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GEORGIAN HARM REDUCTION NETWORK

Harm Reduction Works – Fund It!

HARM REDUCTION NATIONAL REPORT

2015

EURASIAN HARM REDUCTION NETWORK ЕВРАЗИЙСКАЯ СЕТЬ СНИЖЕНИЯ ВРЕДА

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HARM REDUCTION NATIONAL REPORT

Georgia

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Acknowledgments

This report is a publication of the Georgian Harm Reduction Network (GHRN). GHRN is a consortium of 26 professional NGOs, both watchdog/human rights and service providing organizations. Located throughout Georgia and working in the sphere of HIV prevention/harm reduction, was established in 2006 to collectively facilitate harm reduction approach and humanistic drug policy in the country. GHRN is now a major provider of the services to drug users through Needle and Syringe programs Voluntary Counseling and Testing service in Georgia. Main directions of GHRN: Advocating for the liberal drug policy; Delivering Harm Reduction services; Capacity Building of the member organizations.

The report has been prepared by Ms. Darejan Dvalishvili, who holds MSc degree in Social Policy and Contemporary Social Issues (Violence, Justice, Homelessness, Substance Abuse and HIV/AIDs) from Columbia University (USA, 2010) and MD from Tbilisi State Medical University (Georgia, 2002). For last thirteen years, she has been working extensively in direct social work, program administration, social policy and program evaluation and analysis. She has worked with various governmental agencies, local and international non-governmental and intergovernmental organizations, including UNICEF, UNFPA, ChildPact, World Vision, OSI Foundation, Austrian Development Agency, SOS Children's Villages International, EveryChild, UJA-Federation of New York, Ministry of Labor, Health and Social Affairs, Ministry of Justice, Ministry of Corrections, Ministry of Education and Science etc.

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The report reflects findings of Services Monitoring Survey and Economic Analysis of Harm Reduction Programs in Georgia and depicts main areas to be advanced for the sustainability of the evidence based, cost-effective Harm Reduction programs in Georgia including aligning approaches of HIV policy and drug policy and establish implementation of a unified, coherent and consistent approach and allocating national funding for needs based Harm Reduction Services.

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Foreword

The health of every community is affected by problematic substance use. Informed public discourse is critical to developing effective responses to address the harms from drug use. The governments are to provide laws, policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of injecting drug consumption. It is a time to shift the focus from criminalized drug use practices to liberalized medical and social approach to contribute to the reducing the social harms additionally attached to problematic substance use by criminalization.

The social harms associated with injecting drug use range from financial and legal problems to risk of homelessness and social isolation. It is clear that problematic substance use generates high social and fiscal costs reflected to families and individuals causing families breakdown and child neglected, all the social harm chain caused by criminalization of drug use and lack of the access to the comprehensive package of harm reduction services.

The best results can be achieved by managing it as a public health issue that requires a full range of evidence-based interventions. While it is important to have a variety of treatment options available, not all drug users can or will access treatment. Therefore, it is important to provide effective interventions to minimize the negative consequences of active drug use and dependence.

Under the commitment of HIV prevention and continuum of care harm reduction services have been provided covering People Who Inject Drugs communities stabilizing HIV prevalence in the group and contributing to the improved wellbeing of their families and society at large. Strict drug law environment represents a severe obstacle for the effective work of the Needle and Syringe Program, though being the program funded by the Global Fund to Fight AIDS, TB and Malaria is has been supported and implemented in Georgia.

We, as a civil society, count on continued commitment of the government and ensuring the smooth transition of donor to state funded harm reduction services and improved legislative environment for the contributing to the protection of the human rights for every individual contributing to improved health and social outcome indicators-benefiting the society at large.

Tamar Germanashvili

Executive Director

Georgian Harm Reduction Network

Abbreviations

AOT	Anti Oxidant Therapy
ARV	Antiretroviral
BSS	Behavior Surveillance Study
EPP	Estimates and Projection Package
GEL	Georgian Lari
GHRN	Georgian Harm Reduction Network
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HR	Harm Reduction
KAP	Key Affected Population
MDR	Multi Drug Resistant
MoLHSA	Ministry of Labor, Health and Social Affairs
MSM	Men having Sex with Men
NAPCDA	The National Action Plan on Combating Drug Abuse
NGO	Non Governmental Organization
NSCDA	The National Strategy to Combat Drug Abuse
NSP	Needles and Syringe Programs
OST	Opioid Substitution Therapy
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
SW	Sex Worker
TB	Tuberculoses
VCT	Voluntary Counseling Testing
WHO	World Health Organization
HRP	Harm reduction programs

Country Context

HIV Epidemiological Situation

The HIV epidemic remains a significant public health concern in Georgia. Since the detection of the first case of HIV in 1989, the rate of new HIV diagnoses in the country has been increasing steadily and reached 10.9 per 100,000 in 2013. (Global AIDS Response Progress Report 2013/Georgia). The latest estimate of the number of people living with HIV (PLHIV) in Georgia is 6,800, and 45% of these people are not aware of their status. 4,695 PLHIV were officially registered by the end of 2014. Although the infection is mainly located among the male population (69% of total reported cases), the proportion of women affected increased from 25% to 31% in 2014. [1](Spectrum EPP 2014, version 5.03)

The National Response to HIV Epidemic

In order to deal with the emerging health concerns mentioned, the fourth revision of the Georgian National HIV/AIDS Strategic Plan (NSP) has been developed. The NSP builds on the implementation experience of the National HIV/AIDS Strategy for 2011-2016. It describes the achievements and current state of the national response to HIV epidemic, defines priorities for its next phase (2016–2018), highlights innovations in the delivery of essential HIV services, calls for regulatory improvements and emphasizes the need for new partnerships, which will allow for maintaining the achievements and prepare for a reversal of the HIV epidemic in Georgia.

The national response to HIV epidemic prioritizes the development of an effective prevention to care continuum. Priority directions include the further scale up of the outreach and basic prevention services targeting key affected populations, radical increase in the uptake of VCT leading to more effective and earlier detection of HIV cases, comprehensive measures to ensure expedient progression to care and treatment for HIV positive people, as well as improved adherence and retention in quality care leading to suppression of viral load. Improved accessibility and quality of essential services (including opioid substitution treatment), optimized treatment regimens, strengthened surveillance and monitoring, removal of legislative and regulatory obstacles to effective service delivery, protection of human rights, and implementation of stigma reduction measures support the realization of these priorities. Greater collaboration between the governmental structures responsible for HIV interventions and the civil society including people living with HIV and the key affected populations is a significant asset in the enhanced national response designed to achieve the epidemic reversal. A revised case management approach embracing not only clinical but also social aspects of care and involving collaboration of service providers across sectors will be utilized to facilitate progression of clients along the service continuum.

The overarching goal of the national strategy for 2016 -2018 is to turn the HIV epidemic in Georgia in the reversal phase through strengthened interventions targeting key affected populations (KAP), and significant improvement in health outcomes for PLHIV-strengthened commitment of the government, greater involvement of civil society, and optimal integration of various branches of the prevention and care continuum will ensure sustainably strong response to the epidemic through the following three objectives:

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

1 Spectrum EPP (version 5.03) 2014 data provided by the Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC).

Expected Impact, Outcomes and Coverage targets by end 2018:

- Increased funding of HIV response from state budget from 32% (2013) to 70% (2018);
- By the end of 2018 HIV prevalence among PWID, SW and prisoners is contained under 5% each[2];
- By the end of 2018 HIV prevalence among MSM is contained under 15%;
- Rate of late HIV detection is reduced from 62% to 30% by 2018;
- AIDS related mortality is reduced below 2.0 deaths per 100,000 population;

Challenges

Among the cohort of KAPs one of the main challenging still remains programming regarding People who inject drugs (PWID) who in Georgia and elsewhere face a disproportionally high risk of contracting HIV and other blood borne viruses. Georgia is home to at least 49 700 PWID, (size estimation, 2015) a large proportion of whom still do not have access to sterile injecting equipment which in turn results the use of non-sterile needles and syringes and consequent rapid transmission of HIV. Thus despite low HIV prevalence (0.07%) in the general population, Georgia faces a significant risk of an expanding epidemic due to widespread high-risk practices and growing HIV prevalence among MSM and PWID, notable risk of sexual transmission of HIV through bridging populations, high population mobility between Georgia and neighboring countries with higher HIV prevalence. The latest estimate of the number of people living with HIV (PLHIV) in Georgia is 6, 800 and a significant proportion of these people are not aware of their status. The share of newly diagnosed patients who entered HIV care with CD4 cell count <350 cells/mm3 remained above 70% during 2011-2013 peaking at 74% in 2012 and then decreasing to 62% in 2014. This is one of the highest rates in WHO European Region and has detrimental effect on survival, resulting in almost 90% increased risk of short-term mortality. Analysis of engagement in the HIV care continuum in Georgia shows that the major gap occurs at the stage of HIV testing/diagnosis. Out of the estimated 6,800 persons living with HIV almost half is not yet diagnosed. This gap primarily is the result of low HIV testing coverage of KAPs and missed opportunities to test for HIV in the clinical settings (Spectrum EPP). HIV prevalence among TB patients has been relatively low at about 2% over the last several years (2.1% in 2013), the second lowest in EECA region (after Azerbaijan). However, the high prevalence of MDR Tuberculosis (11% among new and 38% among retreatment cases were confirmed with MDR TB in 2013) poses a significant threat of drug resistant tuberculosis to PLHIV. The proportion of HIV positive individuals among MDR TB patients is on the rise and has increased from 3.9% in 2010 to 5.3% in 2013. Active TB is found in more than 16% of people newly diagnosed with HIV, and is the leading cause of death among PLHIV (21.3% overall since the start of HIV registration in 1989).Management of HIV epidemic is further complicated by high prevalence of HCV in this group. Georgia is among the countries with high HCV Prevalence in the World by WHO. The HCV prevalence among HIV infected people is reported as 48,6% and as 73,4% among HIV infected IDUs. (Global AIDS Response Progress Report, Georgia/2013,).

