative Care for HIV/AIDS Patients	636239	1055500
Administration cost	1238500	1022222

Figures of 2012 represent the actual commitment and 2013figures reflect the projected budgets derived from the Georgia National Health Strategy document of 2011-2015 and the estimated budgets provided by the MoLHSA of Georgia. The main responsibilities for providing an effective HIV/AIDS national response has been divided between various state institutions and agencies, which include:

a) CCM
b) Ministry of Labor, Health and Social Affairs (MoLHSA);
c) The National Center for Disease Control and Public Health (NCDCPH)
d) The Infectious Diseases, AIDS and ClinicalImmunology Research Center.

The responsibilities of coordination and oversight of the national programs on HIV/AIDS is shared between the CCM and the MoLHSA of Georgia.

4.1.2 Estimation of Current and Anticipated Domestic and External Funding

Describe how contributions from various sources of funds were estimated, including reference to:

a. Methodology for estimating current and anticipated funding;
b. Composition of reported government spending (part or all of government spending; programmatic costs alone or includes apportioned health system costs; recurrent costs alone or includes capital costs);

c. Whether amounts contributed by each source for the current and previous years pertain to budget, disbursement, expenditure or an estimate of spending;
d. Whether amounts forecast from each source for the future years pertain to estimation or commitment.

The figures on government expenditure on HIV/AIDS include MoLHSA spending. They include recurrent costs as well as human resources costs. Amounts contributed for the previous year's pertain to expenditures, for the current year – to budget, and for the future years – to estimations based on the commitments for overall public financing for health sector and latest trends (since 2011 which was the only year when an annual decrease in health expenditure was documented, due to fiscal constraints resulting from the global financial crisis).

External funding includes several key international financing sources:

- USAID. Spending for 2013-2015is provided as estimated ceiling budget, subject to annual appropriations and negotiation of signed agreements; the data for 2010-2011 are reported as actual expenditures.
- GFATM. Figures are provided by PR; data for 2010 – 2011 are reported as actual expenditures
- UN Agencies. Data for 2013-2015 are provided as a preliminary budget; the information for current years represents actual spending.

According to data from the National financial monitoring system of expenses on HIV (adopted NASA), there are different bilateral and multilateral organizations contributing to the HIV response in Georgia. These funds do not represent a large share in the overall external funding pool compared to those indicated earlier. Also, for the smaller external funds there is no confidence in appropriate forecasting, since donor agencies are not represented in Georgia and act mostly through recipient NGOs.

4.1.3 Financial Gap and Counterpart Financing Data Sources

Please answer the following questions below:

a. Cite the sources used to complete the financial gap analysis and counterpart financing table;
b. Provide an assessment of the completeness and reliability of financial data reported, include any assumptions and caveats associated with the figures;
c. Provide details of how the country plans to improve data quality consistent with the guidelines for reporting of program financial data to technical partners; and
d. If applicable, state if the CCM Request includes a budget for an expenditure tracking study and/or measures to strengthen financial data collection and reporting during the next Phase/Implementation Period.

The information used to complete the financial gap analysis and counterpart financing table was obtained from the MoLHSA Program Planning Department and NSP budget – for domestic resources; USAID, UN Agencies' and other donor representatives in Georgia – for external sources. Official exchange rates were used to present figures in EUR (available at: www.nbg.ge). The exchange rate for 2013 - 2015 calculations was based on avarage2012 rate. The presented financial data are considered to be largely complete and reliable. The data presented in the financial gap and counterpart financing tables is based on the already confirmed commitments or on the budget estimations depended on the assumption that the trend of increasing the Governmental commitment on HIV/AIDS programs will be maintained in the coming years. Concerning the total health spending, the total amount for 2010-2015 was calculated based on retrospective data from 2010 - 2011 (based on Official Report on National AIDS Spending, MoLHSA). For 2013 – 2015, the state budget is included from the approved national program.

The MoLHSA is developing the National Health Information System which will generate data on the actual expenditures related to HIV/AIDS prevention and curative services. The system will capture all actual spending in details and will be reliable data source for monitoring HIV/AIDS related expenditures. It is anticipated that the allocation of governmental resources for medical services of PLHA will by increased as a result of capturing by the newly developed system the benefits of PLHA from Government funded all health care programs that

are currently underreported.

The CCM does not have specific plans to conduct an HIV expenditure tracking study and/or measures to strengthen financial data collection and reporting during the next implementation period; at the same time, the Government overall and the MoLHSA work continuously in this area and conducting different analyses, supported by the World Bank and WHO.

4.1.4 Compliance with Counterpart Financing Requirements

Describe whether the counterpart financing requirements have been met as listed below. If not, provide justification which includes actions planned during the next Phase/Implementation Period to move towards reaching compliance.

a. Minimum threshold for counterpart financing
→Percentage in Line M of the 'Financial Gap Analysis and Counterpart Financing' table must be greater than or equal to the minimum threshold that applies to the applicant's income level.
b. Increasing government contribution to national disease program over the next Phase/Implementation Period
→Figures in Line B of the 'Financial Gap Analysis and Counterpart Financing' table must increase over time.
c. Increasing government contribution to the overall health sector over the next Phase/Implementation Period
→Figures in Line I of the 'Financial Gap Analysis and Counterpart Financing' table must increase over time.

The counterpart financing requirements have been met:

1. As seen from Line M in the 'Financial Gap Analysis and Counterpart Financing' table, the counterpart financing share is 70% and is higher than a minimum threshold set for upper low-middle income countries with sever disease burden (40%)
2. There is an increasing government contribution to national disease program over the next implementation period (figures in Line B of the 'Financial Gap Analysis and Counterpart Financing' table increase over time).
3. There is an increasing government contribution to the overall health sector over the next implementation period (figures in Line I of the 'Financial Gap Analysis and Counterpart Financing' table increase over time).

4.2 Progress towards Proposal Goals and Impact/Outcome

Please refer to the results reported by the PR(s) for impact/outcome indicators included in the Performance Framework and provide additional updates if recent information is available (e.g. survey reports, impact assessment studies, etc.)

Impact/Outcome Indicators	Baseline		2010		2011		2012	
	Date	Baseline	Target	Result	Target	Result	Target	Result
% of adults and children with HIV infection still on treatment after 12 months of initiating ART	2003	88%	>85%	79%	>88%	79%	>90%	86%
% of IDUs with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2009	76%	N/A	N/A	76%	75%	78%	87%
% of most-at-risk population(s) (sex workers) who are HIV infected	2002	0%	<5%	1.44%	<5%	1.44%	<5%	1.1%
% of most-at-risk population(s) (men who have sex with men) who are HIV infected	2008	3.7%	<5%	6.4%	<5%	6.4%	<5%	13%
% of most-at-risk	2002	1.1%	<5%	1.99%	<5%	1.99%	<5%	3%

Impact/Outcome Indicators	Baseline		2010		2011		2012	
	Date	Baseline	Target	Result	Target	Result	Target	Result
population(s) (injecting drug users) who are HIV infected								
% of most-at-risk population(s) (prisoners) who are HIV infected	N/A	N/A	<2%	1.4%	<2%	1.4%	<2%	0.3%
% of injecting drug users who have reported using sterile injecting equipment last time they injected	2002	20.8%	>65%	48.1%	>65%	48.1%	>65%	83.5%
% of FSWs reporting the using of condoms with their most recent client	2002	71.6%	>85%	77.8%	>85%	77.8%	>85%	91.1%
% of patients achieving HIV drug resistance prevention after 12 months of ART	N/A	N/A	N/A	N/A	≥70%	78%	≥70%	83.6%
% of estimated HIV-positive incident TB cases that received treatment for TB and HIV	2006	70%	N/A	N/A	>80%	92.5%	>85%	115%
% of health care workers expressing accepting attitudes towards HIV infected IDUs	N/A	N/A	N/A	N/A	>75%	63%	>75%	N/A

Please confirm if the method of data collection and data source is consistent with the M&E framework agreed at the time of signing the Grant/SSF Agreement(s).

The methods of data collection and data sources are consistent with the M&E framework agreed at the time of signing the Grant/SSF Agreements and implementation letter signed in September 2011. Reporting on impact / outcome indicators relies on official statistics from web-based AIDS health information system (AHIS). All indicators for MARPs, except data on survival rate of HIV positive IDUs, are measured through Bio-BSS surveys conducted in 2008 - 2012.

The most recent Bio-BSS Surveys among IDUs, FSWs, MSM and prisoners were conducted in 2012. Next rounds of Bio-BSS surveys among MARPs are included in the current 2nd Implementation Period grant application along with the of the target population size estimation exercise.

Is there a recent report analyzing information regarding heath impact and outcome available? **Yes**

If yes, when was it conducted? **December 2012**

Please summarize the main findings and include a full copy of the report with the CCM Request.

A comprehensive National HIV Program Evaluation in Georgia was conducted in November – December 2012. The report provides analysis of different components of the National HIV Program, including prevention measures for key most-at-risk populations, treatment, care and support for PLHIV, counseling and testing etc. Also, it provides to various extent the health impact / outcome analysis. It served as basis to build priority interventions for the 2nd Implementation Period covered in this document. The above report is attached to this application.

Do you consider the program is making progress towards the goals and objectives of the proposal? If not, provide justification and explain how you intend to address the issues.

The Program has succeeded in achieving programmatic targets in terms of coverage / output indicators and their performances. Indicators achievement is ranked highly by the Global Fund. At the same time, there are several factors that impede progress in improving impact and outcome targets. First, as shown in many countries, settings and programs, the lifetime period of a Global Fund project is short to document reliable improvements in impact and outcomes in HIV, which is even more evident for 1st Implementation Period of the Program.

Second, there are two major factors preventing from achieving the set-up targets. Early mortality among patients starting ART has shown to be challenge that needs to be improved through increasing proportion of patients diagnosed early in the course of their HIV infection. Initiatives supported by state funded programs and donors addressing the issue of late diagnosis will help to translate Georgia's achievement of universal ART coverage into sustainable survival benefit.

Recent ART cohort analysis showed that baseline advanced immunodeficiency, manifested by AIDS defining illness or CD4 count <200 cells/mm3, is the major risk factor for mortality among patients starting on ART.[18] Analyses also indicate that despite excess early mortality, survival of patients on ART stabilizes after first year resulting in substantial survival benefit on population level. Owing to TGF support AIDS-related mortality has significantly decreased in the era of universal access compared to previous years.

From 2011, with the support of the Global Fund, Georgia started phased implementation of 2010 WHO guidelines on ART. The guidelines envision earlier initiation of therapy at CD4 count ≤350 cells/mm3. Starting from 2012, all eligible patients with CD4 count ≤350 cells/mm3 shall initiate ART. This showed immediate impact on survival by increasing 12-month ART retention from an average 80% recorded through 2011 to 86% in 2012 as well as decreasing the mortality among HIV positive PWID from 75% in 2011 to 87% in 2012.

The data generated through latest Bio-BSS surveys showed that safe injection practices has increased among PWIDs from 48% in 2009 to 83.5 % in 2012, while in same condom use among sex workers increased from 77.8% (BSS 2008) to 91.1% (BSS 2012).

It is expected that the results in the following program period will improve due to experience, accumulated to date by the National Program in management of the program and provision of additional focused interventions with TGF 2nd Implementation Period. Nevertheless, the targets for the 2nd Implementation Period were adjusted to account for the real situation and were aligned with the targets set in the M&E Plan for the National HIV Control Program 2011 – 2015.

As a result of extensive consultations in country and with international partners, first and foremost UNAIDS, WHO, the Performance Framework for the2nd Implementation Period was reviewed and revised to account for the above mentioned issues, and has been agreed with the CCM and international agencies. See more details in attached Performance Framework and M&E Plan.

4.3 Program Effectiveness

4.3.1 Aid Effectiveness

Did you discuss within the CCM how to improve the aid effectiveness of implementation arrangements of Global Fund financing? **Yes**

If no, please explain why no discussion took place, and then proceed to Section 4.3.2.

Not applicable.

[18] Tsertsvadze T, et al. Outcomes of universal access to antiretroviral therapy (ART) in Georgia. AIDS Res Treat. 2011;2011:621078.

If yes, was the process inclusive of key stakeholders, including those involved in donor coordination activities in your country? Please indicate the key stakeholders who participated in the discussion.

Although there were no meetings of CCM dedicated specifically to the issue, different aspects related to external assistance implementation (of the Global Fund and beyond) and aid effectiveness have been paid significant attention by the CCM. The discussion and consultation processes are transparent and inclusive of all relevant national stakeholders and international partner agencies.

Regarding HIV, the key national partners in the CCM and beyond are the Infectious Diseases, AIDS and Clinical Immunology Research Center, Parliament of Georgia, Cabinet of Ministers, MoLHSAand central level health institutions accountable to MoLHSA, Ministry of Corrections and Legal Assistance, Ministry of Education and Science and a variety of non-state actors and professional associations (see CCM list). Among participating international partners, there are country representations of multilateral and bilateral agencies (WHO, UNAIDS, USAID, GOPA/KfW and others).

Please comment on the main findings.

As elsewhere, there has been a growing recognition in Georgia of the need to improve the quality of external aid and development assistance, based on the principles of aid effectiveness enshrined in the Paris Declaration on Aid Effectiveness (2005), namely ownership, alignment, harmonization, orientation for results, and accountability.

The MoLHSA exerts leadership in coordination of any donor activities in the health sector (ownership principle). All activities of the stakeholders in HIV/AIDS control are centered on the National AIDS Control Program (alignment principle). The Global Fund support is currently one of the main sources of external funding support in the field of HIV/AIDS control in the country. The National AIDS Control Program should represent a platform for a comprehensive approach for effective HIV/AIDS control, which is nationally owned and results oriented, and provides a framework for effective implementation of external aid in a coordinated and complementary way to the national effort to be undertaken, in other words, a nationally-owned program approach setting the priorities where aid effectiveness measures are expected to improve implementation and to increase the probability of sustainable, high quality results that achieve maximum impact.

In terms of ensuring transparency and accountability of TGF financing for HIV/AIDS, the grants' cycles have been aligned with country cycles, and TGF financing is reflected in country budgets and in national accounting books. The TGF support complements available domestic resources for disease response.

To align with national systems and procedures, TGF projects use existing systems and aim at further strengthening country capacity in implementation, M&E, procurement and supply management (PSM). To streamline reporting, grant reporting has been aligned with country planning and fiscal cycles. An appropriate part of the grants (in terms of number of activities / tasks as well as the budget) are allocated to M&E.

The Global Fund-financed activities are coordinated with other donor-funded activities, although, as mentioned above, there is an effective coordination of project implementation with technical assistance provided by external partners.

Based on your discussion did you identify any major risks? If so, please describe them and how you plan to address and monitor each in the next Phase/Implementation Period.

No major risks in relation to aid effectiveness issue above have been identified that may affect program implementation or require additional measures to be applied during 2nd Implementation Period of the program.