Legislative and Social Barriers to effective national response to HIV

Continued criminalization of drug consumption drives PWID underground and significantly restricts their access to vital HIV prevention and care services, contributes to low detection of HIV and late presentation for treatment. 2012 IBBSS indicated that drug consumption has become even more hidden with the share of PWID who inject in the streets dropping from 15.2% in 2009 to 2.2% in 2012.

Another factor limiting the effectiveness of the national response to HIV is the widespread stigma towards PLHIV and KAPs among the general public as well as relevant professionals including health care workers.

2 HIV prevalence data will be disaggregated by age (below 25 and more) and the length of drug using career (less than 3 years and more) in order to obtain proxy incidence data;

Civil Society/KAP Meaningful Participation

Despite the significant increase in civil society participation in the development and delivery of essential HIV prevention and care interventions, greater involvement is required in order to address the remaining challenges. Stronger focus and greater role of community-based organisations is expected in the areas of HIV detection among KAPs, facilitated progression of PLHIV to care and treatment and delivery of required psychosocial support services, design and implementation of stigma reduction measures, as well as more focused policy development efforts to bring the existing legislation, regulations and policies in line with the effective public health response to HIV and related social challenges.

Success Stories and Needed Steps Forward

As there is no vaccine against the HIV and Hepatitis C viruses, there is a need for programs that could prevent contracting these viruses, especially among populations that are most vulnerable to contract HIV and HCV. Scaled-up harm reduction (HR) programs including Education, Needle and Syringe Programs (NSP) and access to Opioid Substitution Therapy (OST) have proved their effectiveness in preventing HCV transmission among PWIDs, to prevent HCV by 75-80% (Hagan et al. 2011; Turner et al., 2011). Therefore, the measures for prevention of transmission of hepatitis are to be urgently considered, especially now when Georgia launched a hepatitis C elimination program that will initially focus on treating HCV-infected persons who have severe liver disease with new curative regimens, providing discounted HCV diagnostics to all persons, and building capacity to eventually diagnose and treat all Georgians infected with HCV.

Over the last several years the share of domestic funding allocated to the HIV response in Georgia has been steadily increasing from 12% in 2008 to 48% in 2014. The Global Fund remained the most significant funding source and provided 34.6% of the overall funding in 2014. The contribution of other international sources has been decreasing and reached 7% in 2014. The national success case strengthened by another step forward by the government including expenses of first line ARV drugs in the state budget of 2015. The future period will be marked by a further decrease of external contributions, which should be balanced by a significant increase in state budget allocation for HIV. A gradual transfer of priority programs funded by external sources (including HIV and TB) to state financing will be achieved through development of financial sustainability plans, detailed allocation of financial obligations, and reflection of these obligations in the financial commitments of the government. The funds required to maintain and expand the delivery of essential services are reflected in the Medium Term Expenditure Framework for 2016-2018. Furthermore, Resolution of the Government of Georgia of June 17, 2014 highlights the need for improved efficiency of State funding and integration of vertical state programs (such as disease oriented programs: Diabetes, TB, HIV etc.) into the Universal Health Program.

Executive Summary of the Report

The report is prepared to analyze Harm Reduction (HR) Programs as the response mechanisms to combat HIV and HCV epidemic in Georgia considering the drug situation in the country.

It appears that, despite some recent developments, restrictive Drug Policy, massive searches[3,] and arrests of drug users initiated several years ago, are still seen as solutions to Georgia's drug problem by the state (Kirtadze & Otiashvili, 2015). For instance, just for 2013, 60,196 individuals got tested for presence of drugs and metabolites, of whom only 22,711 had positive results (37.7%) (Javakhishvili et al. 2014); 3,553 individuals had been convicted for just consumption of narcotic substances, among whom 12.2% were imprisoned, 71.7% got conditional sentence and 14.9% paid fines in 2013 (data from the Supreme Court of Georgia[4]), only 4,006 people got treatment through Opiate Substitute Programs (OST) (less than 9% from 45,000); and 600-720 persons got psycho-social rehabilitation services from all three existing out-patient psycho-social rehabilitation centers, funded by Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) (Javakhishvili et al., 2014).

As of 2009, there were an estimated 40,000 regular injecting drug users in Georgia (Sirbiladze, 2010). In spite of anticipated decrease of number of People Who Inject Drugs (PWIDs) due to lack access to drugs, higher fines and even detentions, the estimated number of PWIDs has increased to 45,000 in 2012 (T.Sirbiladze, 2013)[5], indicating that the current punitive policy framework and measures costing 18 million GEL (8.7 million EUR) just in 2008 (Otiashvili, et al, 2012) has been not only ineffective in primary prevention - reducing the use of drugs (Sirbiladze, 2013), but also appeared non-influential on the drug-related behavior of those tested as 83% of convicted persons resumed drug consumption after the imprisonment (Otiashvili, et al, 2012).

Besides, the changing needs of PWIDs became additional impediment to the addiction response system in Georgia. As evidence shows, mostly drug use trends and markets in the country had been shaped by policy response, legislative framework and law enforcement practice implemented at particular periods of time (Otiashvili et al, 2010). And according to the recent data, homemade stimulants and poli-substances use became the major challenges for the drug treatment system in Georgia (Kirtadze & Otiashvili, 2014, Vadachkoria, 2015) and the service providers appeared largely unprepared for the amphetamine type stimulants (ATS) epidemic, as previously they had been focusing on Opioid users (Kirtadze & Otiashvili, 2014).

The services providing addiction treatment is in the process of development and the most widespread care mode is Abstinence Oriented Treatment (AOT)(detoxification), a heritage of Soviet school of Addiction treatment. However, today this traditional method is competing with the Opioid Substitution Treatment (OST) programs both in terms of the capacity and the number of the patients involved (Javakhishvili et al. 2014). Additionally, there are three out-patient psycho-social rehabilitation centers, funded by GFATM – "Kamara", Patriarchy of Georgia Psycho-social Rehabilitation Centre, and the rehab unit of the Mental Health and Addiction Prevention Centre serving monthly altogether 50-60 clients of OST, AOT and ex-drug users monthly (Javakhishvili et al. 2014). Therefore, in spite of diversification and advancement of treatment approaches with substance addicted individuals, psycho-social component is still missing in the entire chain of continuous care for addicts, due to which treatment results within the existed treatment modus are not sustainable enough (Javakhishvili et al., 2014).

Furthermore, neither state-funded insurance nor private insurance programs cover either screening/assessment or treatment for substance-use-related problems (Javakhishvili et al., 2014). Despite advancement and increased state and donor funding for treatment of substance use disorders in Georgia for last years, the substance use treatment

3 Otiashvili et al (2012) indicated that more than 43,000 people have been randomly tested in 2008; 60,196 individuals in 2013 (Javakhishvili et al. 2014)

4 part III criminal cases http://www.supremecourt.ge/files/upload-file/pdf/2013-weli-wigni-1kari-sisxli.pdf

5 Sirbildze (2013). Estimating the prevalence of injecting drug use in Georgia: Consensus report, 2013. GFTAM.

and harm reduction programs altogether are able to deliver services to only 5–10% of adults with problem substance use in the country (Javakhishvili et al., 2014).

Therefore, it becomes obvious that drug policy still needs to find a right balance between the law enforcement on one side and secondary prevention, treatment and psychosocial measures on the other hand (Javakhishvili et al., [6]2014).