4.3.2 Equity

Did you conduct an equity assessment, or was an equity assessment conducted by the national program or other stakeholders, in the current Phase/Implementation Period? **No**

If no, please explain why an assessment was not conducted.

There is no specific assessment focused on equity relevant to HIV/AIDS control in the country. At the same time, relevant issues pertaining to equity are continuously assessed in different ways and are presented, inter alia, in a number of reports by development assistance partners.

Promotion of equitable and rights-based approach to health is a core principle of health protection and care in Georgia and is stipulated in the Constitutions and relevant laws and bylaws. The key dimensions of the health system reform in the country are fully compliant with the equity considerations.

Despite this, certain geographical parts of the country have received additional focus from donors with regard to HIV/AIDS, such as the USAID, EU etc. However, the National HIV/AIDS Control Program, supported by the Global Fund grants, is built and implemented at ensuring universal access to HIV/AIDS services for all people regardless of age, sex, socio-economic status, geographical location, or other factors commonly considered for in terms of discrimination or limited access. It is well known that HIV/AIDS has profound socio-economic grounds and affects first of all persons from most-at-risk population groups and other disadvantaged populations such as PWID, FSW, MSM and prisoners. In this regard, TGF program, covering the entire country and supporting essential interventions, is seen as fully relevant in terms of upholding equitable access. Besides these, the 2nd Implementation Periodprogram aims to uphold and streamline relevant interventions targeting most-at-risk population groups mentioned above.

HIV positive patients are vulnerable in terms of risk of death as well as in terms of likeliness of incurring catastrophic expenditures during complex and lengthy treatment if essential treatment and support services are not provided free of charge at the point of delivery. The Global Fund provides support to cover funding and programmatic gaps which are currently not possible to be bridged with domestic resources, such as supply of ARV and anti-HCV drugs and a set of follow up interventions to ensure adherence to treatment.

If yes, please comment on the process for developing the equity assessment.

Not applicable

Please comment on the main findings of the assessment and include additional data, if available, which supports your findings (e.g. disaggregated data by relevant population groups for key indicators, findings from qualitative research, grey literature, etc.).

Not applicable

Based on your discussion did you identify any major risks (e.g. gaps in data availability or data use to assess equity, inequities in service coverage and impact/outcomes, gaps or weaknesses in planning, programming or implementation, or structural barriers)? **No**

If yes, please list and describe the following: (a) how you plan to address those risks in the next Phase/Implementation Period; (b) how progress will be monitored in the next Phase/Implementation Period; and (c) how the M&E system may need to be strengthened to provide data to monitor results.

Not applicable

4.3.3 Value for Money

Please comment on the three dimensions of value for money listed below, demonstrating how the program is maximizing the health impact that can be achieved with available resources.

Economy: is the program minimizing the cost of resources and inputs whilst maintaining quality of services?

Yes. In 1st Implementation Period of the program, all implementers of the grant made efforts to minimize the cost of activities. First of all, 10% efficiency savings were implemented during grant negotiation process. Procurement made also largely contributed to ensuring value for money through competitive prices and assured quality of the products. One of the key interventions supported by the program is using voluntary pooled procurement (VPP) of ARV. In this instance, it works for both minimizing the cost and maintaining quality by obtaining quality products from WHO-prequalified manufacturers.Switching to voluntary pooled procurement (VPP) of ARVs resulted in savings of 486 088 EUR. Good cooperation with national counterparts and national commitment to the disease control also contribute to most rational use of grant funds.

In addition to procurement ARVs through VPP, during 2nd Implementation Period of the program a competitive procurement of health products will be conducted, while relying to the highest possible extent on national systems for quantification, quality control, and supply-chain management. Efficient procurement and supply management procedures applied during 1st Implementation Period, as well as price-reduction negotiations with local suppliers resulted in economy for several pharmaceuticals and health products such as laboratory test-systems and medical equipment. Use of economically efficient and transparent international electronic competitive bidding helped to attract international and local suppliers, and provided equal opportunity to bid for the required goods.

These efforts resulted in significant price reductions. For example, unit cost of HCV medicine (Pegilated Interferon) reduced form from average local market price of 450 GEL to 315 GEL (43% reduction) with another HCV combination treatment medicine - Ribavirin being provided for free. The total savings related to HCV treatment over 1st Implementation Period is 30% of budgeted amount.Also, from 2010 to 2012 unit cost of real-time PCR viral load test reduced by 24% from 165 GEL to 133 GEL. These price reductions allowed to establishing new price ceilings for pharmaceutical and other health products, which were incorporated in current financial request.

Further, human resource costs in the program are fully aligned with relevant national and international salary scales, ensuring minimum reasonable costs necessary for implementation of grant activities. Grant consolidation contributed to achieving savings related to program management costs, programs funded by different grants were streamlined under one SR, objectives implemented by same SR are consolidated, which resulted in savings in program administration, overhead and other budget categories. Costs of other inputs are being maintained at recent levels/brought to country scales, e.g. travel allowances are provided based on the governmental per diem rates (Presidential decree #231, 20.04.2005), which is uniform requirement for all implementers. The human resources costs are averagely in accordance with the country health and social sector salary scales.Finally, as in proposal, this Request for Renewal was planned to be a part of national programme and complements efforts supported from public resources as well as key donors (USAID, UNAIDS, EUetc.).

Efficiency: is the program maximizing the output that can be achieved from available resources and achieving its results at the lowest possible cost?

The 25th Global Fund Board Meeting (November 2011) and 26th Board Meeting (May 2012) endorsed a revised application and approval process for renewals to ensure strategic investments. In accordance with the requirements, the CCM made revision of the work plan for the 2nd Implementation Period in order to prioritize activities within the 90% of the originally approved budget. Moreover, revision is done to take into account current country context, past issues with implementation and lessons learned in the 1st Implementation Period.

Efficiency was an underlying principle for the initial design of the Proposal: the best practices and evidences from other countries with similar HIV epidemiology were taken into account for planning interventions in

Georgia. Efficiency gains were achieved due to operational efficiency of the PR and selection of SRs - using to largest extent existing structures and already developed resources. To minimize costs, the program is fully relying on existing health system workforce, which will be trained to provide services in line with recommended standards.

In line with focus of the proposal only those activities that were considered as essential or as necessary to ensure recommended quality of services were included in Request for Renewal.

Standard national or organizational (as applicable) DSA rates are budgets for travel and training participation. Travel is considered as per most economic route.

Efficiency loss through wastage of pharmaceuticals and reagents will be avoided by more accurate projections for the needs, faster customs clearance, inventory control and compliance with the standards of HIV treatment.

A comprehensive technical assistance program will be implemented in 2nd Implementation Period for strengthening the health system, including the in-country supply chain management.

Effectiveness: was the program approach and activities well designed to achieve the objectives and correspond to what needs to be done given the disease and local context?

The implementation experience shows that the program approach is well designed to achieve the objectives and fits well in the disease and local context. At the same time, there were no studies or evaluations conducted on effectiveness of the investment in reaching impact and outcomes of the program in Georgia. However, since its inception in 2004, TGF supported programs have been built on National HIV/AIDS Control Program plan of action. The current request builds on strategic priorities of 2011-2016 National HIV/AIDS Control Program.

The focus of current program is to deliver prevention of HIV among key populations at risk and treatment, care and support services for PLHIV. The current program also targets advocacy for establishing supportive environment for national response t and stigma reduction – activities, which contribute to achieving targeted health outcomes and impacts, while Bio-BSS surveys conducted within the program generate essential evidence for impact/outcome measurement. The focus of the program will be retained in the next period. Interventions implemented under the TGF support are based on guidance provided by WHO, UNAIDS and other authoritative organizations and best international practices.

Also, there are a number of factors that influence the changes at impact and outcome level; the positive changes in this regard are expected after achieving the full performance of initiated interventions which requires time and may extend until the end or beyond the program cycle.

In the process of Request for Renewal development, the needs were identified for ordinary reallocations of funds compared with the originally approved budget. The CCM was guided by the principle, aimed at increasing funding for critical needs of the program, which influence on ultimate goals of the grant and ensure equal access to diagnosis and treatment of PLHIV.

Finally, the Request for Renewal was prepared in close cooperation between WHO, UNAIDS, USAID and other program implementing partners. Due to focus of proposal on essential services, only necessary and key health system strengthening activities were included in the 2nd Implementation Period of the program. These activities are necessary to ensure provision of services in line with international standards and recommendations. Despite lack of specific studies on cost-effectiveness of planned interventions, the interventions included are in line with recognized best practice and recommended approaches adopted to current situation in Georgia. In particular, they are in line with specific evidence gathered by WHO and UNAIDS within the Region related to prevention, care, treatment and support.

Have any major risks been identified related to value for money? **No**

If yes, describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

Not applicable

4.4 Quality of Services Assessment

This section is not applicable for a cross-cutting HSS grant/programs. Please continue to section 4.5 'Partnerships' if you are submitting the CCM Request for a cross-cutting HSS grant/program.

Please comment on systems to manage quality (quality improvement/quality assurance) that ensure adherence to national guidelines and Standard Operating Procedures (SOPs).

There are a number of measures that are currently applied in country in order to assure quality of HIV/AIDS services. The main document outlining measures of HIV/AIDS case detection and diagnosis, treatment, referral and functions of different levels of involved services, recording and reporting, supervision and M&E and other special aspects such as TB/HIV, is the National HIV/AIDS Control Program. The Program for 2011 - 2015 was approved by the Cabinet of Ministers. The document incorporates the emerging international guidance and recommendations. In addition, there are complementary MoLHSA orders regulating certain aspects of HIV/AIDS control, in particular in terms of roles, functions and responsibilities of public health services.

The quality and safety of medical services are ensured by the National Council on Clinical Guidelines, which was founded in 2005 to facilitate implementation of evidence-based clinical practice through coordinating development, approval and implementation of clinical practice guidelines. The second entity - State Regulation Agency for Medical Activities has been designated by MoLHSA to monitor implementation of national health programs, including HIV-related programs, against standards set by guidelines.

Services supported by TGF are delivered in accordance with national and international guidelines. HIV/AIDS treatment and care guidelines have been in place since 2004 and are updated regularly. The set guidelines encompass various areas of HIV clinical care, including ART, HIV/TB co-infection and prophylactic ART for pregnant women. National HIV/HCV guidelines have been updated and are currently under review. ART guidelines are being updated in accordance with 2012 revision of WHO Europe ART guidelines. National STI management guidelines have also been approved by MoLHSA and address STI management among FSWs and MSM. Protocols for HIV testing and counseling are provided in the national HIV Surveillance guidelines.

These national guidelines contain requirements for quality of services, which are to be observed by all health institutions in the country. The implementation supervision function lies with the Infectious Diseases, AIDS and Clinical Immunology Research Center, which carries this function through regular supervision visits to all peripheral service units in the country (and general health services sites as required), issuing and updating specific guidance and methodological materials, collecting and validating HIV/AIDS statistics, and performing other relevant activities.

Please comment on major quality of services risks which have or could have a negative effect on performance, if any. Describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

Sustaining quality of HIV/AIDS services is a general challenge for the National HIV/AIDS Control Program. Activities such as external technical assistance and trainings for medical specialists and other layers proposed within the grant aim at maintaining the quality of the HIV/AIDS services and advancing in accordance with the recent developments.

The major risk with controlling quality of services is lack of specialists strong in monitoring and evaluation within the National Program. M&E is an important means for quality control but its usefulness depends on experience and skills of the supervisors. The 1st Implementation Period implementation demonstrated that the

number of skilled doctors who can provide supervision is limited both at central and regional levels. Also, civil society actors are not very much involved in the quality control issues. Further strengthening, as well as training to medical and non-medical staff will be continued during the 2nd Implementation Period. In addition, a series of capacity building measures to greater involvement of civil society representatives are planned.

If the RSQA (Rapid Service Quality Assessment) assessment was not conducted in your country, please continue to section 4.5 'Partnerships'

Please refer to the latest available information on quality of services annexed to the CCM Invitation Letter and provide updated information (updated national guidelines/protocols), if available.

The CCM is aware of the new TGF-developed strategy to assess quality of services and integrate this assessment in the performance-based funding model, based on Rapid Services Quality Assessment (RSQA), to be applied during program implementation by the Local Fund Agent in conjunction with the On-Site Data Verification (OSDV). The CCM is also informed that RSQA will be rolled out in a phased manner and the country will participate in the exercise as agreed upon with TGF Secretariat.

4.5 Partnerships

Using the table below, please indicate the technical assistance (TA), if any, already received in the current Phase/Implementation Period or confirmed to be conducted in the next Phase/Implementation period by the PR(s) and /or SR(s).

TA source/TA category	Current Phase/Implementation Period	Next Phase/Implementation Period
Bilateral	√	√
Multilateral	√	√
CSO	□	□
Private Sector	□	□
Academic Inst.	□	□
Mixed/other (specify)	□	□

Describe any current gaps and/or needs in the capacity building that are not being met by the existing TA providers.

The state services in Georgia as well as the civil society partners have a good overall technical capacities and expertise in different aspects of HIV/AIDS control, e.g. strengthened through a number of technical assistance activities during earlier stages of TGF support implementation and from different agencies (ex: USAID, UNAIDS etc).WHO and UNAIDS through their Regional Officescontinue to provide technical assistance and monitoring and evaluation of program interventions. For the 2nd Implementation Period, an additional need in external TA was identified by the CCM (more details are presented in the workplan and budget).

SECTION5: CURRENT PHASE/IMPLEMENTATION PERIOD PERFORMANCE (PR 1)

5.1 Programmatic Achievements and Management Performance

5.1.1 Programmatic Achievements

Provide an overall assessment of the progress of the PR during the current Phase/Implementation Period based on the key programmatic indicators in the Performance Framework.

The Global Projects Implementation Center (GPIC) is a not-for-profit legal entity founded on 25 January 2011 by the core staff of the Global Fund Projects Implementation Unit atGeorgia Health and Social Projects Implementation Center.On 1 April 2011, GPIC became the principle Recipient of TGF grant in Georgia based on the nomination by CCM and approval of the Global Fund.GPIC mission is to contribute to the improvement of health and social wellbeing of population in Georgia and abroad. GPIC serves primarily the public interests and builds up its credibility with key stakeholders and partners not only by delivery of expected results but though transparent governance and managerial processes.

During the implementation of the 1st Implementation Period HIV/AIDS program,in collaboration with SRs and partners, GPIC has demonstrated good progress towards achieving Program goals, objectives and indicators. Assuming the proactive role, GPIC has proposed and agreed with TGF the possibility of funding the most crucial and vitally needed products, namely medicines and pharmaceutical products for HIV, HCV, STIs treatment, test-kits, reagents and medical supplies for CD4 monitoring, HIV drug resistance, HCV, HIV diagnostics and other MPP/health products for HIV prevention purposes, including methadone.