The right balance in response mechanisms to drug abuse is becoming even more crucial considering the situation of HIV and HCV in the country where PWIDs are one of the most vulnerable groups of populations. While HIV prevalence in the general population (adults 15-49 years) was 0,3% (UNAIDS, 2014) in 2013, the HIV prevalence among PWIDs was 3% (UNAIDS AIDS info database). In terms of HVC, Global Commission on Drug Policy (2013) has indicated that Hepatitis C is three times more prevalent among PWIDs than HIV and causes early death among them. The evidence shows that approximately 60–70% and even higher percent of PWIDs have HCV antibodies (Dershem et al., 2007; Karchava et al. 2009; Stvilia et al., 2006; Bouscaillou et, al, 2014[7]; Otiashvili, et al, 2014).

As there is no vaccine against the HIV and Hepatitis C viruses, there is a need for programs that could prevent contracting these viruses, especially among populations that are most vulnerable to contract HIV and HCV. **Scaled-up harm reduction (HR) programs including Education, Needle and Syringe Programs (NSP) and access to Opioid Substitution Therapy (OST) have proved their effectiveness in preventing HCV transmission among PWIDs, to prevent HCV by 75-80%** (Hagan **et al.,** 2011; Turner et al., 2011).

Harm reduction (HR) is usually used as an umbrella term to define interventions, programs and policies that seek to reduce the health, social and economic harms of substance use to individuals, communities and societies. Thus, harm reduction aims to prevent the negative consequence of the drug use, that is, to reduce the burden of disease and improve the health of the population, to reduce premature mortality and long-term health and social problems during periods of substance use (Lenton and Single, 1998, Hikman 2010).

A comprehensive package of evidence-based interventions to reduce harms associated with injecting drug use is outlined in the WHO/UNAIDS/UNODC (2012)[8] technical guide, which identifies[9] key interventions to reduce such harms among PWIDs:

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counseling
4. Antiretroviral therapy
5. Prevention and treatment of STIs
6. Condom programs for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
9. Prevention, diagnosis and treatment of HIV

Recently, one more intervention is emerging as a very important intervention among PWIDs that is – overdose prevention. According to the evidence from the western European countries, success in the scaling up of harm reduction activities is shaped by political leadership, the legal environment, health system organization, the availability of domestic financing and the engagement of civil society and depends on strong political leadership, a reform of the

6 Drug Sitauation in Georgia. Available at: http://altgeorgia.ge/2012/myfiles/drug-2012-geo-eng-bolo-bolo-bolo_ENG.pdf (last accessed on 01.12.2015)

7 Bouscaillou, J., et al (2014). Hepatitis C among people who inject drugs in Tbilisi, Georgia: Urgent need for prevention and treatment. International Journal of Drug Policy, 2014

8 WHO/UNAIDS/UNODC (2012)Technical Guide for Setting Targets for HIV Prevention, Care and Treatment for Injecting Drug Users ('the Target Setting Guide') from: http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf?ua=1

legal and regulatory norms to create a more enabling environment and respect the human rights of PWIDs, sustained domestic funding, the strengthening of civil society and their robust engagement in advocacy and service provision, the planning and delivery of harm reduction programs, as well as the organization of vertically structured health systems to create client-centered.

Furthermore, as noted by Rehm et al. (2010), the harm reduction programs must take into account the social and economic factors that led to the initiation of drug use and that increase drug users' vulnerability. Therefore, it is crucial to engage drug users in program design to provide insights on how best to address and serve their needs Moreover, this marginalized group must be given the opportunity to enjoy human rights — like any other citizen (EMCDDA, 2010). Additionally, it is crucial to have domestic/state funded HIV programs with targeted interventions for high-risk groups (Matic et al., 2008; Dehne et al., 2000).

Since 2002, Harm Reduction approach has been rapidly developing in Georgia due to the efforts of the international donor community (GFATM, USAID, UN agencies, Open Society Foundations, European Union programs, etc.). One of the significant outcomes of these efforts is the emergence and rapid growth of the harm reduction focused non-governmental organizations (NGOs). In 2014, Georgian Harm Reduction Network (GHRN) brought together 26 organizations. However, despite increased funding for treatment of substance use disorders in Georgia for last years, the substance use treatment and harm reduction programs altogether are able to deliver services to only 5–10% of adults with problem substance use in the country (Javakhishvili et al., 2014).

In 2014, GHRN conducted two surveys to analyze the situation of harm reduction programs in Georgia. The financial data from 2012-2013 years from OST and NS Programs were analyzed and information from 1,100 clients of the harm reduction programs collected. The purpose of the economical analysis was to analyze the costs of the program and project any funding gaps for coming years. The objectives of service monitoring were to get feedback from the program beneficiaries about harm reduction programs in Georgia and involve them in program advancement process. Based on the findings, this report proposes some crucial recommendations to increase the coverage and the effectiveness of harm reduction programs.

Key Recommendations:

1) **Ensure gradual transition to Donor to State Funding for the sustainability of harm reduction services**

Allocate/gradually increase state funding for HR services in the national transition plan for ensuring sustainable provision of the PWID community needs based HR services after the limitation/quitting of the GFATM and other bilateral donor funding.

2) **Develop/Apply for Mechanisms for NGO funding from public sources for implementing harm reduction community based services;**

Provide PWID community services by means of piloting social contract schemes and/or other effective funding mechanisms from 2017 for running Harm Reduction service sights.

3) **Improve Legal Environment for Needle and Syringe Program (NSP)**

Eliminate barriers for the access to NSP services through regulating favorable legal environment and regulatory framework.

4) **Increase state funded NSP services during transition period and ensure they are in line with the PWID community needs**

Ensure sufficient state funding allocation since 2019 for NSP program reflected in transition plan and provide the services based on PWID community needs and in accordance of changing drug situation, also scale-up the community provided programs both in terms of number of covered people but also in terms of diversification of services.

5) **Ensure sufficient coverage of Opioid substitution treatment (OST)**

Ensure sufficient spectrum for OST coverage (by 2018 – 5400 people up to 12%) via amending specific criteria for the free of charge service (payment capacities minimal wage plus monthly cost of methadone program) OST clients categorization systems are in place by 2017. The options to allow home-take dose for stable clients and reimbursement of transportation costs for clients living under the poverty line are considered.

6) **Endorse gender sensitive approach in harm reduction services**

Endorse women specific Harm Reduction programs (trained staff, women specific medical services, rehabilitation services for victims of violence), encouraging more women to seek support and improved infrastructure and procedures meet the specific needs of women.

Findings from Services Monitoring Survey and Economic Analysis of Harm Reduction Programs in Georgia

Based on the desk review and findings from Services Monitoring Survey and Economic Analysis of Harm Reduction Programs in Georgia, the report proposes to advance the harm reduction programs in the following areas:

1. Align approaches of HIV policy and drug policy and establish implementation of a unified, coherent and consistent approach

According to the Georgian legislation, substance/drug abuse is a disease that should be treated (A law on Narcotic drugs, psychotropic substances, precursors and drug abuse treatment); On the other hand, consumption of drugs is considered a violation at least of the Administrative Law leading to 500 GEL fines (Article 45) and or Criminal Code causing imprisonment (Article 273). For last several years, 60,000 persons have gone through forced street random screening and more than 8,000 persons have been prosecuted[9]. However, the data shows that these harsh punitive measures have any positive effect nether on number of PWIDs nor their behavior (contrary, the number of PWIDs increased from 40,000 in 2009 up to 45,000 in 2012 – BSS 2012).

In addition, it appears that prevalence of HIV (3% - 9%) and HCV (3-9%) and HCV (70% - 80%) among PWIDs should put PWIDs on higher level on public health agenda. European practice shows that, scaled-up harm reduction (HR) programs including Education, Needle and Syringe Programs (NSP) and access to Opioid Substitution Therapy (OST) have proved their effectiveness in preventing HCV transmission among PWIDs, to prevent HCV by 75-80% (Hagan et al., 2011; Turner et al., 2011).

Considering the number of potential beneficiaries (45,000 drug users, among them approximately 3,000 women), prevalence of HIV and HVC among PWIDs and coverage of the harm reduction services (5-10%), the importance of increasing of coverage of the programs is not doubtful. As the GFTAM indicates to leave the country in the coming years, it is crucial not only to increase the number of sites of the harm reduction programs, but also ensure sustainability of existing services through allocation state funds.

Moreover, the legal framework should be reviewed to protect beneficiaries while they are in treatment and decrease drop-out rates through offering services with various schemes (mobile services, home-in dosages, support with transportation costs etc.). In addition new outreach measures and gender sensitive services should be employed to increase number of beneficiaries. Besides, the roles of service provider NGOs should be strengthen to monitor the changing drug situation and needs of beneficiaries and implement various procurement mechanisms to prevent any gaps in service provisions.

Taking into account the costs, coverage and positive impact on reducing the risky behavior and to prevention of new cases of HCV and HIV associated with harm reduction programs, it is strongly recommended to extend state funding for harm reduction programs to ensure that higher ratio of people in need are covered.

2. Allocate national funding for NSPs

The State HIV Prevention strategy on HIV prevention among PWIDs, stipulates that as NSPs remain fully funded by external sources, the development of measures and mechanisms to enable the handover of these services to the government is urgently required. However, according to the same strategy, the public funds are not allocated for NSPs for the coming years.

However, the public funds are crucial as GFTAM plans to leave the country by 2020. Therefore the transition plan

9 data from the Supreme Court of Georgia

indicating specific measures and mechanisms are compulsory. Moreover, to make a transition smoother, it is important to make sure that HIV prevention strategy and HCV state program puts appropriate emphasis to harm reduction services in prevention and treatment of HIV and HCV. Furthermore, the implementation of handover measures and mechanisms should be started in the nearest future to prevent any gaps in service provision.

This process should be used to implement the practice taking into account the lessons learnt during GFTAM funding and make the programs and services even more flexible and diverse both in terms of service provision and funding/procurement mechanisms to make sure that there is no break in service provision.

In the transition, the state should start not only substitute GFTAM, but also fill the gaps in practice and service provision. Therefore a comprehensive evaluation of NSPs is needed. After that, starting from 2016, the state should allocate funds to finance at least two NSP sites at the pilot phase and increase funding gradually per year. As a result, the NSPs should not only be funded by the state, but also should be scaled-up to meet the needs of increased number of beneficiaries.

3. Modify services delivered within NSPs and OSTs to meet the individual needs and the changing modes of the drugs used in the country.

Due to the changing Drug situation and fixed schemes for commodities for a certain period to time, the drug treatment system becomes unprepared for the shifting patterns of substance consumption reality and thus the changing needs of PWIDs (GHRN, 2015). According to WHO Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014), injecting equipment and services should be appropriate to the local context, taking into account such factors as the type and preparation of drugs that are commonly injected.

Considering the crucial role Harm Reduction programs in prevention of HIV, HCV and HBV not only among PWIDs, but in general population, it is important not only meet the needs of the beneficiaries and provide the services based on the their need in accordance of changing drug situation, but also scale-up the programs both in terms of number of covered people but also in terms of diversification of services. Therefore, a revision of the composition of commodities and services on a regular basis should be conducted in order to ensure that the needs of program beneficiaries are met. Moreover as the services are available in limited number of cities, it is crucial not only increase number of sites, but also diversify the means of service provision (mobile sites, home-take dosages, support with transportation costs etc.) to prevent high rate dropouts.

Moreover, the Service Monitoring Survey (GHRN, 2015) has revealed that beneficiaries lack gender sensitive services, procedures, and professional social work practice.

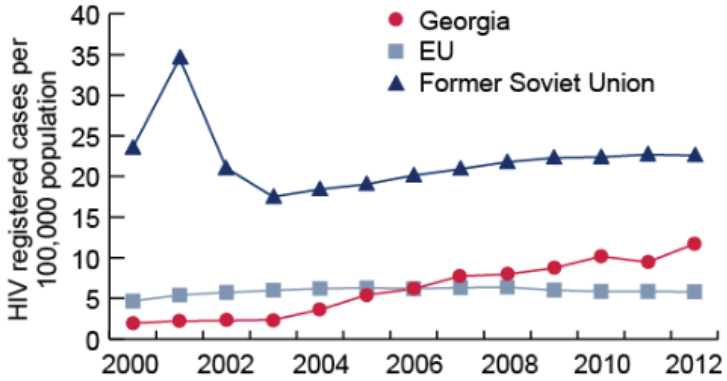
Epidemiological situation of HIV and HCV and Harm Reduction Programs (HRP) in Georgia

Epidemiological situation of HIV and HCV

To date, Georgia has managed to keep its HIV prevalence at low levels in the general population and among people injecting drugs (PWIDs). As of 2013, the HIV prevalence in the general population (adults 15-49 years) was 0,3% (UNAIDS, 2014)[10], while the HIV estimated prevalence ranges from 0,4 to 9,1% among PWIDs depending on locality[11] and in general has been kept as low as 3% (UNAIDS AIDS info database).

However, according to experts of the Infectious Diseases, AIDS & Clinical Immunology Research Center (IDACRC, 2015), unless urgent measures are undertaken immediately, the rapid spread of HIV/AIDS is expected in Georgia in the near future, which will ultimately threaten the low HIV prevalence rate achieved to date. The annual number of newly registered HIV cases per 100,000 population has been steadily increasing over the past 15 years and this increase has been steeper compared with EU and former Soviet Union countries[12] (Figure 1)

Figure 1: The number of newly registered HIV cases per 100,000 population per year, 2000–2012



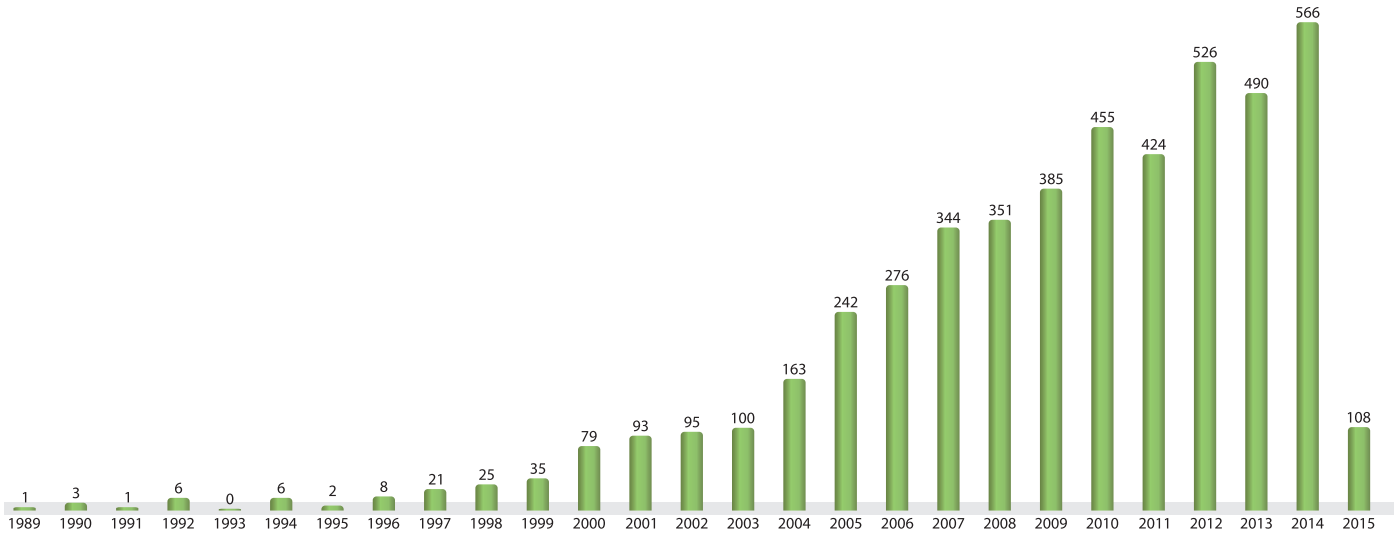
In 2014, the highest number of new HIV cases in one year had been observed – 566 new HIV cases (Figure2). It is likely that new HIV cases for 2015 are not going to decline. Just by 12 of March, 2015, 108 new cases of HIV infections have been registered at the AIDS Center (Figure2).