The Program has achieved noticeable progress in capacity development of Opioid Substitution Treatment centers and SRs implementing support intervention, and established efficient management platform both at the National and regional levels. Efficient collaboration platform with the Government is essential to ensure provision of life-saving treatment and implementation of systematic changes in HIV service.

Over 21 months period, 4 of 11 top-ten or equivalent output indicators to be reported are over-performed, 3 indicators have over 93% performance, and two indicators have65-76% achievement rate. The latter indicatorsare "Number of STI cases treated among FSWs, their clients and MSM" and "Number of PLWHA receiving counseling services through hotline and self-support centers". For the last one due to the increase of online counseling that is preferable by target group, the cumulative number of counseling sessions that are defined for indicator by approved M&E plan showed underachievement.

As a result of actions from GPIC and its partners, a decision was taken to implement online counseling in the 2nd Implementation Period of the performance framework. Major achievement was made in reaching graduallyPWID by needle exchange programs that are based on peer driven interventions launched by the Round 10 project. GPIC has taken an active role in preparation of the new National HIV/AIDS Control Program, which was approved by the Government. Five-year Program covers the period of 2011 – 2015, addresses key international recommendations, and includes TGF –supported program.With the support of GPIC, a number of Orders of the MoLHSA, including revision of treatment Protocols were developed or revised and approved.

One of the important initiatives directly linked to ART program is implementation of HIVdrug resistance (HIVDR) strategy, which started in 2011. The strategy aims to support ART program in terms of preventingemergence and transmission of HIVDR. The other initiative addresses burden of HIV/HCV co-infection. A study conducted bythe National AIDS Center identified high prevalence of HCV infection and resulting morbidity inPLHIV in Georgia. In 2011 web-basedAIDS health information system (AHIS) developed by the National AIDS Center was launched. AHIS networks all HIV/AIDS clinical facilitiescountrywide and has been regarded as exemplary for other fields of healthcare. AHIS captures epidemiological, clinical andlaboratory data on all patients registered since the start of the epidemic. Its implementation represents

importantadvancement for individual patient management, as well as program monitoring and planning.As result, the 1st Implementation Period program improved quality of patient support interventions as well.

In partnership with USAID funded programs implemented by RTI international, GPIC continues coordination of the activities targeted at HIV prevention among MSM and FSWs in Georgia. Although the necessary steps are implemented slower than planned, an important progress has been reached in creation of unified database for MARPs gathering all related information in similar format. The 1st Implementation Period program through targeted CCM advocacy efforts has reached progress in approval of Drug Legislation by Georgia Government developed by team of experts supported under the Global Fund Round 2 program.

The AIDS center, with the support of GPIC has conducted operational research on "Analysis of HIV treatment adherence in Georgia".The objective of this analysis was to identify gaps in the continuum of HIV care and to identify factors associated with treatment adherence.The analysis findings demonstrated overall good treatment adherence rate in Georgia compare to data reported from both developed as well as resource-limited countries. The analysis depict that the default occurs at each level of the continuum of HIV care, but the major gap is at the level of HIV diagnosis.

Additional efforts are needed to reduce the number of HIV infected persons unaware of their status and to increase HIV treatment adherence of PWID. Earlier initiation of ART, may improve adherence rate. Issues identified will be addressed in the comprehensive plan of action currently being developed. GPIC supported operational research aimed at identifying key factors related to stigma and developing evidence-informed interventions. The survey was used to assess baseline level of knowledge, behavior and stigma related to HIV among health care workers and identified needs of key vulnerable populations. Based on the survey results, a number of strategies were developed and approved; materials for training of HCWs were prepared.

Please provide a description of the related actions the CCM/RCM/sub-CCM will take, in its oversight capacity, to address these identified performance issues?

The CCM of Georgia owns the oversight mechanisms described in section 2.1.3 of this document, e.g. oversight Plan. As mentioned above, during 1st Implementation Period, majority of indicators were achieved or over-achieved. Only two indicators reached 65 - 76% achievement rate.The indicator ""Number of STI cases treated among FSWs, their clients and MSM"was under-achieved because low admission of target group representatives,especially in summer due to seasonal migration (Including migration abroad).

Considering HIV program evaluation recommendation PR in partnership with relevant SR decided to minimize the administration cost related to STI treatment and dedicate the amount to enhance interventions targeted at improvement of coverage of MARPs, elaborate new strategies to improve referral to free of charge STI treatment points. All indicators, including this one will be reported to CCM and Oversight Commission.

Please summarize the current challenges in M&E systems and capacity based on any recent assessment undertaken during the current Phase/Implementation Period, and provide an update on status of implementation of M&E systems strengthening recommendations supported through Global Fund grant/SSFs and other partners during the current Phase/Implementation Period. Please also comment on the expenditures on M&E (variances, if any) against approved funding under the Global Fund grant/SSF during the current Phase/Implementation Period.

Considerable progress has been made in terms of the development of one national HIV M&E system. Under the auspices of the CCM and with financial and technical support from the UNAIDS national HIV M&E Framework was elaborated and endorsed by the CCM of Georgia in June 2011. The M&E Framework articulates organizational structures, linkages, reporting relationships and indicators to measure inputs, outputs, outcomes and impact of HIV/AIDS national response

NCDCPH has been identified as a key national agency responsible for operationalization of the new M&E

system. For that purpose M&E unit has been established at NCDCPH. Decisions has been made to establish national M&E working group comprising of national experts to support implementation of the system by the end of 2012. As an essential step towards operationalization of national M&E system activities are already undertaken for harmonization of indicators with international requirement and between country implementers, as well as for standardization of data collection and reporting tools.

Establishment of functional M&E system will strengthen national coordination and multisectoral response through moving away from information sharing to using M&E framework, monitoring the progress of implementation, uncovering the implementation weaknesses, taking decisions on corrective measures and advocating for the needed governmental decisions on the level of government or sector ministries.

With regard to TGF program specific M&E issues, external data quality audit conducted in December 2011 classified data quality of the program as "Minor Data Quality Issues". No major data discrepancies were found at any of the four indicators audited. The audit provided recommendation to address system-level weaknesses emphasizing the need for standardizing data management procedures at all levels of service delivery and reporting, accompanying with detailed written policies. As data quality audit covered period of July-December 2010, some of the recommendations were not any longer relevant by the time of audit.

PR works closely with SRs to correct remaining weaknesses, including strengthening data verification procedures. Data quality assurance protocols have been updated to ensure accuracy at all levels of data collection, data entry and analysis. The protocol is being tested and responsible personnel will be trained to facilitate its rapid implementation. Funds are budgeted to strengthen M&E capacity of the program. All M&E activities will be mainstreamed with the national HIV M&E system that is currently being developed.

5.1.2 Grant/SSF Risk Management

Please comment on the major grant/SSF management risks and issues, if any, including those attached to the CCM Invitation Letter. Describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

Since the first submission of the CCM request for Renewal, the Principal Recipient has addressed all recommendations provided by the Global Fund Secretariat and the Office of Inspector General. Based on the issues included in the CCM Invitation Letter for resubmission, the PR implemented the following measures to improve the mechanisms of grant management (programmatic, financial, M&E, and quality of the data reported to the Global Fund) to be used by the PR during period of 2013-2015 years:

- Fully independentGPIC supervisory board has established. In order to exercise its power in a more practical and effective manner, the majority of the members of the Supervisory Board are nominated by the Country Coordination Mechanism (CCM) through the open selection process and board is granted a power to accept new members independently;
- GPIC governance model consists of two tiers, where the supreme governance body is the Supervisory Board, while the Executive Director along with the Senior Management Team represents the 2nd governance tier;
- Enterprise Resource Planning (ERP) system '1C Pro' based software, modified by GPIC to grant management requirements including GFATM needs, which was in the testing mode at the time of submission of request on renewal, has become fully functional. Respectively, GPIC core business processes - organization's administrative operations, management of grants to SRs and supply management – is done through the Enterprise Resource Planning system, which diminishes risk of errors and fraud due to existing multi-level authorizations. The system ensures timely production of quality reports;
- With the establishment of ERP system, GPIC has created a virtual stock which ensures minimization of the

risk of stock-outs through effective management of procurement and inventory levels, including appropriate order quantity and buffer stock;

- To ensure an open, transparent and competitive environment for procurement, GPIC has established own Electronic Procurement System, which is a portal located on the official websitehttp://www.gpic.ge.
- To strengthen sub-recipient management and monitoring and evaluation, GPIC has expanded Terms of Reference of SR monitoring. Farther more, in regards to identify existing bottlenecks in program implementation, GPIC has already contracted service provider for ERP for inclusion of programmatic data in the system and expansion of the ERP at sub-recipient level;
- Data Quality Audit which was conducted in December 2011, reports that "The Georgian TGF HIV program faired well in this DQA – no major findings of vulnerabilities were found – and indeed many strengths only compliment the program";

Overall, GPIC has significantly improved its performance, which is stated in the management letter of The Global Fund Secretariat.Despite of above mentioned, CCM Georgia decided to seek for other options and initiated process for alternative PR ship modalities through a public call (please, see the details under p.2.1.5.).

At the same time, TGF Country Team, as result of the Program assessment, recommended a number of actions to be taken by the CCM during Phase 2 HIV program implementation in order to reduce possible operational risk of the Program. The CCM carefully analyzed the identified issues and took necessary measures described in the relevant parts of the current document (please see #1.3.2. – proposed programmatic, budgetary and implementation arrangements; #2.1.3. – program oversight; #2.1.5. – CCM process description; #3.1. and 3.2. – epidemiological situation and country context; #4.2. – progress towards the goal and impact; 5.1.2. – grant risk management; section #6.6.1. Program objectives, SDAs, indicators and targetsetc).

5.1.3 Grant Performance Rating

Please answer the following questions if you are submitting the CCM Request for a Phase 2 or RCC Phase 2. If you are submitting the CCM Request for Periodic Review, proceed to section 5.2 'Financial Performance'.

Grant Performance Rating for the current Phase (Phase 1/RCC Phase 1)

☐	**A1**	☐	**A2**	☑	**B1**	☐	**B2**	☐	**C**

Please provide a rational and justification for the rating.

The PR has made good progress against most indicators. Based on latest available quantitative data, average performance on all indicators was 75% qualifying for B1 rating as of 30 June 2012. However, rating assignment took into account that underperformance on several output indicators is the result of objective external reasons rather than weaknesses in performance from SRs or PR. Taking into account this circumstance along with reliable grant management performance demonstrated by the PR the CCM upgraded the quantitative data rating from B2 to B1.

5.2 Financial Performance

5.2.1 Financial situation at cut-off date

Cash at cut-off date

Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package **Renewals_FinancialTemplate_FinancialRequest_Cash-at-cut-off-date***– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word*

document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!

5.2.1 Financial Situation at Cut-off date

Cash at Cut-off date

	PR	SRs	Total
a. Disbursed to PR to cut-off date	5,089,995	N/A	5089995
b. Less: Disbursed from PR to SRs	-1,807,041.55	1807041.55	0
c. Less: Expenditure incurred tocut-off date	-1,501,908.87	-1,589,383.57	-3091292.44
d. Add: Interest received	126,035.91	0	126035.91
e. Add: Other income - please specify	50,181.47	0	50181.47
f. Equals: Cash at cut-off date	1957261.96	217657.98	2174919.94

Please include a **Liabilities summary at cut-off date** with the CCM Request(goods and services received/ordered but not yet paid for).

As of 31 December 2011, PRhad liabilities (including commitments) of a total amount EUR 10,306,134.63 for the goods, services, consultancy received/ordered but not paid yet. For more information please refer to "List of liabilities and commitments as of 31.12.11" attached to this application.

Have all liabilities at cut-off date been taken into account in the post-cut-off date budget? **Yes**

5.2.2 Analysis of expenditures versus budget

With reference to the latest available EFR at cut-off date, please summarize the main reasons for any under-spending or over-spending against budget.

Please comment on whether the overall % expenditure versus budget variance at the cut-off date is in line with the average % achievement against all indicators in the performance framework. If not, please explain the reasons.

For the 1st Implementation Period program, the cumulative expenditure rate (taking both PR and SR expenditures into account) at cut-off date was 50% of the budget; however, the most of delayed activities from 2011 are implemented after the cut-off date in 2012 (included into a request for the Period 1 extension, submitted separately). The PR's expenditures for the last 6 months before the cut-off date constituted 75% of the semi-annual budget. At the same time, the programmatic performance of the project and the total grant rating as of June 2012 is B1.

SECTION 6: CCM REQUEST FOR RENEWAL (PR: GPIC)

6.1 Programmatic Proposal

6.1.1 Program Objectives, SDAs, Indicators and Targets

Please provide a Performance Framework for the next Phase/Implementation Period and comment on whether indicators and targets are aligned with the national program strategy, plans and systems.

This application represents a Resubmission Request for Renewal of The Global Fund HIV Grant GEO-H-GPIC (Principal Recipient: Global Projects Implementation Center), which covers the entire period from 01 January 2013 to 31 December 2015 (2nd Implementation Period). However, to avoid interruptions and allow CCM to revise and resubmit the request for the second implementation period, the 1st semester 2013 is currently covered by the 1st Implementation Period no-cost extension approved by TGF separately on 03 December 2012 (Extension to the first implementation period, attached to this application).

The Grant Renewals Panel of TGF had a series of concerns, questions and clarifications to the Request for Renewal submitted on 30 April 2012 and recommended to address them in a Resubmission Request. In the current application, the CCM responded to the specific concerns and questions, provided additional contextual information and described all remedial actions that have been taken to address program weaknesses from the 1st Implementation Period of the grant (please see #1.3.2. – proposed programmatic, budgetary and implementation arrangements; #2.1.3. – program oversight; #2.1.5. – process description; #3.1. and 3.2. – epidemiological situation and country context; #4.2. – progress towards the goal and impact; 5.1.2. – grant risk management etc.)

The HIV Program evaluation commended by CCM determined the impact and outcome of the HIV program in Georgia to-date, assessed the quality of services based on available data and defined the most effective interventions to accelerate the impact on the epidemic. All the findings and recommendations of the evaluation determined the strategic approach and key programmatic interventions for the 2nd Implementation Period of the program and served as basis for the thorough analysis and justifications of the proposed implementation strategy and activities.

In particular, the HIV Program Evaluation report confirmed that Georgia is currently experiencing a national concentrated epidemic with demonstrated over 10% prevalence among MSM; prevalence among PWID is over 5% in two sites. The coverage with needle and syringe programs as well as by OST is unsatisfactory. Respectively, the report recommended establishing much ambitious targets for activities targeting MSM and increasing coverage of PWID with harm reduction services. Also, the report encourages continuation of VCT activities, ARV and hepatitis C treatment to further contribute to universal treatment coverage. All these recommendations were taken into consideration by the current application for renewal.