10 UNAIDS Gap Report from: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

11 Curatio International Foundation, Bemoni Public Union. (2013). HIV risk and prevention behaviors among people who inject drugs in six cities of Georgia. Bio-Behavioral Surveillance Survey in Tbilisi, Batumi, Zugdidi, Telavi, Gori, and Kutaisi in 2012. Study Report. Tbilisi: http://www.curatiofoundation.org/uploads/other/0/103.pdf

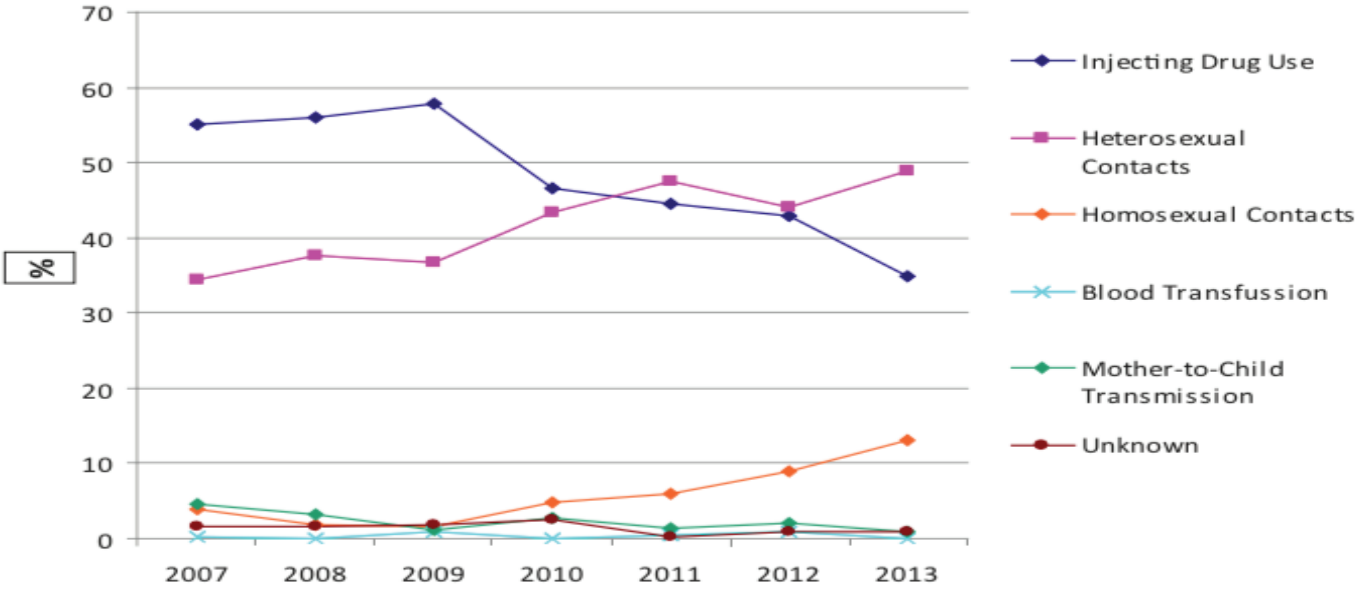
12 WHO/Europe, European HFA Database, April 2014

Figure 2: New cases of HIV registered in Georgia (data of the National AIDS Center)



The main mode of HIV transmission remains to be injecting drug use (49,1% of HIV cases). However, since 2009, transmission has shifted toward the heterosexual mode (Figure 3.) which became dominant by 2011 and the trend escalated in 2013 (41,6%) (IDACRC, 2015).

Figure 3: Distribution of HIV cases by routes of transmission[13] in Georgia



According to Georgia country report prepared for UNAIDS in 2014, despite a relatively low prevalence rate, the HIV/AIDS epidemic remains a significant public health concern in Georgia. The epidemiological distribution of the disease by gender and age indicates more cases among the 25-40 age groups. The biggest difference between the number of infected men and women was also detected in this age group (25+), while the gender difference is minimal among the 15-24 year olds. In previous years, the proportions of male and female HIV+ cases were 75% and 25% respectively. In 2011, the proportion was changed, with males accounting for 70% of cases and females for 30%. This shift would be explained by the spread of HIV among sexual partners of PWIDs. The trend is still maintained in last two years.

13 Georgia Country Report http://www.unaids.org/sites/default/files/country/documents//GEO_narrative_report_2014.pdf

According to the National HIV surveillance database (2010)[14], the percentage of PWIDs living with HIV, among all screened PWIDs, is 3.91% (male-3.95% and female-2.08%) with prevalence being 0.32% in the younger group (below 25) and 4.44% in the older group (above 25). According to Bio-Behavioral Survey (2012)[15], among 18 years old or older PWIDs in six cities of Georgia, HIV prevalence is higher among 31-40 and 41+ age groups and odds of HIV exposure is increased for injecting drug users of greater age, with greater duration of drug use and with a history of imprisonment or detainment[16] (Bemoni, 2013).

However, while Georgia proved to be rather successful in controlling the HIV epidemics, the data shows that prevalence of Viral Hepatitis C (HCV) is much higher. It is estimated that there are approximately 200,000 people living with Hepatitis C in Georgia (the prevalence of Hepatitis C is 6.7% in general population of Tbilisi) (Stvilia et al., 2006)[17]. However, little is known about the HCV epidemic among PWIDs in Georgia. Global Commission on Drug Policy (2013) has indicated that Hepatitis C is three times more prevalent among PWIDs than HIV and causes early death among them. According to several studies, approximately 60–70% of these individuals have HCV antibodies (Dershem et al., 2007; Karchava et al., 2009; Stvilia et al., 2006) and even higher prevalence: 73.4% among the persons injecting Buprenorphine (Subutex) (Otiashvili, et al, 2014) and 82.0% (Bouscaillou et, al, 2014[18]).

Furthermore, hepatitis C prevalence in Georgia is especially high in people living with HIV (48.6%) (Badridze et, al, 2008)[19]. More recent data shows even higher prevalence among PWIDs on HCV/HIV co-infections - 78%[20] and dual HBV/HCV infection in HIV positive patients 75% (NCDC, 2012, WHO/UNICEF, 2012).

In 2014, the Ministry of Health, Labor and Social Affairs (MoHLSA) initiated new state HCV treatment program. The number of the beneficiaries for partially funded treatment for the first year have been limited to 750 patients, According to MoHLSA calculation given in state budget, 6-month treatment course – 2,200 USD (approx. 4,884 GEL). The partially funded treatment just for 10,000 patients budgeted by MoHLSA costs to the state approx. 1,393,200 USD (3,120,768 GEL) for 2014-2015. However, despite paid millions, the coverage of the program will not be big, as there are approximate 200,000 persons infected by HCV in the country (Stvilia et, al, 2008), and for just 2011-2013 years, there have been officially registered new 6,628 cases of virus hepatitis in Georgia (GeoStat, 2015[21]-Georgian Statistics yearbook). Although the situation with access to HCV treatment services is about to be improved in the country overall, additional efforts are needed in expanding access to these services to PWIDs as PWIDs identified a barrier of the lack of access to these services despite the high demand (Stoové, Gifford, & Dore, 2005). According to the survey administered by Georgian Harm Reduction Network in 2014, HCV prevention, testing and treatment have been identified as the highest priority among 36% of OST and NSPs program beneficiaries (GHRN, 2015).

As there is no vaccine against the HIV and Hepatitis C viruses, there is a need for programs that could prevent contracting these viruses, especially among populations that are most vulnerable to contract HIV and HCV. **Scaled-up harm reduction (HR) programs including Education, Needle and Syringe Programs (NSP) and access to Opioid Substitution Therapy (OST) have proved their effectiveness in preventing HCV transmission among PWIDs, to**

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14 collecting country-wide data on HIV/AIDS and functioning only during 2010 at NCDC

15 conducted by Curatio International Foundation and Bemoni Public Union

16 CIF, PUB, HIV risk and prevention behaviors among People Who Inject Drugs in six cities of Georgia ,2012 [p.10]; [p28-29];

17 Stvilia, et, al (2006) Prevalence of Hepatitis C, HIV, and Risk Behaviors for Blood-Borne Infections: A Population-Based Survey of the Adult Population of T'bilisi, Republic of Georgia, J Urban Health. 2006 Mar; 83(2): 289–298.

18 Bouscaillou, J., et al (2014). Hepatitis C among people who inject drugs in Tbilisi, Georgia: Urgent need for prevention and treatment. International Journal of Drug Policy, 2014

19 Badridze N, Chkhartishvili N, Abutidze A, Gatserelia L, Sharvadze L, "Prevalence of hepatitis B and C among HIV-positive patients in Georgia and its associated risk factors". Georgian Medical News 12: December 2008, pp. 54-60.

20 It was estimated in 2009 that there were around 41,000 PWID in Georgia among a total population of about 4,500,000 (Sirbiladze, Tavzarshvili, Zabransky,& Sturua, 2009).

21 National Statistics office of Georgia http://www.geostat.ge/?action=page&p_id=196&lang=geo

prevent HCV by 75-80% (Hagan et al., 2011; Turner et al., 2011). Therefore, the measures for prevention of transmission of hepatitis should be urgently considered. Taking into account the costs, coverage and positive impact on reducing the risky behavior and to prevention of new cases of HCV associated with harm reduction programs, it is strongly recommended to extend state funding for harm reduction programs to ensure that higher ratio of people in need are covered.

Harm Reduction Programs in Georgia

Harm Reduction Program (HR) in Georgia covers the following activities:

- provision of OST (Methadone /buprenorphine and naloxone (Suboxone®))
- distribution of injecting equipment, condoms, information materials (NS program)
- risk reduction counseling to PWIDs
- voluntary counseling and testing (VCT) on HIV, HBV, HCV and syphilis
- peer driven interventions and outreach to PWIDs
- rising awareness among PWIDs
- advocacy for legislative changes and policy reform facilitating provision of harm reduction services

The National Strategy to Combat Drug Abuse[22] (NSCDA) underlines that the Harm Reduction Programs should be extended and the State should ensure the proper environment to implement such programs. However, so far, the state funds Harm Reduction services in the context of drug abuse treatment and only substitute programs. Despite the fact, that the National Action Plan on Combating Drug Abuse (NAPCDA) for 2014-2015 identifies the issue with legal framework for Harm Reduction Programs and especially for Needles and Syringe Programs, nothing substantial has been done for last several years as drug use per se constitutes an offence under Georgian legislation and is punishable with both administrative and criminal sanctions[23.] Moreover, all Harm Reduction activities covered mostly with NSPs (screening for HBV, HCV, STDs, distribution of needles and syringes and trainings for peer educations etc.) and are defined in the National Action Plan, are under the financial responsibility of donors, international organizations and NGOs (National Action Plan on Combating Drug Abuse, 2014-2015[24]).

The National Action Plan also identifies women along with children as a particular target group requiring specific services and empowerment to extent their enrollment in the psycho-social rehabilitation programs (NAPCDA, Objective 3.3). According to the data, women comprise fewer than 2% of patients in substance use treatment (Otiashvili et, al, 2014). It has been suggested that both socio-cultural and structural barriers impede the demand for and access to substance abuse treatment for drug-using women in Georgia (Kirtadze et al. 2013). Thus the role of policy makers, service providers, and clinicians in removing the structural and cultural barriers is critical as well as there is a need of shaping programs in a way that would facilitate women access to these services, including through gender-oriented interventions in the package of services.

As development of harm reduction programs, such as NSP and OST, was primarily driven by international technical and donor organizations, integration of these programs into the country's national system experiences a number of shortcomings. These shortcomings exist at various levels:

- **Strategic/Policy/Legal Framework: Main focus on an abstinence oriented treatment and punishments, lack of understanding of drug abuse as a psychosocial issue.**

22 State strategy of the fight against drug abuse
http://www.justice.gov.ge/Multimedia%2FFiles%2Fsabchoebi%2Fნარკომანიასთან%20ბრძოლის%20სტრატეგია.pdf

23 Baseline Assessment of Drug Situation in Georgia under the GFATM funded regional Project "Harm Reduction Works-Fund It!";

24 2014-2015 years action plan of the fight against drug
http://www.justice.gov.ge/Multimedia%2FFiles%2Fsabchoebi%2Fსამოქმედო%20გეგმა.pdf

The NSCDA defines drug abuse as a chronic and progressive disease that is correlated with mental derangement, HIV and viral hepatitis and deaths and thus prioritizes medical approaches. On the other side, the Criminal Code and Administrative Code define drug abuse as an offence and impose fines and even detention as an intervention measures. Despite NAPCDA outlines importance of harm reduction along with primary prevention and treatment and rehabilitation as one of the main objectives, all harm reduction related activities but OST are mostly under financial responsibility of the donors and international and local non-governmental organizations.

- Strategy and policy: approaches of the existing strategies and policies do not place sufficient focus and remains not a strong basis for implementation of the harm reduction approach as the key approach of the secondary prevention, which would also be consistent and aligned across all key strategies and policies in the country such as HIV response and drug policy alike. In some other countries, these policies are aligned and where harm reduction plays a role in strategic directions for addressing social and health issues in countries. While recognizing that complete elimination of the drug use will not be possible, the adequate responses are needed to reduce health and social harms – harm reduction – which is considered also as more effective measure than punishment of the individual use.

- Legal and regulatory framework: individual use of drugs is criminalized in Georgia. According to the Administrative law, a person consuming drugs violates the law and has to pay fine of 500 GEL. Moreover, according to Criminal Code, the use of drugs might be entitled to get imprisonment sentence (Article, 273).

- Financing and its mechanisms: no legal basis to finance harm reduction programs except substitute therapies. In spite of the state budget allocates several millions for harm reduction services for last several years, so far there is no legal framework to finance NSPs as the consumption of drugs is considered as a violation of administrative and criminal codes. In General, the mechanism for the government to fund NGOs exist in Georgia. The same mechanism of funding could be applied for harm reduction services, including NSPs; however, in practice this mechanism for NSPs has not been employed. The government has not allocated national funding for providing NSP services. The government of Georgia, however, funds OST services. The Georgian government funded the OST program in the proportion of 77,8% of the total funding for OST programs in the country and by 83,23% of the total funding for OST programs in the country in 2013 (IMG, 2014). However, it must be noted that two modalities of the OST provision were applied in the country – OST services funded by the GFATM, which were free of charge to the OST patients and OST services funding by the government, which were subject to charge for the OST patients (IMG, 2014). Despite the fact the beneficiaries living below the poverty line and/or HIV positive are eligible for free services, for the majority of OST program participants services fee (110 GEL[25])

❖ **Programmatic and management frameworks: lack of flexibility of programs in terms of changing needs of target population, lack of infrastructure, no programs designed with participation of beneficiaries etc.**

The harm reduction programs have been operating in Georgia since 2005 with support of GFTAM.

- Programmatic and management framework: Drug situation in Georgia indicates that homemade stimulants and poly-substance consumptions are the major challenges for the professionals working in the field of Harm Reduction in Georgia (Kirtadze & Otiashvili, 2014). Moreover, as there are no flexible schemes to adjust commodities on a regular basis, the system becomes unprepared for the shifting patterns of substance consumption reality and thus the changing needs of PWIDs (GHRN, 2015). According to WHO Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014)[26], injecting equipment should be appropriate to the local context, taking into account such factors as the type and preparation of drugs that are commonly injected. Considering the crucial role Harm Reduction programs in prevention of HIV, HCV and HBV not only among PWIDs, but in general population, it is important not only meet the needs of the

25 1 USD = 2.25 GEL (July, 2015)

26 WHO Consolidated guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations (2014, Geneva). http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

beneficiaries and provide the services based on the their need in accordance of changing drug situation, but also scale-up the programs both in terms of number of covered people but also in terms of diversification of services. Therefore, a revision of the composition of commodities and services on a regular basis should be conducted in order to ensure that needs are met.

Moreover, the Service Monitoring Survey (GHRN, 2015) has revealed beneficiaries are limited with gender sensitive and professional social work services. Additionally, the harm reduction programs lack referral mechanisms to other services including medical and social services.

As the new funding cycle starts next year, it is important to ensure, that the PWID community is involved in the process of designing of the policies and programs for the next program cycle. Therefore, Georgian Harm Reduction Network (GHRN, 2015) has conducted Service Monitoring Survey (SMS) to evaluate the HRP from the beneficiaries' perspective and Investment Monitoring Survey to make economic analysis of the harm reduction programs in Georgia.

In Total 1,120 (385 - OST, 735 - NSP) program beneficiaries have been interviewed under the GFATM regional project "Harm Reduction Works-Fund It!" implemented by EHRN and GHRN in Georgia. In addition, focus groups have been conducted. Initiatives covered 3 regions of the country. Three instruments have been developed to track expenditure costs, individual unit costs and project funding gap for 2016-2018.

Table 1: Total expenditures of harm reduction programs from the Census of Sites (GHRN, 2015)

Census of Sites	NSP		OST	
	2012	2013	2012	2013
TOTAL in GEL	1,648,430	1,343,774	4,531,932	5,934,531
Clients	7,592	13,253	2,523	3,468
Expenses per patient	217	255	1,796	1,711
Expenditure by Primary Funding Source				
Global Fund	1,648,430	1,357,724	1,006,571	995,419
Government	0	0	3,525,362	4,939,112
Other(Out of pocket money?)	0	0	681,476	932,484

Based the specifically developed instrument and a draft of Revision of Georgia National HIV Strategic Plan for 2016-2018, Harm Reduction programs' economic analysis shows that, in the coming years, there will be a possibility to increase coverage of the program (GHRN, 2015)

Table 2: Projected Gap based on prioritized services for 2016-2018

Harm Reduction Program	2016			2017			2018		
	required	planned	deficit	required	planned	deficit	required	planned	deficit
NSP									
High priority	1,745,747.55	3,293,384.325	1,547,636.775	1,898,972.1	11,115,943.19	9,216,971.09	2,052,025.65	3,833,084.143	1,781,058.493
Medium priority	2,051,962.65	157118.7937	-1,894,843.856	2,231,799.3	140,772.7181	-2,091,026.582	2,411,968.95	134,301.7995	-2,277,667.151
Low priority	0	0	0	0	0	0	0	0	0
Deficit	3,797,710.2	3,450,503.119	-347,207.0811	4,130,771.4	11,256,715.91	7,125,944.508	4,463,994.6	3,967,385.942	-496,608.658
OST									
High priority	9,486,589.04	7,876,234.768	-1,610,354.272	10,686,138.08	12,009,600	1,323,461.92	1,177,6647.12	13,344,000	1,567,352.88
Medium priority	263,565.33	0	-263,565.33	296,861.46	0	-296,861.46	327,171.39	0	-327,171.39
Low priority	98,050.425	0	-98,050.425	110,378.85	0	-110,378.85	121,686.775	0	-121,686.775
Deficit	9,848,204.795	7,876,234.768	-1,971,970.027	11,093,378.39	12,009,600	916,221.61	12,225,505.29	13,344,000	1,118,494.715
Total	1,364,5915	11,326,737.89	-2,319,177.108	15,224,149.79	23,266,315.91	8,042,166.118	16,689,499.89	17,311,385.94	621,886.057