The Georgian Government is committed to fight the epidemic and increasingly allocates financial, human and infrastructural resources for this purpose. However, substantial financial and programmatic gaps exist, especially in regard to the complex and costly interventions in HIV/AIDS treatment and prevention activities among most-at-risk population groups. Taking the above into consideration, the CCM has therefore decided to re-submit the application for renewal and solicit support from the Global Fund in bridging the gap in the field and ensure continuation, consolidation and scaling up of activities initiated within the current SSF HIV program.

The overall Goal is to reduce transmission of HIV among most-at-risk populations (MARPs) and reduce mortality among PLHIV in Georgia. The goal is set in accordance with the international recommendations stipulated in the United Nations General Assembly Declaration on Scaling Up HIV Prevention, Treatment, Care and Support and other WHO and UNAIDS guiding documents calling for the ensuring of universal access for HIV prevention, treatment, care, and support.

OBJECTIVES, SERVICE DELIVERY AREAS AND INTERVENTIONS

The interventions included in the proposal for 2nd Implementation Period are aligned with the priorities of the National HIV Control Programme 2011 -2015 and continue to be focused on providing a comprehensive HIV prevention services to most-at-risk populations, ARV and HCV treatment, supporting patients and communities, ensuring supportive environment for HIV/AIDS and conducting operational research to document effectiveness of the interventions.

The application is built to uphold the goal, scope and key directions of the on-going TGF-financed HIV program. At the same time, this application complies with current TGF requirements, including mandatory budget reduction. As result of the new epidemiological data analysis and HIV Program Evaluation recommendations, the activities implemented during the previous phase of the grant have been re-focused and prioritized, and were re-organized under the following four main ***Objectives***:

1. **To establishsupportive environment for HIV/AIDS prevention, treatment, care and support;**
2. **To increase coverage and quality of preventive interventions targeted at MARPs;**
3. **To sustain treatment, care and support for PLHIV including Abkhazia frozen conflict area;**
4. **To generate evidences and document HIV program effectiveness.**

The accomplishment of the project's Objectives will be ensured through developing and sustaining relevant HIV policies; providing a comprehensive HIV prevention package to most-at-risk populations (PWID, MSM, FSWs, inmates); provision of up-to-date ARV and HCV treatment with appropriate patient care and support to ensure adherence; and strengthening capacities for programme management, coordination, monitoring and evaluation.

The proposed project has an important focus on MARPs, particularly PWID with documented HIV prevalence of less than 5% and MSM – more than 10%. The CCM proposes scaling-up of HIV prevention among PWID in 7 most affected regions in Georgia covering East and West Georgia. In addition, Tbilisi is seen as a priority for HIV interventions as it is home to more than 26% of total population, 32% of registered number of PLHIV and 60 - 67% of the estimated number of PWID. The prevalence of PWID in Georgia is 1.5%. MSM will be targeted in three cities of Georgia – Tbilisi, the capital city, Batumi and Kutaisi, located in West Georgia.

At the same time, with the scope of achieving universal access to treatment, **the program targets to enrol a total of 2,970patients in ARV treatment and 450 (150 annually) patients in HCV treatment in the next 3 years** in both the civilian and the penitentiary sector. The program emphasises care and support as important intervention to effective control of HIV/AIDS, increase treatment adherence and ultimately decrease mortality associated with HIV/AIDS.

The anticipated impact of this project is that an average of 55% of PWID and 18% of MSM (estimation from 17,900 MSM in Georgia, source: Modes of Transmission and Data Triangulation study) will have access to integrated harm reduction and other appropriate prevention services, and by referral to VCT services, hepatitis B and C testing and treatment, STI diagnosis and treatment, TB screening and treatment, OST and ART. It is expected that the provision of necessary services to these most-at-risk groups will contribute to greatly reducing not only HIV transmission, but also of Hepatitis B and C and STIs, thus bringing a society-wide benefit.

In total, the project will support access to evidence-based harm reduction services of about 22 068 people who inject drugs, 5 584 men having sex with men, 3 641 female sex workers and 19 500 prisoners of Georgia over three years. 2800 MSM and FSWs will be treated on different STIs during the project period. The program aims at getting 700 patients in OST and provide non-medical care to 2 500 PLHIV and their family members over the program life. In addition, the project targets largely community organizations and service providers, high level

officials, managers and general health service institutions: during three years, over 3500 people will be covered by different training and capacity building activities with the project support.

The Global Fund resources will be additional to domestic resources that will be allocated to cover substantial costs of the staff, medical interventions and facility expenses, funding of VCT, ART and HCV treatment, OST and NSP. The 2nd Implementation Period program aims at ensuring continuation of the activities covered under the 1stImplementation Period and the project will be implemented in a coordinated manner with the support provided by other external partners in the area of HIV/AIDS control.

A brief description of activities under each Objective is presented below; more details are to be found in the Workplan and Budget files.

Objective 1. To establishsupportive environment for HIV/AIDS prevention, treatment, care and support

1.1. Developing and sustaining relevant HIV policies

[SDA: Policy development]

The Global Fund significantly contributed to improving legal environment for the effective implementation of HIV/AIDS prevention, treatment, care and support interventions during the 1st implementation period.The new law on HIV/AIDS was developed and approved by the Parliament of Georgia in 2009. The policy work was done on country's drug regulations, including amendments for the Drug Control Law and the Law on Narcotics, Psychotropic Substances, Precursors and Drug assistance.

The current proposal intends to continue developing and sustaining further the relevant HIV policies, especially in view of newly elected Government (October 2012). The program will further focus on HIV/AIDS and drug abuse related issues by preparing necessary regulations and bylaws and their harmonization with other legal documents.

Late HIV diagnosis, often resulting from missed opportunities to diagnose HIV in healthcare settings constitutes one of the major causes of death among PLHIV. The current proposal will expand provider initiated HIV testing and counselling (PIHTC) in health sector, based on adjusted national guidelines (endorsed by WHO). The activity will support dissemination of national guidelines, training of healthcare professionals, including laboratory specialists. While particular attention will be paid to implementing PIHTC in most affected areas of the country, overall goal is to ensure full geographic coverage. Funds are requested for training, M&E and operation of the activity, while expenses related toHIV screening and confirmatory testing will be mobilized through state funded national HIV testing and counselling program.

During 1st Implementation Period, activities related to implementation of the HIV drug resistance (HIVDR) strategy have been piloted by the National AIDS Center. During the 2nd Implementation Period, the program aims to expand these initiatives at the regional facilities and improve it based on pilot lessons learned. It is intended to sustain the implementation of HIVDR strategy in order to prolong and maximize the quality of life for PLHIV by minimizing emergence of preventable HIVDR through supporting optimal ART program functioning. In this respect, a special set of early warning indicators will be set up to monitor the DIVDR strategy; a specific working group will be set-up to oversight the activities, analyse and distribute the obtained data.

1.2. Reducing stigma, advocacy, communication and social mobilization

[SDA: Stigma reduction in all settings]

The 2nd Implementation Period activities will be focused on implementing effective advocacy campaigns, conducting policy meetings with the participation of policymakers and law enforcement people, as well as NGO representatives in order to promote the proper execution of new laws by the adoption of bylaws and

regulations. A series of reporting and advocacy workshops with the participation of key stakeholders, ombudsman office and mass media representatives will be organized. Different communication materials will be developed and distributed.

During next 3 years the program will support a series of trainingsfor health workers on stigma and discrimination, while helping them to understand their own attitudes about HIV/AIDS and PLHIV. The training will cover human rights aspects related to health care services, information about the use of standard precautions and proper infection prevention techniques to help minimize the risk of occupational exposure of HCWs to HIV. It is expected that about 2000 health care providers will be trained during the program life.

Objective 2. To increase coverage and quality of preventive interventions targeted at MARPs

2.1. Providing a comprehensive HIV prevention package to PWID

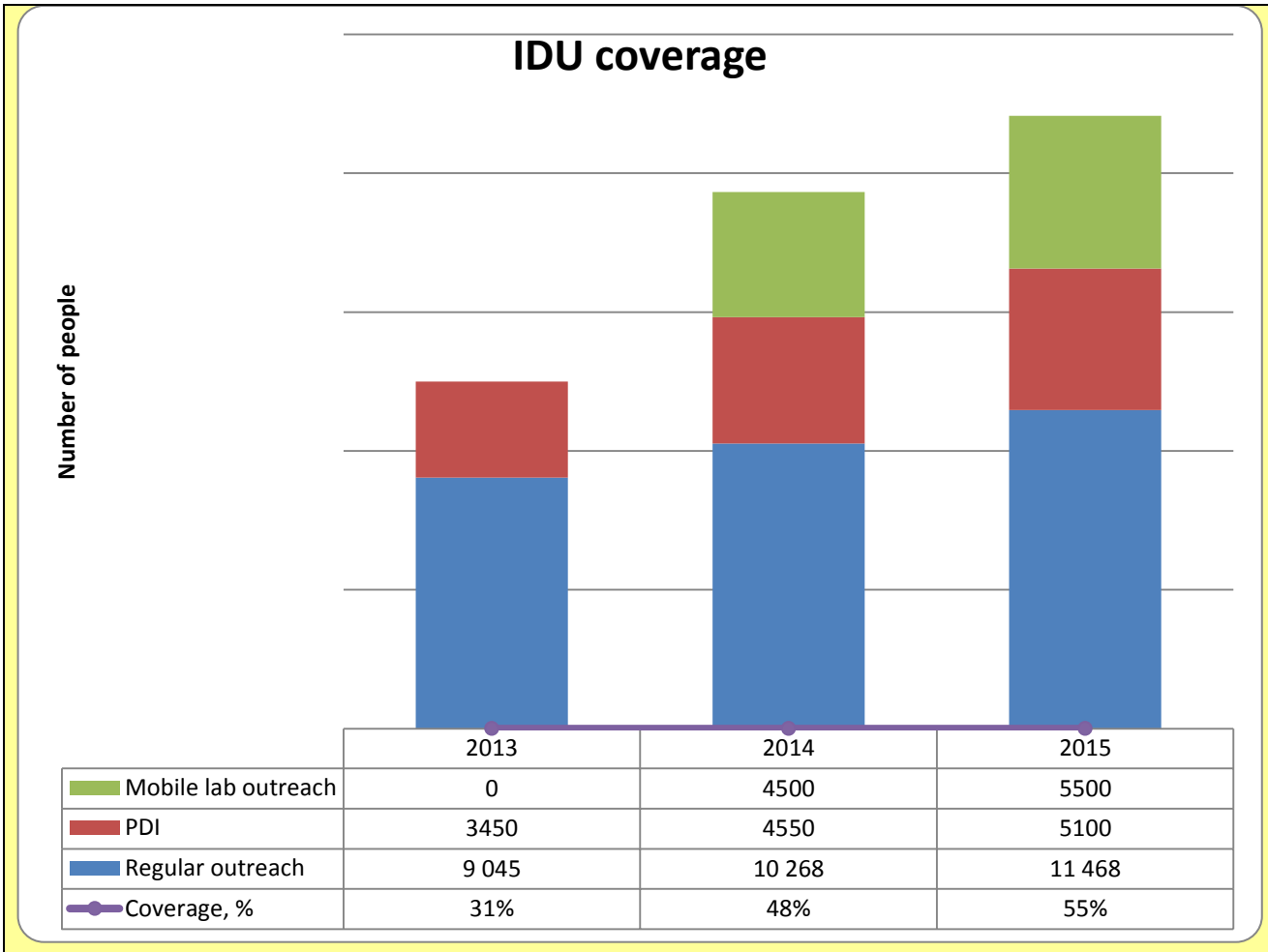
[SDA: Community based activities and services - delivery, use and quality]

The interventions targeted at most-at-risk populations remain essential to control HIV/AIDS in the country and constitute a priority for the 2nd Implementation Period of TGF grant. The current application focuses on developing and delivering of a comprehensive package of HIV prevention services for MARPs. The program will further contribute to quality of services, will facilitate case management approach, will stimulate gender-specific interventions, and will expand new methods piloted during the 1st Implementation Period of the grant (eg. Peer driven interventions for IDUs).

In particular,PWID will receive needles and other sterile injecting equipment, condoms, lubricants, IE materials. The program will cover the existing 10 most affected regions: Tbilisi (2 sites), Gori, Zugdidi, Batumi, Sokhumi, Telavi, Kutaisi, Samtredia and Poti. Also, the activities are oriented to open four new centers– additional in Tbilisi, Kvemokartli region and the SamtskeDjavakheti region.

The targets for annual coverage (number of people reached by HIV prevention services defined as "package of services" during 12 months) were estimated on basis of existing field program capacities and new outreach strategies planned for coverage scale-up. Coverage was calculated separately for each geographical region, taking into account local programs current reach as well as estimates of risk group size. Gradual increase of coverage each year was planned to balance technical ability of local field staff and introduction of the new outreach strategies. Example of this analysis is presented below.

Graph 1:Coverage of IDUs by years and by combination of different outreach strategies



	2013	2014	2015
Mobile lab outreach	0	4500	5500
PDI	3450	4550	5100
Regular outreach	9 045	10 268	11 468
Coverage, %	31%	48%	55%

As it shown on graph above the following outreach strategies are planned to increase program coverage to 55% or to reach **22 068 IDUs** in 48 cities (size estimation: 40,000).

1. Regular outreach: increase in number of outreach workers, increase in number of centers
2. Mobile labs
3. Peer Driven Intervention (PDI)

The combination of these strategies will evolve through program implementation from 2013 to 2015. In **2013** 11 new outreach workers will be hired in existing centers. In the second half of 2013 it is planned to open 4 new centers in addition to 10 existing. PDI will facilitate reach to new clients in 13 sites.In**2014** 11 new outreach workers hired. 4 new centers will greatly contribute to coverage. 6 mobile labs will provide HIV prevention services in 37 cities and 2 mobile labs will operate in Tbilisi. PDI will facilitate reach to new clients in 13 sites.In**2015** it is planned to have 3 more outreach workers and continue gradual increase in coverage through use of regular and mobile outreach and strategic use of PDI.

Table 1. Geography of IDUs coverage by years (percentage from size estimate)

Cities	**2012**	**2013**	**2014**	**2015**
Kutaisi	**14%**	**26%**	**37%**	**42%**
Samtredia	**58%**	**67%**	**67%**	**67%**
Telavi	**57%**	**66%**	**66%**	**66%**
Poti	**55%**	**69%**	**69%**	**69%**
Batumi	**24%**	**39%**	**46%**	**51%**
Zugdidi	**27%**	**42%**	**44%**	**50%**

Gori	**57%**	**77%**	**77%**	**77%**
Sukhumi	**41%**	**41%**	**50%**	**60%**
Rustavi	**0%**	**37%**	**58%**	**66%**
Ozurgeti	**0%**	**57%**	**66%**	**76%**
Tbilisi	**6%**	**18%**	**30%**	**36%**
37 small cities			**63%**	**75%**

In Table 1 planned coverage of IDUs was taken as percentage of estimated IDU prevalence in corresponding cities. The data on IDUs population size was taken from publication "Estimating the Prevalence of Injection Drug Use in Georgia", 2012. Bemoni. In 2012 only few site had coverage over 30% with most of cities with very low or none coverage. In 2013 it is planned that in 5 cities coverage will reach 60% and more. In 2015 out of 48 cities all but 4 will have coverage over 60% and all will have coverage of more than 30%. In Tbilisi, city with largest IDU population in the country coverage is planned to be increased from about 6% in 2012 to 36% in 2015. This will mean 9000 IDUs in absolute number as presented in Table 2.

Table 2. Geography of IDUs coverage by years (number of people reached)

	2012	**2013**	**2014**	**2015**
Kutaisi	**800**	**1000**	**1400**	**1600**
Samtredia	**919**	**739**	**740**	**740**
Telavi	**774**	**724**	**724**	**724**
Poti	**878**	**722**	**722**	**722**
Batumi	**1104**	**1350**	**1600**	**1800**
Zugdidi	**943**	**1100**	**1150**	**1300**
Gori	**951**	**982**	**982**	**982**
Sukhumi	**405**	**405**	**500**	**600**
Rustavi	**0**	**450**	**700**	**800**
Ozurgeti	**0**	**600**	**700**	**800**
Tbilisi	**2149**	**4423**	**7600**	**9000**
37 smallcities	**0**	**0**	**2500**	**3000**
TOTAL	**8923**	**12495**	**19318**	**22068**

During 2nd Implementation Period, the program will continue to support voluntary counselling and testing (VCT) to PWID. The services will include rapid testing for HIV, HCV, HBV and TP-syphilis. In order to increase testing coverage, the program will support additional 6 mobile laboratories. The mobile units will distribute sterile equipment to PWID as well. Using this technology, it is expected that the program will rapidly scale-up this intervention and bring the total number of covered cities to 48.

The Global Fund supported program will contribute to strengthening participation of civil society and communities in HIV/AIDS control in Georgia. It is expected that a national network of PWID will be established starting from 2013. On-going technical assistance will be provided to self-support community based organizations; a series of capacity building activities will be provided to increase the role of communities in improving access and quality of services in Georgia, including training.

With the contribution of TGF and the Government of Georgia, the OST programs cover most of the country regions and more than 1500 patients are enrolled to date. At the moment, there are 5 OST centers supported

by TGF. An important achievement of TGF supported program is the implementation of OST in prison settings: since 2009 about 650 PWID have been enrolled in two prison sites. During the 2nd Implementation Period, the activities will be focused on scaling-up methadone maintenance therapy by development of capacities of existing centers, opening a new one and applying cost-efficient measures. It is expected that the program will support 6 OST centers in civilian sector and 2 centers in prison sector, and will cover more than 1000 beneficiaries; the overall costs will be decreased by 15% compare to 2012.

In order to increase the outcome of OST treatment, the program will provide psycho-social support to beneficiaries and their families. In parallel with the medical treatment, the beneficiaries will benefit from counselling, group/family/individual psycho-therapy, art-therapy, religious support etc. The program will actively involve civil society organizations, eg. Research Institute on Addiction, Anti-Drug Center at the Patriarchate of All Georgia, NGO Kamara.

During the 2nd Implementation Period, the program will continue to support capacity building interventions, training of OST staff as well as involving peer educators. The program will support VCT unit to continue to serve OST beneficiaries. The beneficiaries of the OST centers will receive a minimum set of information and education materials. The special web-page on will be updated regularly.

Table. Number of OST beneficiaries to be covered by services in Georgia during 2nd period of the program

# Beneficiaries	2013	2014	2015	Totally
Number of patients on simultaneous treatment on MMT in Civil sectors	450	650	700	700
Number of patients receiving MMT in Civil sectors during the time period	550	800	1000	1200
Number of inmates on methadone treatment in prisons	60	120	120	300
Number of clients undergoing psycho-social rehabilitation	150	200	200	350
Number of Peer educators trained	220	430	450	1100
Number of VCT conducted among clients of MMT and rehabilitation centres	300	700	700	1700
Number of hot-line counselling for IDUs and their peers, family members	900	1800	1800	4500
Number of IE materials distributed among beneficiaries	2000	5000	5000	12000

2.2. Scaling-up prevention programs among MSM, FSWs and prisoners

[SDA: Community based activities and services - delivery, use and quality]

The 2nd Implementation Period prevention activities will be accomplished through community outreach, peer education and increasing awareness among MSM, FSWs and prisoners. The program will support 5 VCT and outreach centers to serve FSWs, MSM and their clients nationally through face-to-face and green-line counselling, free HIV and STIs testing and STIs treatment. The HIV counselling, testing, STIs treatment and other preventive measures will be conducted based on involvement of community outreach workers and

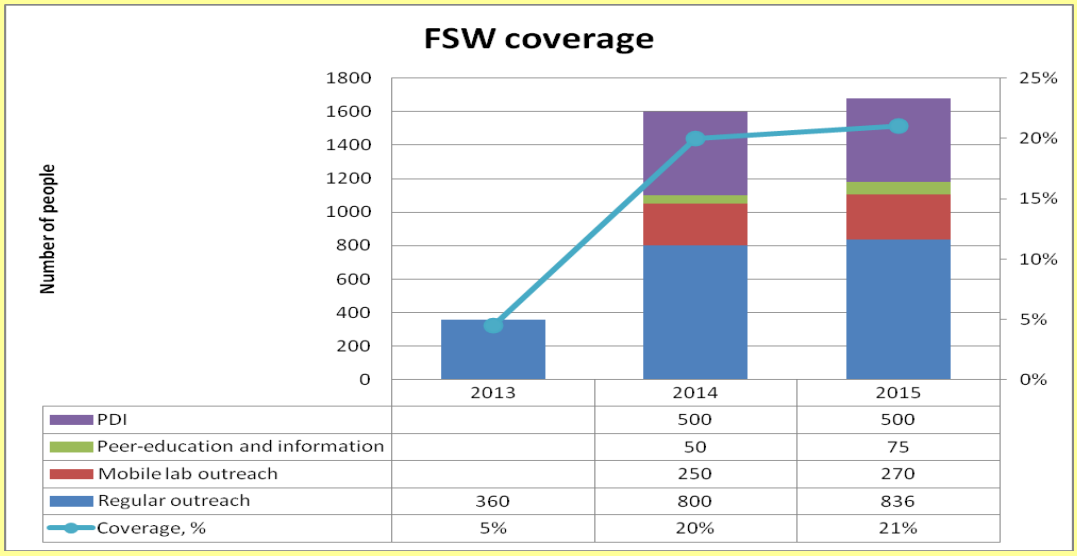
mobile units. Special focus of the program will be made on MSM as one the main drivers of the epidemic in Georgia by peer-to-peer interventions, educational group community meetings, internet-based interventions and Popular Opinion Leader program. Condoms, lubricants and IEC materials will be distributed by the program.

The activities targeting prisoners will include VCT capacity building, HIV and STIs awareness improvement, capacity building of prison medical staff and ensuring access to basic diagnostic, treatment and care services for PLHIV. It is expected that all prisons of Georgia will be covered by testing and counselling services. The program will support extensive capacity building activities, including training of counsellors and laboratory technicians. During the 2nd Implementation Period, the prison inmates will be covered by a minimum set of preventive services, including condoms, lubricants, IEC materials, self-support groups etc. The program intends to reach about 12 000 inmates through VCT as well as other preventive services.

The coverage of FSWs will be increased up to 21%, 1 681 in 5 cities (size estimate 8,000).

1. Increasing the frequency of regular outreach
2. Mobile labs outreach
3. PDI model for FSW

Graph 1: Coverage of FSWs by years and by combination of different outreach strategies



	2013	2014	2015
PDI		500	500
Peer-education and information		50	75
Mobile lab outreach		250	270
Regular outreach	360	800	836
Coverage, %	5%	20%	21%

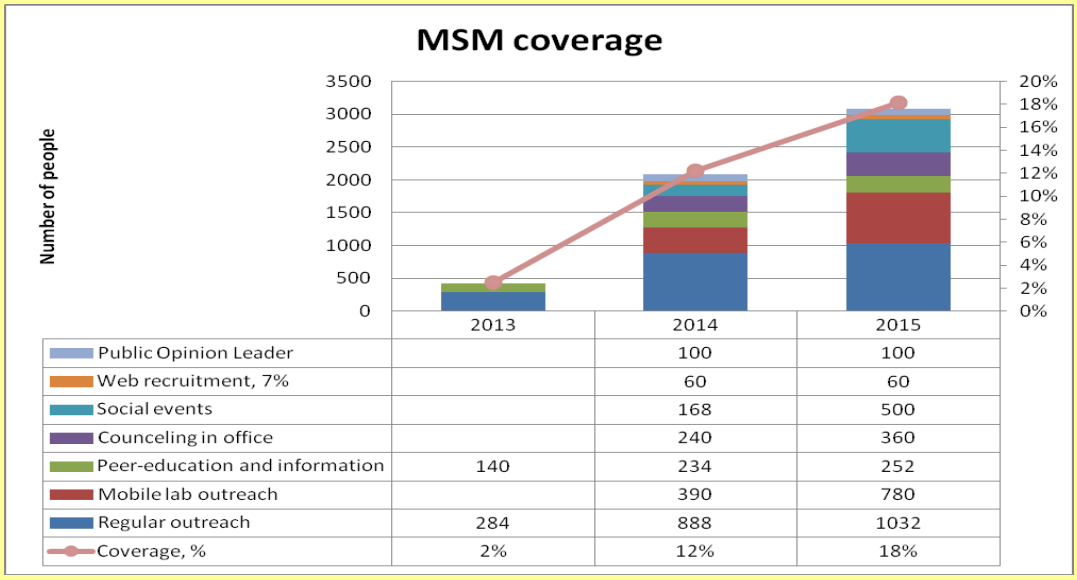
It is important to note that there is no reliable data on FSWs size estimation. There are many expert opinions on this including one that population size of street based and other most at risk FSWs is much lower in which case program coverage of 1681 FSWs will reach majority of this group.

The coverage of MSM will be gradually increased and will reach up to 18% (size estimation of 17000) or 3084 MSM in 3 cities through use of the following approaches:

- Increasing the frequency of regular outreach and recruiting MSM outreach workers for prevention programs
- Peer education trainings and information-educational meetings
- Popular opinion leaders program
- In-office counseling and testing
- Mobile labs outreach

- Organizing special awareness rising events and social networking and internet based interventions

Graph 2: Coverage of MSM by years and by combination of different outreach strategies



	2013	2014	2015
Public Opinion Leader		100	100
Web recruitment, 7%		60	60
Social events		168	500
Counceling in office		240	360
Peer-education and information	140	234	252
Mobile lab outreach		390	780
Regular outreach	284	888	1032
Coverage, %	2%	12%	18%

The size estimation of MSM conducted in 2010 by Tanadgoma suggests that there 7900 active MSM in Tbilisi and 1200 MSM with low socio-economic status. Given that most of coverage is planned in Tbilisi it is expected that the proposed program coverage will have visible impact on HIV epidemic in this group. At the same time it should be noted that given current level of stigma and marginalization of this group the target set for this program is very ambitious and could be achieved only with support of advocacy work directed on changing of social and policy environment.

The activities targeting prisoners will include VCT capacity building, HIV and STIs awareness improvement, capacity building of prison medical staff and ensuring access to basic diagnostic, treatment and care services for PLHIV. It is expected that all prisons of Georgia will be covered by testing and counselling services. The program will support extensive capacity building activities, including training of counsellors and laboratory technicians. During the 2nd Implementation Period, the prison inmates will be covered by a minimum set of preventive services, including condoms, lubricants, IEC materials, self-support groups etc. The program intends to reach about 12 000 inmates through VCT as well as other preventive services.

Objective 3. To sustain treatment, care and support for PLHIV including Abkhazia frozen conflict area

3.1. Improving access and quality of treatment

[SDA: Antiretroviral treatment (ARV) and monitoring]

Georgia made substantial progress in scaling up HIV/AIDS treatment and care After the arrival of the Global Fund grant. Since 2004 Georgia remains the only country in Eastern European region that achieved and maintained universal access to antiretroviral therapy for all patients in need. Recent HIV program evaluation commissioned by the Global Fund described the Georgian model of ART program as exemplary for the entire Eastern European region.

Recent analysis of spectrum of engagement in HIV care in Georgia showed one of the highest levels of linkage and retention around the globe, which provides the basis for maintaining universal ART coverage. It should be mentioned that The Global Fund supported program has already shown impact – universal access to ART has translated into significant reduction in mortality. HIV population level analysis of all registered HIV patients in Georgia showed more than 2-fold decrease in all-cause

mortality and more than 3-fold decrease in AIDS-related mortality among HIV patients.

Success of Georgian ART program has been possible through crucial support from the Global Fund. This support allowed Georgia to fill existing gap and establish effective service delivery model. Current request for next phase of funding seeks support to continue activities implemented in the first phase of grant implementation, which significantly contribute towards high engagement and retention in HIV care, universal access to ART and improved health outcomes.

The proposed activities are built on strategic directions of 2011-2016 National HIV/AIDS Control Program, which identifies earlier initiation of ART and provision of adherence support as priority interventions to improve treatment outcomes. During 2nd Implementation Period, the program will support provision of ARV drugs, overall administration of the program and monitoring of ART effectiveness.

Within the TGF RCC project funds have been secured to treat all patients with CD4 cell count <200 cells/mm3. During 2010 - 2011, efficiency gains, achieved during the grant consolidation process and switching to VPP mechanisms for ARV drugs, were reprogrammed to implement WHO recommended ART initiation criteria of CD4 count <350 cells/mm3. The phased implementations of new criteria for ART initiation has been completed in 2012 and currently treatment is provided to all patients with CD4 count <350 cells/mm3. The current request for renewal took into consideration TGF comments from previous submission and has made reprogramming. This resulted in efficiency gains, part of which were directed to accommodate additional treatment need with ART initiation criteria of CD4 count <500 cells/mm3. The request envisions to begin implementing this new criteria in 2014. Based on epidemiological dynamics and ART programmatic data, implementation of the new criteria will require enrollment of additional 200 and 300 patients 2014 and 2015 to meet the 95% of treatment need among registered PLHIV.

Table. Number of PLHIV to be enrolled in ART program during 2nd Implementation Period

	2013	2014	2015
Number of PLHIV enrolled in ARV treatment	2130	2740	3270

In parallel to ARV drugs, the program will ensure procurement of laboratory test-systems essential for optimal delivery of treatment in accordance with national protocols endorsed by WHO.The routine use of requested laboratory test-systems allows us to timely select patients eligible for ART, monitor treatment success and timely identify those who will benefit from additional interventions. Request includes tests for measuring CD4 count, HIV viral load, HIV drug resistance and tropism testing for prescribing CCR5 antagonists among heavily treatment experienced patients.