It appears that funds will be not properly distributed as while some activities will be in surplus, others are expected to be unfunded including:

Table 3: Gap is projected in terms of the following services (GHRN, 2015):

NSP	OST
HIV testing and consultancies	Case management
Distribution of condoms	TB screening and diagnosis
Informative booklets	Peer education
	Distribution of condoms

Moreover, according to HIV National Strategy, Georgia aims to increase coverage and funding of both NSP and OST programs for 2016-2018

Table 4: Projected coverage and funding resources (in GEL)

	NSP coverage / funds	OST coverage / funds
2016	25,650 / 4,868,155	4,300 / 8,862,651
2017	27,900 / 5,117,575	4,900 / 13,025,159
2018	30,150 / 5,830,618	5,400 / 14,388,701

However, while comparing projected coverage of the HR Progrm and funds given in HIV Strategic Plan without prioritizing services, the deficit appears in terms of 2016 only:

Table 5: Projecting gap for 2016-2018

	Required			Planned			Deficit		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
NSP	3,797,710.2	4130771.4	4463994.6	4,868,155	5,117,575	5,830,618	1,070,445.103	986,804	1,366,623
OST	9,848,204.795	11093378.39	12225505.29	8,862,651	13,025,159	14,388,701	-985,554	1,931,780	2,163,196

Opioid Substitution Therapy (OST)

In Georgia, the OST with methadone was launched in 2005 with support of GFATM and Buprenorphine-naloxon was introduced as agonist treatment in 2010. The evidence shows that both medications (buprenorphine-naloxone (Suboxon®) or methadone) along with weekly counseling are highly effective in reducing opioids. Moreover, OST (methadone or buprenorphine-naloxone) is considered as a useful for preventing HIV infection as the OST program has been associated with a significant reduction in reported HIV risk injection behaviors over the 12-week treatment period in both Suboxone® and methadone groups, with improvements persisting by the 20-week follow-up. However, despite the unsafe injecting risk behavior has been virtually eliminated, sexual risk behavior has not change over the course of treatment with about half of the program participants with never using condoms during sex, and about a third of them having 2 or 3 sexual partners over the past 30 days[27].

The Georgian government launched the State OST program in 2008 which is based on the co-funding principle: the cost of the methadone and some expenses (e.g. guard and security) is covered by the State, while services (e.g. human resources, office expenses etc.) are self-paid by the patient. Those patients who are HIV/AIDS positive or are registered in the National Base of the Socially Un-protected Families are offered services for free. Remarkable scale-up of agonist treatment and state support for it (since 2008) represents a major achievement in a history of addiction treatment in Georgia. In 2011, more than 2,300 patients received agonist medication treatment in 17 sites throughout the country (Javakhishvili et al. 2012) and the number of OST program coverage has reached up to 3,658 beneficiaries in 2013 through 20 sites (Javakhishvili et al., 2014).

In 2009, MoLHSA issued a Ministerial Decree No. 37/n on substitution therapy in opioid drug users defining methodology, maintenance, patient selection criteria and regulations, regulations on the control of narcotic drugs/psychiatric substance use without doctor's prescription, conclusion of treatment and patient exclusion criteria, the rules of use, storage and distribution of substitution narcotic drugs and rules on processing of medical documentation of the program. According to the amendments from July 3, 2014 (order #01-41/n by MOHLSA) new special rules for implementation of OST in particular situations (such as hospitalization of OST client, take-home dose), the list of opioids and medications for OST have been introduced (Javakhishvili et al., 2014).

Nowadays OST is functional through three different stakeholders in the country: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), The State Treatment Program and the private sector. Two different types of OST are available in the country: (1) methadone maintenance program and (2) combined preparation with buprenorphine and naloxone (Suboxone®) (Javakhishvili et al., 2014).

According to governmental resolution No. 279 (January 31, 2013), the cost of treatment voucher in the state treatment program on substitution therapy is regulated and the state program is based on the co-funding principle: the cost of the methadone and some expenses (e.g. guard and security) is covered by the state (from The State Program on Addiction Treatment budget) while other technical services (for instance human resources, office expenses etc.) are self-paid (out-of-pocket) by patient at GEL 110 (€ 40) a month. Co-payment does not apply to HIV-positive individuals as well as to those who are under poverty line. Monthly, up to 1,800 beneficiaries are financed by the State, out of whom 110 are taking combined medication. There are 12 OST sites operated by the state in the different regions of Georgia: 6 sites in Tbilisi and one in each of the following towns: Poti, Kutaisi, Batumi, Zugdidi, Ozurgeti, Telavi (Javakhishvili et al., 2014).

There is one private Suboxone® substitution treatment program in Tbilisi, which was launched in 2012. In 2013, 342 males and 6 females were admitted there. The cost of one visit is GEL 28 (€ 13).

GFATM provides treatment via five OST sites, free of charge – three in Tbilisi, one in Gori and one in Batumi. Addi-

27 Otiashvili, (2013) Methadone and buprenorphine-naloxone are effective in reducing illicit buprenorphine and other opioid use, and reducing HIV risk behavior—Outcomes of a randomized trial.

tionally, two GFATM sites are functioning in the penitentiary institutions providing detoxification with methadone in the strict regimen prison #8 in Tbilisi since December 2008 and in the Kutaisi penitentiary institution no. 2 since December 2011. In 2013, 352 prisoners received opioid detoxification services, 2 females among them. In addition, through the OST program in penitentiary, 7,000 have been tested for HCV and 141 patients got treatment in 2014 (MOC, 2015)[28.]

In total, there are 20 OST sites, including 12 OST sites operating by the State in limited number of cities in Georgia. In 2011, 1,878 beneficiaries received services in frame of the State OST program (17 females among them) (Javakhishvili et al. 2012). The coverage of the OST program has been increased in following years up to 2,523 in 2012 and 3,658 (among them only 38 (1%) were female) in 2013. Additionally, in 2013, 348 individuals (6 females) were covered by private Subuxone® substitution treatment service (Javakhishvili et al., 2014) and 352 prisoners received opioid (methadone) detoxification services (2 females among them) (MOC, 2015).

However, despite several year history of implementation of OST in the country, no system of comprehensive treatment approach has been implemented that would utilize treatment planning, case management, and notion of continuum of care (Javakhishvili et al. 2012). Therefore, GHRN conducted a survey to assess the OST program implementation and identify the needs of the beneficiaries in 2014. In total 385 of OST program participants from 5 cities completed the survey.

The survey revealed that beneficiaries are for diversification services based on the individual needs of the clients (GHRN, 2015). Beyond the distribution of opiate substituting medication (in home and take away dosages), the clients are looking for case management/social work services and medical consultations (hepatitis and overdose preventions, HIV testing and Pre- and Post- consultancies, STDs testing etc.) and condom and informative materials distribution etc. (see the table below)

Table 6: Services prioritized by the beneficiaries for OST Programs

High priority	Medium priority	Low priority
Methadone / Buprenorphine+naloxoneprovision	Condom distribution	STDs testing
Take away dosages	Distribution of informative materials	
Case Management	HIV testing and Pre- and Post- consultancies	
Hepatitis Prevention		
Treatment for side illnesses		
Overdose prevention		

Although funding for treatment of substance use disorders in Georgia has been increasing in recent years, and introduction of a specific funding model (about 50/50 co-payment by state and individual patient) allowed for rapid expansion of opiate agonist treatment, it still remains highly inadequate to the needs identified (Javakhishvili et al., 2014). Public expenditures on demand reduction was approximately €44 per adult with problem drug use in 2013.

In terms of economic analysis of OST programs conducted by GHRN in 2014, it looks like that weighted unit cost per patient per year according prioritized services is 2,263.9 GEL, while expenditures per client per year was 1,753.74 for 2012-2013(total budget of 4,025,000 GEL with 2,523 beneficiaries (2012) and 4,388,500 GEL with 3,468 beneficiaries (2013).