ART will be provided in 5 existing locations countrywide – National AIDS Center in capital city of Tbilisi, regional centers in Kutaisi, Batumi, Zugdidi, and Sokhumi regional center in breakaway region of Abkhazia. While all 4 regional centers operate in Western Georgia, National AIDS Center in the capital city is the only facility providing ART for patients living in Eastern parts of the country. Therefore, the program include additional resources to support opening and operation of new facility in Eastern Georgia in the city of Telavi. The new centerwill provide treatment and care services to more than 300 PLHIV in Eastern Georgia (excluding Tbilisi). The opening of a new center requires refurbishment of facility to create acceptable environment for service delivery. Procurement of a vehicle is requested for this new center, which is essential for service delivery, such as transportation of medicines and health products, outreach and operation of adherence mobile units.

Also, it is important to mention that during 1st Implementation Period, an adequate ART, including clinical, laboratory and human capacity has been developed in the Abkhazia frozen conflict region and treatment center has been established in the capital of Abkhazia – Sokhumi. The activities under 2nd Implementation Period will be oriented to sustain the program operation in the region through bilateral Abkhaz-Georgia commission and strengthen communication between the National AIDS Center and the regional center in Sokhumi.

The program will support antiretroviral drugs for the prevention of mother-to-child transmission of HIV. It is expected that 30 HIV positive pregnant women and their new-borns will undergo the course of ARV prophylaxis annually. Vaccines for common infections affecting HIV patients, such as hepatitis B and influenza will be provided.

The 2nd Implementation Period activities are also oriented to ART monitoring, including maintenance of AHIS (AIDS Health Information System), routine data management, implementation of data quality control and assurance and on-site data verification. The proposed M&E activities will be mainstreamed with the national M&E system. In parallel, the program will ensure tests to measure CD4 cell count and viral load based on national protocols endorsed by WHO. It also will sustain HIV drug resistance testing among patients to improve treatment outcomes.

The co-infection with hepatitis C virus (HCV) in PLHIV is one of the major problems in Georgia, influencing mortality high rates. About 50% of PLHIV have HCV antibodies in Georgia. The program will continue to support HCV therapy with pegilated interferon (IFN) and ribavirin (RBV), as well as monitoring of patients (including laboratory tests and elastography). Clinical management of HIV/HCV co-infection is provided based on the National Guidelines on Management of Hepatitis C and HIV Co-infection endorsed by WHO.Based on HCV treatment eligibility criteria it is expected that 150 HIV/HCV co-infected persons will be treated annually.

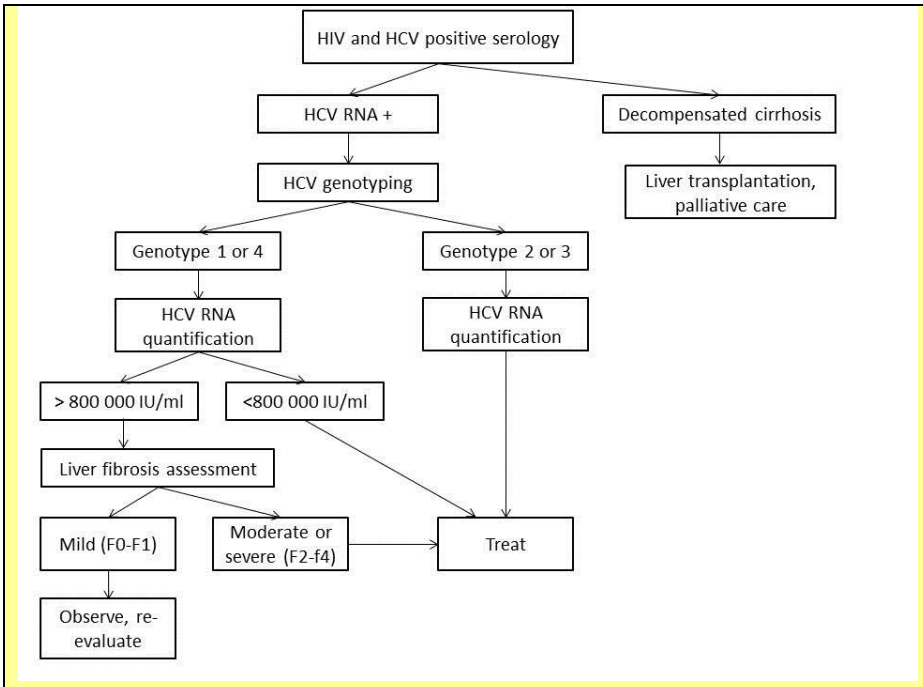
The edibility criteria for starting treatment with pegilated interferon (IFN) and ribavirin (RBV) can be classified into patient related factors, HIV diseases related factors and HCV disease related factors. Most important and common contraindications for treatment with IFN+RBV include:

- Decompensated liver cirrhosis or history of decompensation
- Significant hematological disorders (e.g. leucopenia, thrombocytopenia, anemia)
- Uncontrolled thyroid dysfunction
- Psychiatric illnesses
- Active drug or alcohol abuse
- Severe cardiac diseases
- Active opportunistic infections

HCV treatment is recommended at CD4 count >350 cells/mm3, but can be considered in low values among patients on stable ART. Among eligible patients HCV treatment decision is based on HCV genotype, HCV viral load and liver fibrosis stage (See algorithm).

The program will continue to support HCV therapy with IFN and RBV, as well as laboratory tests and elastrography for selection of eligible patients and HCV treatment monitoring.

Figure. HCV treatment algorithm in HIV positive patients



3.2. Ensuring care and support, and capacity building

[SDA: Care and support for the chronically ill]

The treatment adherence is of particular attention. A strategy to monitor and promote adherence has been in place since the roll-out of ART program in 2004. During 1st Implementation Period, mobile units to provide home-based adherence monitoring and support have been established and operationalized. Due to documented success of the intervention (adherence rate increased from 82% in 2008 to 93% over subsequent years), the program will continue the support during 2nd Implementation Period.

The 2nd Implementation Period activities aim at ensuring delivery of palliative care services to chronically ill people. Home-based and institutional (hospice) palliative care services were established within round 6 HIV project; starting from 2011 the institutional-based palliative care services to PLHIV are supported entirely by the state budget allocations. The Global Fund program will continue home-based palliative care service delivery and ensure coordination between TGF and state funded palliative care programs.

The network of four self-support centers of PLHIV established through TGF support will continue its operation, providing telephone and face to face counselling and psychosocial assistance to HIV/AIDS patients and family members reaching more than 60% of registered PLHIV. The program will support remunerations of the staff with the majority being HIV positive, rent and operational costs. Along with psychological assistance, art-therapy, English language and computer lessons will be provided to PLHIV and family members to improve their integration and employment opportunities.

During 2nd Implementation Period, the program will continue support of PLHIV meetings at central and regional levels, exchange visits, training abroad and other events targeting both adults and children (e.g. summer camps). The events provide PLHIV with an opportunity to discuss the common problems and set the common goals to improve access to counselling, diagnostic, treatment, care and social assistance programs and employment opportunities. In addition, the Program will support PLHIV events on World AIDS Day and AIDS Commemorative day.

Objective 4. To generate evidences and document HIV program effectiveness

4.1. Conducting operational research to document program effectiveness

[SDA: HSS - Information system & Operational research]

To collect additional evidence, inform decisions and facilitate effective operational planning of HIV/AIDS control interventions, an operational research component is included in the proposal. The studies will address priority problems related to HIV/AIDS control in Georgia with special emphases on MARPs. The studies will be conducted by national and international organisations, which will be selected by the PR on a competitive basis taking into account technical and financial parts of the submitted proposals. The results of the studies will be published and publicly discussed, and relevant recommendations will be developed on the basis of the findings.

To document effectiveness of the program activities, to monitor the national response, evaluate coverage and quality of preventive programs, measure impact of prevention interventions on behaviour change and disease prevalence, the 2nd Implementation Period will cover implementation of Bio-BSS in Georgia. Due to technical delay, the survey from 2011 was transferred to 2012. Also, due to changes in other donors commitments the planned surveys among PWID, FSWs and MSM have been cancelled. In this respect, the 2nd Implementation Period activities are oriented to cover the gap and support a round of Bio-BSS in 2014 - 2015 among PWID, FSWs, MSM and prisoners.

In addition, the program will support conducting a survey to monitor HIV drug resistance and associated factors in ART sentinel sites as well as the HIV drug resistance threshold survey. Both will allow decision makers to understand extend of transmitted HIVDR and document evidences on resistance associated factors.

In parallel, the 2nd Implementation Period will cover operational research in line with the National HIV/AIDS Control Program priorities targeted to PLHIV, including accessibility to the health and social care services, patterns and levels of stigma and discrimination, impact of care and support services on health outcomes and assessment of care and support services.

* * *

The workplan is presented below; the detailed description of the proposed project activities is presented in the Workplan and Budget files attached to this application.

No.	*Activity*	*Description*	*Implementing agency*
1	**Objective 1.To establish supportive environment for HIV/AIDS prevention, treatment, care and support**		
1.1	**Developing and sustaining relevant HIV policies**		
	[SDA: Policy development]		
1.1.1	Review of the legal and administrative documents on HIV/AIDS and drug abuse related issues	Experts will continue working on the HIV/AIDS and drug abuse related issues by preparing relevant regulations and bylaws to ensure protection of rights and freedom of PLHIV and MARPs and their harmonization with other legal documents acting in the country.	GPIC
1.1.2	Organization of law enforcement workshops and round table discussions and other events on HIV/AIDS prevention issues	The project will support the reporting and advocacy workshops for the main stakeholders, ombudsman office and mass media that will be held on quarterly basis. Round table discussions, formal and informal meetings and seminars with relevant governmental and NGO sector representatives will be organized on HIV/AIDS, drug addiction and STIs issues to increase awareness and build public support for the HIV/ AIDS prevention.	GPIC
1.1.3	Scale-up of provider initiated HIV testing and counseling	The proposed activity envisions expanding provider initiated HIV testing and counseling (PIHTC) in health sector. The activity will support dissemination of national guidelines for indicator condition guided HIV testing and counseling in healthcare facilities, training of healthcare professionals, including laboratory specialists M&E and operation of the activity.	IDACIRC

1.1.4	Support functioning of national HIVDR working group to coordinate implementation of HIVDR strategy	HIVDR working group provides oversight for the HIVDR strategy implementation ensuring partnership in all aspects of work. The working group is also responsible for strategy related data analysis, as well as preparation and dissemination of HIVDR annual reports	IDACIRC
1.2	**Reducing stigma, advocacy, communication and social mobilization**		
	[SDA: Stigma Reduction in all settings]		
1.2.1	Development of ACSM materials	Different type of radio and TV spots on HIV/AIDS prevention issues as well as HIV related stigma and discrimination will be prepared and broadcasted. Also, relevant newspaper articles will be prepared and printed by the trained journalists to increase public awareness and support.	GPIC
1.2.2	Maintenance of Internet Site and Forum	TGF has assisted the PR as well as implementing organizations with development of the web sites and forum for promotion of the activities implemented with GPIC support. The current proposal will ensure a non-stop operation of these sites.	GPIC
1.2.3	Stigma reduction in all settings	A series of stigma related trainigs will be organized in Tbilisi and in regions of the country (Samegrelo-ZemoSvaneti, Imereti, Guria, Ajara). An estimated 2000 health care providers will be trained during Year 2013-2014. Special registration system will be used for registering the doctors and nurses who will be trained through the project.	HAPS
2	**Objective 2. To increase coverage and quality of preventive interventions targeted at MARPs**		
2.1	**Providing a comprehensive HIV prevention package to PWID**		
	[SDA: Community based activities and services - delivery, use and quality]		
2.1.1.	Provide comprehensive HIV prevention package to IDUs	The package comprising of needles and other sterile injecting equipment, condoms, IE materials will be delivered to IDUs in existing 10 locations: (Tbilisi (2 sites), Gori, Zugdidi, Batumi, Sokhumi, Telavi, Kutaisi, Samtredia and Poti) and plus three new centers - one in Tbilisi, one in Kvemokartli region and another in SamtskeDjavakheti region. Accordingly new staff will be trained and prepared for outreach and other work.	GHRN
2.1.2.	Provision of HIV testing and counselling	VCT to PWID will be provided in eleven cities of Georgia (13 harm reduction sites), which will include rapid testing for HIV, HCV, HBV and TP-syphilis. For increasing the coverage of testing on HIV, 6 Mobile Laboratories will be added to outreach work. Mobile laboratories will support increased delivering of sterile equipment to IDUs as well and will be carried out in 48 cities.	GHRN
2.1.3.	Establishing National Network of PWID for advocacy, support and advice to government agencies about HIV and Hepatitis C	GHRN will build on existing strategy for empowerment of IDU community and will contribute to formalization and institutionalization of Georgian Network of People who Use Drugs (GeNPUD). Members of the network will undergo advocacy trainings to advocate for their health and human rights and promote adoption of non-discriminatory evidence-based drug policy that safeguards fundamental human rights and improves the lives of drug users. The network will be based on the base of community organization ,,New Vector", that has been implementing needle exchange programs for more than 7 years.	GHRN
2.1.4.	Involve National Network in advocacy of drug policy reform and access to health services	The trained members of the Network will meet on a quarterly basis and according to preliminarily elaborated advocacy plan elaborate action plan. Based on this plan they will conduct presentations with stakeholders, information meetings with different groups of society. They will participate in working groups created by governmental bodies (e.g. in the monitoring of penitentiary system etc.)	GHRN
2.1.5.	Facilitate up-take of preventive interventions by IWID through introducing peer driven interventions	The pilot PDI program has shown to be successful in reaching the target population in a short period of time with educational intervention and HTC, for which drug users themselves are involved. According to this successful experience PDI will be further implemented along with traditional outreach	GHRN

2.1.6.	Case management for clients within harm reduction programs	Case Management will be implemented in 12 harm reduction centers in order to improve the retention of clients in harm reduction programs, helping them with different social problems and increase positive changes in terms of HIV risk behavior	GHRN
2.1.7.	Provide gender specific HIV prevention to female IDUs	The activity include information on gender issues associated with illicit drug use and severer outcomes of drug dependence among women and girls, and female hygienic items (including pregnancy tests). This will be complemented by education on HIV topics and referrals to other service providers (gynecologist, STI service, child care service etc) when appropriate. PDI will also be used for attracting female PWID and include them in the program. New approach will be offered to female drug users by teaching them needlework and fancy work. This innovation will be implemented in new center in Tbilisi.	GHRN
2.1.8.	Training of peers and local staff	Training sessions will be delivered to peer educators and volunteers permanently, that are involved in PDI and outreach activities, as well as to local staff at harm reduction centers to raise awareness about risky behaviour and it's prevention measures.	GHRN
2.1.9.	Prevention of HIV and Hepatitis through OST treatment in civil sector	One new OST centre will function in the beginning of 2014 in Tbilisi. At the same time the capacity of already existing centers will be strengthened. 6 OST centers will be functional during proposed period in Tbilisi and regions. The main priorities for inclusion in those programs will be HIV-positive status and pregnancy. These 6 centers will have the capacity to serve 700 opioid users simultaneously. One patient's MST treatment cost will decreased by 15% in comparison with 2012.	IMHPA
2.1.10.	Prevention of HIV and Hepatitis through methadone treatment among prisoners	2 Centers in prisons (#8 in Tbilisi and #2 in Kutaisi) will continue treatment of opioid dependent inmate patients both in east and west parts of the country. In average 100-120 inmates will benefit from the service per year. Approximately 300 -350 inmates will be treated during the 2,5 years of the SSF second stage period.	IMHPA
2.1.11.	Psycho-Social support of opioid dependent IDUs	3 Psycho-social rehabilitation centers will serve the IDUs during and after medical treatment. 10 church/monastery rehabilitation units, with specially trained priests will serve PWID to support their healthy/safe life-style throughout the country. Approximately 100 IDUs will benefit from psycho-social rehabilitation centers per year. Totally more than 300 IDUs will undergo this service	IMHPA
2.1.12.	Recruitment and training of IDUs as peer educators	Monthly up to 36 IDUs will be recruited and trained as PEs on the bases of OST and rehabilitation centres in Tbilisi. 3 centres (Research Institute on Addiction, NGO Anti-Drug Centre at the Patriarchate of All Georgia and NGO "Kamara") educate them safe HIV behaviour and facilitate behaviour change of their peers. Totally 1100PE IDUs will be trained during the proposed period	IMHPA
2.1.13.	VCT for the clients of OST centers and Hot-line counseling	Specially trained VCT staff will conduct pre-counselling, rapid testing and post-consultation of IDUs unrolled by OST centers, PE-s and social workers. The educational materials will be provided to beneficiaries. 1700 IDUs will receive VCT. 3 hot-lines will work day-times in 3 centres and serve approximately 4500 IDUs and their family members or sexual partners.	IMHPA
2.1.14.	Human resource Capacity building of the OST staff (civil sector and prisons), VCT and rehabilitation staff	12 training for OST centers staff both in civil and penitentiary sectors will be conducted and 60 persons will be trained in modern approaches of IDUs treatment and HR. During proposed period 3 training will be carried out for VCT and rehabilitation staff. 15 training are going to conduct for priests (60 persons) involving in rehabilitation and HR of IDUs. In Total, 60 members of medical and rehabilitation staff, 15 VCT staff and 30 priests will be trained during 3 years.	IMHPA

2.1.15.	ACSM support	The IEC materials will be created, updated, reprinted and disseminated among the IDus by staff members of OST centers, Rehab centers, VCT and Peer Educators. Total of 9000 IEC booklets, triplets and posters will be printed and distributed. The special web-page about OST treatment will be updated in regular base. 4 TV/Radio show will be addressed to HR and OST for IDus per year. One round-training meeting will be conducted for OST treatment and rehabilitation field representative and one conference will be carried out for stakeholders and media per year.	IMHPA
2.2	**Scaling-up prevention programs among MSM, FSWs and prisoners**		
	[SDA: Community based activities and services - delivery, use and quality]		
2.2.1.	STI diagnosis and treatment (healthy cabinets) among FSWs, MSM and their clients	Total of 5 VCT and outreach centers will serve FSWs and MSM countrywide. Those cabinets will provide STI diagnostic and treatment services for FSWs, MSM and their clients. 576 VCT will be conducted in these centers during 2013. From 2014 Tanadgoma will take responsibility to do HIV testing (Mob. laboratory, indoor counseling and testing). 2800 STI cases will be treated among FSWs and MSM during the project period (1720 among MSM and 1080 among FSWs).	Tanadgoma
2.2.2.	Community Outreach	Outreach targeting MSM will be conducted by the community representatives, since they are able to reach different subgroups that are not visible and easily identifiable. The major vector for the outreach will be the informal education activities, such as peer-to-peer intervention, educational group community meetings, internet-based interventions and POL (Popular Opinion Leader) program. With internet interventions (social networks, Tanadgoma web site, gay web pages etc.) Tanadgoma intend to contact 850 person per 2014 and 850 – per 2015 years. According to international experience 7% of contacted people would reach VCT centers or get minimal package in terms of HIV services. Therefore 60 MSM will be reached by internet interventions in 2014 and the same number in 2015. POL model will be introduced from 2014. 2 POLs will be contracted in Tbilisi in 2013, 4 POLs – in 2014 and 10 POLs – in 2015. Each POL will be able to reach 10 new MSM, therefore 20 MSM will be covered by POL program in 2013, 40 – in 2014 and 100 – in 2015. During these activities trained MSM will educate and facilitate behaviour change of their peers.	Tanadgoma
2.2.3.	Recruitment and training of FSWs and MSM as peer educators in Tbilisi & 4 regions	FSWs and MSMs will be recruited and trained as peer educators for each Counselling Centre, reaching the total of 125 FSWs and 390 MSM (30 – in 2013, 180 in 2014 and 180 in 2015) during the project period . They will be sharing the evidence based information and promote safe sex skills among their peers.	Tanadgoma
2.2.4.	Outreach sessions for FSWs and MSM in Tbilisi and 4 regions	Regular outreach sessions will be planned and conducted on weekly basis at the locations identified through mapping exercises. MSM outreach will be conducted in 3 cities of Georgia (Tbilisi, Batumi, Kutaisi). Different types of outreach will be conducted: outreach done by MSM outreach workers (2 pairs of MSM outreach workers will be contracted), outreach done by Tanadgoma social worker and MSM outreach worker together and outreach with mobile laboratory for doing HIV testing In total 284 MSM will be reached during 2013, 888 MSM – in 2014 and 1032 in 2015. VCT done during outreach with mob. lab: 780 in 2014 and 1560 in 2015. In total 360 FSWs will be reached during 2013 by outreach, 800 – in 2014 and 836 – in 2015. With Mob. laboratory 250 VCT will be done in 2014 among FSWs and 270 in 2015. FSWs oiutreach will be conducted in 5 cities of Georgia (Tbilisi, Kuataisi, Batumi, Zugdidi and Telavi). Relevant IEC materials will be developed and distributed among FSWs and MSM during the outreach sessions. Condoms and lubs will be distributed among target groups during the outreach.	Tanadgoma

2.2.5.	Informational – Educational meetings among MSM.	Informational – educational meetings will be conducted for MSM. Reaching totally 18, 54 and 72 MSM in 2013, 2014 and 2015 relevantly. IEC materials, condoms and lubricants will be also distributed during these meetings.	Tanadgoma
2.2.6.	Organization of special awareness raising events for MSM	Special awareness raising events (such as movies screening, photo exhibition, discussions etc) will be conducted in 2014 and 2015 (12 events in 2014 and 30 events in 2015, 42 events totally) per site, 21 events in total). Special focus will be given to HIV in particular and health in general. Events will be organized for MSM in Tbilisi, Kutaisi and Batumi. About 168 MSM will be reached through these interventions in 2014 and up to 500 MSM in 2015.	Tanadgoma
2.2.7.	Indoor counseling and testing for MSM.	Indoor counseling and testing for MSM will be conducted at Tanadgoma offices (5 sites). 140 MSM will be reached in 2013, 240 – in 2014 and 360 – in 2015. Relevant IEC materials, condoms and lubs will be also distributed during these indoor activities.	Tanadgoma
2.2.8.	PDI- A peer-driven intervention (PDI) for female sex workers (FSWs)	PDI model will be introduced from 2014. Within the project duration 350 women will be recruited and interviewed in 2014 and 500 FSWs in 2015. Recruiters were rewarded by earning tickets to win special prizes in a weekly/monthly lottery.	Tanadgoma
2.2.9.	Distribution of condoms, lubricants and IEC materials	Condom distribution will be an essential component of all activities addressing MARPs. In total during the project 279 000 condoms and lubs will be distributed among MSM and 364 000 condoms for FSWs. In total 6400 relevant IEC materials (3 types) developed within the project will be developed and distributed among MSM and 3400 (2 types) for FSWs.	Tanadgoma
2.2.10	Strengthen capacity of HIV/AIDS voluntary counselling and testing (VCT) centers in all penitentiary institutions	The activity covers all prisons of Georgia. All counsellors and laboratory technicians from VCT centers will be retrained on pre-post counselling and diagnostic issues (32 counsellors and 16 laboratory technicians in total). Currently, there are about 12 000 persons in penitentiary institutions with the flow of 500-700 new inmates per month. All newly incarcerated inmates will receive VCT shortly after entering the penitentiary system. The program will cover more than 90% of inmates. Funds are required to purchase necessary medical supplies for testing approximately 6500 inmates per year.	Tanadgoma
2.2.11	Support HIV/AIDS and STI awareness rising among prisoners through distributing IEC materials and peer education programs; prevent spreading of HIV/AIDS and STIs by distributing condoms and lubricants	Peer Education among prisoners will be launched at 8 semi-open type penitentiary institutions of common and strict regime. Eighty inmates will be trained as peer educators. The new IEC materials will be created, printed and disseminated among the inmates by staff of VCT units and Peer Educators. 3 types of printed materials will be created: booklet, triplet (in two languages: Georgian and Russian) and a poster-calendar. 6000 booklets, 6000 triplets and 2000 posters will be printed and distributed (14 000 per project implementation period). 50 000 condoms (40 000 for MSM inmates and 10 000 for general inmates) and lubricants (40 000) will be distributed among prisoners during the project implementation period.	Tanadgoma
2.2.12.	Medical Staff Capacity building of the penitentiary system	One hundred representatives of medical staff will be trained on HIV/AIDS diagnostics and treatment issues through 10 training sessions.	Tanadgoma
2.2.13.	Supporting HIV positive prisoners through assuring easy access to medical and psychological services	Under this activity inmates diagnosed with HIV will receive further support in terms of necessary medical examination, treatment (if indicated) and care. This will be coordinated with the national treatment program implemented by the National AIDS center. Along with the direct care provision, special trained personnel will be organizing and supporting self-help groups with HIV positive inmates (9 meetings in 8 prisons will be conducted, 72 meetings in total).	Tanadgoma

2.2.14.	Providing special preventive program on HIV/AIDS with MSM inmates	Counsellors of the VCT centers will be trained on specifics of preventive work with MSM in prisons. Workshops will be held with MSM in all penitentiary institutions (1 workshop in each penitentiary institution per year, 16 in total), conducted by VCT centers' counsellors and an expert from NGO working in prisons.	Tanadgoma
3	**Objective 3. To sustain treatment, care and support for PLHIV including Abkhazia frozen conflict area**		
3.1	**Improving access and quality of treatment**		
	[SDA: Antiretroviral treatment (ARV) and monitoring]		
3.1.1	Provision of ART	ART will be provided in 5 existing locations countrywide – National AIDS Center in capital city of Tbilisi, regional centers in Kutaisi, Batumi, Zugdidi, and Sokhumi regional center in breakaway region of Abkhazia. Funds also are requested for antiretroviral drugs for the prevention of mother-to-child transmission of HIV. It expected that 30 HIV positive pregnant women and their newborns will undergo the course of ARV prophylaxis annually. Activity seeks funds to procure vaccines for common infections affecting HIV patients, such as hepatitis B and influenza.	IDACIRC
3.1.2	Provision of laboratory test-systems for ART monitoring	According to National HIV/AIDS Treatment and Care guidelines monitoring of patients on ART relies on measurement of CD4 cell count and viral load three times a year. In addition, HIV drug resistance testing is performed among patients with virological failure. HIV tropism testing is performed in cases when treatment with Maraviroc is considered. Procurement of test-systems for key laboratory methods are requested.	IDACIRC
3.1.3	Monitoring and evaluation of ART program	The activity includes maintenance of AHIS (HIV/AIDS clinical database), including routine data management, implementation of data quality control and data quality assurance protocols, on-site data verification and on data management and other M&E topics. Up to know AHIS included information from only four centers - Tbilisi, Kutaisi, Batumi and Zugdidi Centers, under this activity it is planned to integrate data from Sokhumi center as well.	IDACIRC
3.1.4.	Management of HIV/HCV Co-infection	Funds are requested for the procurement of medications for HCV therapy with pegilated interferon (IFN) and ribavirin (RBV), as well as for the monitoring of patients, including laboratory and elastography. Clinical management of HIV/HCV co-infection will be provided according to the National Guidelines on Management of Hepatitis C and HIV Co-infection. It is envisaged to 150 HIV/HCV co-infected persons to be treated annually	IDACIRC
3.2	**Ensuring care and support, and capacity building**		
	[SDA: Care and support for the chronically ill]		
3.2.1.	Provision of adherence support and monitoring through operation of mobile units	Within the Round 6 project mobile units to provide home-based adherence monitoring and support have been established, operation of which continued under current SSF grant. The service proved to be very successful as median refill adherence increased from baseline 82% in 2008 to up to 93% over subsequent years. The request for renewal envisages continuation of operation of mobile units	IDACIRC
3.2.2.	Sustaining operations of palliative care services for patients with advanced AIDS	The activity will ensure delivery of palliative care services to chronically ill people. Home-based and institutional (hospice) palliative care services were established within round 6 project, since 2011 institutional-based palliative care to PLHIV are provided under state budget allocations. The request for renewal seeks assistance to continue home-based palliative care service delivery and ensuring coordination between TGF and state funded palliative care programs	HAPS
3.2.3.	Sustaining Operation of PLHIV Self-support Centers	The network of self-support centers (4 Centers) of PLHIV established through the GFATM support will continue its operation, providing telephone and face to face counseling and psychosocial assistance to HIV/AIDS patients and family members reaching more than 60% of registered PLHIV. The GFATM fund will be spent on salaries of the staff with the majority being HIV positive , rent and operational costs (heating, telephone, internet, stationary, etc)	HAPS

3.2.4.	Organizing group therapy sessions and quarterly meetings for PLHIV and family members	Within the proposal, support is requested for conducting group psychological therapy sessions for PLHIV at the Tbilisi and regional self-support centers. Along with psychological assistance, art therapy, English language and computer skill lessons will be provided for the PLHIV and family members to improve their mental wellbeing and employment opportunities. Different meetings will be organized at the central and regional levels, including exchange visits and other events both for adult and children PLHIV. In addition, the Program will support PLHA events on World AIDS Day and AIDS Victims days	HAPS
3.2.5.	Visiting PLHIV organizations abroad for experience sharing and networking	PLHIV will be provided with an opportunity to visit CBOs of PLHIV abroad to learn their experience and adopt effective interventions having high demand among HIV positive people in Georgia. Two persons will travel per year, total 6 during 3 years.	HAPS
3.2.6.	Organizing summer camps for HIV positive people	HIV positive people and their families will be offered to spend vacation in summer camps twice, in 2013 and in 2015. Summer camps will help HIV infected people to deal with self-stigma, socialize and improve physical and mental health. All costs of the summer camp vacation, including travel, accommodation and meal, will be covered through the project. Total 15 PLHA will spend summer in camp in 2013 and 45 in 2014 and 2015 each	HAPS
4	**Objective 4. To generate evidences and document HIV program effectiveness**		
4.1.	**Conducting operational research to document program effectiveness**		
	[SDA: HSS - Information system & Operational research]		
4.1.1.	Conduct Bio-BSSs and population size estimation study among IDUs	Bio BSSs among IDUs will be carried out in 6 cities of Georgia (Tbilisi, Batumi, Telavi, Gori, Zugdidi and Kutaisi) during 2013-2014. Respondent Driven Sampling (RDS) Methodology will be used for recruitment of the study participants. In total 1,800 IDUs will be surveyed, of which 360 will be recruited in Tbilisi, 280 in Batumi and 290 IDUs in each other city. Biomarker component will include testing on HIV and Hepatitis C.	CIF
4.1.2.	Conduct Bio-BSSs and population size estimation study among FSWs	Bio-BSS among FSWs will be carried out in 2014 in Tbilisi and Batumi. Time Location Sampling (TLS) methodology will be applied for recruiting study participants. TLS takes advantages of the fact that some hidden populations tend to gather or congregate in certain types of locations. To develop a survey sampling frame, preliminary mapping exercises will be undertaken to identify the numbers, sites and working hours of FSWs. In total 280 FSWs will be interviewed in both cities.	CIF
4.1.3.	Conduct Bio-BSSs and population size estimation study among MSM	Bio-BSS among MSM will be carried out in 2014 in Tbilisi and Batumi. RDS methodology will be used for recruitment of study participants. Using the same methodology enables to compare study data with the previous study results. In total 500 MSM will be recruited in both cities, of which 300 MSM will be studied in Tbilisi and 200 in Batumi. Prior to Bio-BSS a formative research will be conducted to identify seeds, MSM networking patterns and the amount of incentive required for participation in the Bio-BSS. The formative research will include 2 focus group discussions and 10 in-depth interviews with MSM.	CIF
4.1.4.	Conduct Bio-BSSs among Prisoners	Bio-BSS among Prisoners will be carried out in 2015 in Tbilisi. Simple Random Sampling (SRS) methodology will be used for forming the study sample. It is well known that such approach requires the existence of precise data on a target population. Since such data exist and are available within the penitentiary system, Simple Random Sampling Method will be selected for this survey. An advantage of this method is that it guarantees low risk of selection bias and, therefore, provides a highly representative sample. In total 300 prisoners will be surveyed. Bio-marker will include testing on HIV, Syphilis, and HCV.	CIF

1.1.5	Monitoring Early Warning Indicators (EWI)	One of the key elements of the HIVDR prevention and assessment strategy is ART site-based HIVDR early warning indicators (EWIs). These indicators are ART site factors that may be associated with preventable emergence of HIVDR, and can be acted on at the ART site or program level. Results can inform national decision-making on ART program planning and other HIVDR prevention measures. The following WHO recommended EWIs will be monitored: ARV prescribing practices, on-time ART drug pick-up and clinic appointment-keeping, percentages of patients lost to follow-up and still on first-line ART at 12 months, and ARV drug stock-outs and shortages, will be monitored	IDACIRC
4.1.6.	Surveys to monitor HIVDR prevention and associated factors in sentinel ART sites and to evaluate transmitted drug resistance	The method is designed both to evaluate prevention of HIVDR during the first year of treatment in cohorts of patients starting first-line ART in sentinel sites and to utilize routinely available information on ART program factors potentially associated with unnecessary HIVDR emergence. Along with EWI monitoring this survey provides essential information on the relationship of key ART program factors to HIVDR prevention. In addition, WHO recommended a minimum-resource method called the HIV drug resistance threshold survey will be employed to evaluate the extent of transmitted HIVDR.	IDACIRC
4.1.7.	Operational research in PLHIV	The activity envisages conducting operational research in line with NSP priorities, including the research into the following areas: PLHIV awareness about and accessibility to the health and social care services ; research among PLHIV to identify patterns and levels of stigma and discrimination; research into impact of care and support services on health outcomes among PLHIV and assessment of care and support services.	HAPS
4.1.8.	Survey of HIV/AIDS related stigma among HCWs	At the end of the program in 2015 final survey will be conducted in order to evaluate the effectiveness of the intervention. Survey will use the same instruments as during baseline evaluation. 500 HCWs will be interviewed again in Tbilisi, Zugdidi, Kutaisi and Batumi. The survey results will be disseminated at the stakeholders meeting organized within the program	HAPS

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INDICATORS AND TARGETS

Since the key activities during the 2nd Implementation Period of HIV program are directed to support key preventive interventions in MARPs, treatment, care and support to PLHIV, the list of indicators is formulated in accordance with them (for a more detailed information, please see the Performance Framework).

The PF includes the following indicators

Impact Indicators:

- Percentage of adults and children with HIV infection still on treatment after 12 months of initiating ART;
- Percentage of IDUs with HIV known to be on treatment 12 months after initiation of antiretroviral therapy;
- Percentage of most-at-risk population(s) (sex workers) who are HIV infected
- Percentage of most-at-risk population(s) (men who have sex with men) who are HIV infected
- Percentage of most-at-risk population(s) (injecting drug users) who are HIV infected
- Percentage of most-at-risk population(s) (prisoners) who are HIV infected

Outcome Indicators:

- Percentage of injecting drug users who have reported using sterile injecting equipment last time they injected

- Percentage of FSWs reporting the using of condoms with their most recent client
- Percentage of patients achieving HIV drug resistance prevention after 12 months of ART

As mentioned above, as a result of extensive consultations in country and with international partners, first and foremost UNAIDS and WHO, the Performance Framework for 2nd Implementation Period was reviewed and revised to account for the above mentioned issues, and has been agreed within the CCM technical working group comprised by all relevant national stakeholders and international agencies. See more details the attached Performance Framework and M&E Plan.

Output / coverage indicators are presented as per Program Objectives (please see the details included into the Performance Framework document).

Based on the identified gaps and challenges under section 5.1.1 "Programmatic Achievements" please summarize the key M&E systems strengthening activities, including any planned operations research or evaluations to be undertaken during the next Phase/Implementation Period. Does the CCM propose reallocation of resources to support the above stated M&E strengthening initiatives? If yes, comment on the budgetary and programmatic implications, if any, on the overall request.

As mentioned above, the external data quality audit conducted in December 2011 classified data quality of the program as "Minor Data Quality Issues". The audit provided recommendation to address system-level weaknesses emphasizing the need for standardizing data management procedures at all levels of service delivery and reporting, accompanying with detailed written policies. The current proposal includes strengthening data verification procedures, M&E capacity building and implementation of updated quality assurance protocols.

Although M&E cost category share is 2 % of the total budget, enough funds are envisaged for both proper programmatic monitoring and strengthening National M&E system during 2nd Implementation Period. As the Proposal contains a substantial drugs and equipment procurement component, which does not require additional M&E funds to be allocated, this technically reduces the percentage of M&E cost category. The 'true' share of M&E cost category is thus 10.6% calculated on the basis of proposal amount less procurement of drugs and equipment. This is also important to note that M&E trainings are categorized as 'trainings', and salaries of M&E staff are budgeted under 'human resources' cost category, further increasing the real share of funds allocated for M&E.

6.1.2 Pharmaceutical and Health Product Management (if applicable)

Please complete this section only if procurement of Pharmaceutical and Health Products is planned in the next Phase/Implementation Period. Otherwise, continue to section 6.2 "Financial Proposal".

Based on the key risks and challenges in the PHPM area in the current Phase/Implementation Period as identified under section 5.1.2 "Grant/SSF Management", please summarize the measures and/or mechanisms that have been put in place or are proposed in the PSM plan (or the Country Profile if this is already in place) for the next Phase/Implementation Period. Please include an assessment of the risk of treatment interruptions at the health facilities in the next Phase/Implementation Period and a list of the possible underlying causes related to PHPM activities that may have a negative impact on the continuous availability/access to key health products (such as stock outs, diversion and theft of health products).

Management of ARV medicines and health products will be performed according to the PSM Plan attached to this request for continued funding. The key actors covering the coordinating roles in PSM are the Principal Recipient and the Infectious Diseases, AIDS and Clinical Immunology Research Center with participation of government staff, experts, and other stakeholders. Technical working group meetings will also support the PR and Infectious Diseases, AIDS and Clinical Immunology Research Center in their coordinating role.

The PR will ensure good coordination with all partners through regular meetings with other projects funded by USAID, EU and other partners at the CCM meeting, at the regional level and with the representatives of local governments responsible for health sector coordination. The PR will also facilitate and support regular meetings with the representatives of regional and district HIV services and organizations involved in implementation of National HIV/AIDS Control Program discuss strengths and weaknesses of the program, findings of monitoring visits, ways to overcome problems found during program implementation etc.

Product selection for drugs is conducted in accordance with National and WHO guidelines. All procurement of pharmaceuticals and health products within the grant will be completed by the PR in accordance with Global Fund requirements. Procurement and supply management procedures are detailed in PR's revised program operational manual and will be conducted in accordance with approved PSM plan.

The products will be procured through the Voluntary Pooled Procurement (VPP) mechanism for ARV procurement Georgia initiated in 2010 and will continue using the mechanisms in next period of the grant.

Procurement of ARVs that may not be available through VPP (e.g. some second-/third-line drugs) will be implemented by PR. PR conducts electronic procurement through own Electronic Procurement System (EPS), which is developed from the existing GPIC operational procurement system, based on the best practices and experience of WB, EU and state procurement units. EPS ensures conducting procurement in an open, transparent and competitive environment; it ensures publicity of procurement and building public confidence. EPS is used for the International Electronic Competitive Bidding (IECB) and National Electronic Competitive Bidding (NECB).

Quantification/forecasting for pharmaceutical and health product needs are done by SRs in compliance with the national and international (WHO) guidelines. Information is reviewed and verified by PR against stock-levels and utilization records; compliance of selected products to national and international standards will be checked. In addition, there are regular validation visits by different entities (e.g. Principal Recipient, MoLHSA). PR will conduct quality control of finished pharmaceutical products procured with TGF grant based on the random sample selection at different points of supply chain.

PR is responsible for delivery of pharmaceutical and health products to SRs. When procurement is done through VPP or other international procurement with the CIP/CIF delivery term, goods are delivered to SRs central level by PR, ensuring security during transportation as indicated. Local suppliers will directly deliver products to SRs. Receipt and inspection of procured goods will be conducted by representatives of PR and SRs. Products will be stored at SRs central level storage facilities. SRs are responsible for supply of all health products to actual service delivery points. SRs and SSRs have adequate storage and distribution capacities meeting the minimum requirements as outlined in internationally recognized standards, including sufficient storage space and storage conditions at all levels of the distribution chain.

SRs will monthly report on product consumption and stock levels with expiry dates for each batch in the format of inventory register annexed to the grant agreement with SR. Reported data will be entered into recently established electronic resource planning (ERP) system, which ensures minimization of the risk of stock-outs through effective management of procurement and inventory levels, including appropriate order quantity and buffer stock.

6.2 Financial Proposal

6.2.1 Resources available to finance the grant/SSF after cut-off date

Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package* Renewals_FinancialTemplate_FinancialRequest_Resources-available*– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!

Please note that TRP Clarified Amount must take into account Global Fund Board mandated adjustments based on Income level as follows:

- ***90% for LICs and LLMICs***
- ***75% for ULMICs and UMICs***

Please refer to your invitation letter for your income level.Further guidance can also be found in the Financial template.

6.2.2 Summary funding request from cut-off date to end of next Phase/Implementation Period

Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package*Renewals_FinancialTemplate_FinancialRequest_FundingRequest*– the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!

Total Budget required (after cut-off date for the next Phase/Implementation Period

	Year 2012 after cut-off date	Year 2013	Year 2014	Year 2015	Total
a. Total Budget required (after cut-off date for the next Phase/Implementation Period)	12,754,114	6,143,820	9,843,253,382	10,480,277	**39,221,464**
b. - Undisbursed amount at cut-off date					**12,714,135**
c. - Cash at cut-off date					**2,174,919**
d. = Incremental amount requested					**22,071,274.06**
e. % of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)					**80%**

6.2.3 CCM Budget Request for the next Phase/Implementation Period

Please explain how lessons learned from the current Phase/Implementation Period have been factored into this funding request (e.g. budget reallocations, under-spending leading to more realistic budget estimates, reflection of price changes).

Experience in 1st Implementation Period has lead to adjustment of costs for ARV, the prices per unit have been taken from the last invoices. Also, the PSM costs linked to ARV drugs management have been correlated to the last expenditures too, including the storage and external drug quality control costs.

A reassessment of unit costs has been also performed for the consumables and reagents for laboratory investigations. The prices per unit have been taken from the last contracts, as well as from the invoices for the closed type equipment. The number of examinations has been calculated on the basis of the estimated number of patients to be diagnosed and treated.

The cost estimations of the activities linked to the monitoring visits in regions, as well as the costs of software maintenance and staff involved in data-base analysis, has been performed on the basis of actual real costs.

Does the budget request reflect the average programmatic performance in the current Phase/Implementation Period? If not, please provide an explanation.

For the Georgian HIV grant GEO-H-GPIC, the overall grant implementation rating at the cut-off date is B1. By the end of 1st Implementation Period extension the implementation rate will be increased. Therefore, no additional reductions were made to the 2nd Implementation Period budget except 90% TGF Board mandated adjustments (i.e.10% cut) from the TRP clarified amount allocated to PRs for the next implementation (updated ceilings on the maximum amount which can be requested by upper – low middle income country with moderate disease burden).

6.3 Compliance with Focus of Proposal Requirement

This question is not applicable for Low Income Countries.

Describe whether the focus of proposal requirement has been met per the threshold based on the income classification for the country.

Based on the Global Fund eligibility criteria,Georgia, as upper –low middle income country (ULMIC) with a moderate burden of tuberculosis,must focus at least 50% of the renewals budget on special groups and/or interventions.

For the 2nd Implementation Period program, the majority of activities are aimed at supporting specific interventions and special groups (PWID, MSM, FSWs, PLHIV and prisoners). As per the work-plan and budget PR will cover HIV preventive activities to MARPs with a total value of EUR 7,966,353 for 2013-2015 and patient support activities at cost of EUR 14,296,269. As a result, the total amount of sources budgeted for support of the special groups and/or interventions are EUR 24,430,031, which represents 93% the requested amount of EUR 24,429,620 for years 2013-2015.

LIST OF ANNEXES

Annex No.	*Annex name*
1	Minutes of the CCM meetings related to discussion on the CCM Request and other supporting documents
2	Performance Framework
3	National M&E Plan and program M&E attachments
4	Procurement and Supply Management (PSM) Plan
5	Renewal Financial template
6	Detailed budget and work plan
7	List of liabilities at cut-off date
8	National Program Review/Evaluation report
9	Reports _ Behavior Surveillance Surveys among MARPs