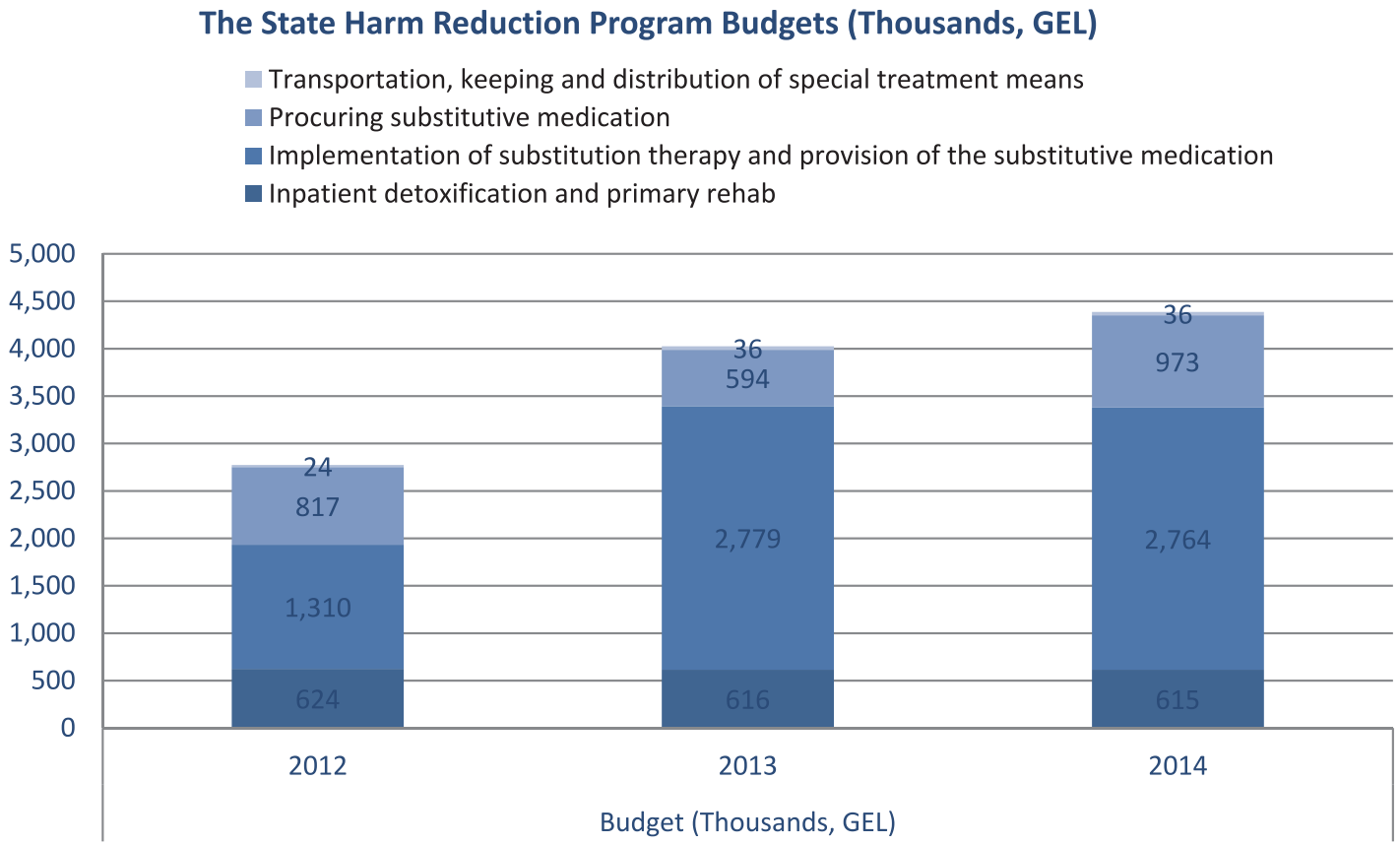
28 Ministry of Corrections (2015) from: http://moc.gov.ge/ka/HepatitisC on March 30, 2015

Table 7: OST unit costs per patient per year (GEL) per prioritized activities

Prioritized activities	Percent of all OST patients receiving activities	Direct unit cost	Indirect unit cost	Total unit cost
High	100.00%	1961.9	218.9	2180.8
Medium	54.76%	33.0	77.7	110.6
Low	28.69%	4.2	74.3	78.5
Weighted overall unit cost per patient per year	**2,263.9 GEL**			

The state budget for Harm Reduction Programs covering state running OST programs considering co-funding principle (the cost of the methadone is covered by the State, while services are self-paid by the patient) defined by the Governmental decrees "Health Care Programs" and for 2012, 2013 and 2014 years[29] were the following (Figure 4)

Figure 4: The State Harm Reduction Program (OST) budgets in GEL (Thousands)[30]



29 Source: Legislative Herald of Georgia. www.matsne.gov.ge

30 Source: State budget for 2012-2014 from www.matsne.gov.ge

In terms of total costs of service per client, the economic analysis of the OST program shows that total costs of service per client is 1,057 GEL.

In more details, analysis shows that the several doctors working part-time per site especially with smaller number of clients make the program more expensive and less affordable. It also appears that indirect and overhead costs associated with salaries for additional staff and administration are associated with largest portion of expenses (Table 9).

Table 9: Cost of OST service per client per a year (GEL)

Categories	High priority	Medium priority	Low priority
Direct personnel	387.6	0.1	0.0
Medical supplies	4.2	4.3	4.2
Medical equipment	1.6	1.4	0.0
Other direct	0.0	197.3	0.0
Total direct	**393.4**	**203.0**	**4.2**
Indirect personnel	97.3	91.7	3.6
Non-medical equipment	28.2	51.5	98.3
Overhead	106.0	193.6	369.6
Total indirect	**231.5**	**336.8**	**471.5**

Recommendations related to OST programs in Georgia:

Based on the findings from the Service Monitoring Survey and Economic Analysis of HRP in Georgia, GHRN proposes to advance the OST program in terms of:

1. Expansion of the coverage
2. Quality of services
3. Gender sensitive infrastructure and procedures

1. Expansion of the coverage of the program

There are several ways to increase coverage of OST program through extending working hours and/or broadening geographical coverage to increase coverage of the program by attracting new clients and decrease the number of dropouts. In the context of OST in Georgia, the both geography and limited working hours of the sites appeared key challenges to prevent high-level dropouts.

Specifically, the survey shows that the extend service hours (earlier opening are requested by 25% and later closure by 56%) will prevent a lot of beneficiaries to miss their treatment. Furthermore, the survey reveals that new program sites will additionally decrease financial burdens on the beneficiaries and avert high dropouts from the program as long distance is an issue for 45% clients of OST program. In overall, it looks like that only 17% the beneficiaries do not face any challenges to attend the program site on a regular basis.

Table 10: Challenges with access to OST program

Reasons mentioned as the challenges to attend OST Program on regular basis	Percent
Transportation costs	58%
Health issues	52%
Far from Home	45%
No challenges exist	17%

The analysis also shows that average attendance per a state funded OST program is 243 (GHRN, 2015). Considering that there is no home-take dosage practice in the country still, this attendance rate means that a lot of patients miss their daily dosages that make the treatment less effective.

Moreover, the procedures practiced at OST sites appear as additional triggers to drop-outs from the programs (62%) along with the stigma (27%), quality of medication (27%) and long waiting lists (16%).

Table 11: Reasons preventing from participation

Reasons preventing to participate in OST Program	Percent
Procedures at the Program site	64%
Other (friends') opinion/Stigma	27%
Quality of medication	27%
Long waiting lists	16%

Moreover, almost two-third of the survey participants (65%) have requested for support with transportation costs – the most demanded support and it has been mentioned as one of the main reasons to practice home-taking dosages.

Note: The data triangulation shows that based on information from Centre for Mental Health and Prevention of Addiction there are no waiting lists in the OST program, the outcome might be driven by the interpretation of the beneficiaries regarding the lack of geographic accessibility, their desire to be enrolled in the program but non existence of possibility.

Table 12: Additional support needed in OST program

Additional support required in regards to	Percent
Transportation costs	65%
Employment	63%
Psychological support	32%
ID documentation/Driving license	18%
Other services (free service, prescription)	13%
Peer education	8%
Gender specific entrance/schedule[1]	5%

Considering the demand from beneficiaries of OST program and high level of drop-outs, to increase the coverage of OST and efficiency of the program, **it is recommended to extend patients' admission hours per site, review procedures and implement "home-in" dosage in practice**

2. Quality of services

In terms of quality of provided services, the beneficiaries of the OST program have identified several issues:

- Impossibility of Home-in Away dosages
- Poor Quality of counseling and social work/case management
- Imposed treatment plan/non-participatory approach

31 All Women have mentioned the need of gender specific entrance/schedule

The matter of take home dosages has been highly emphasized by the OST program beneficiaries. The survey has revealed that that this is the issue that concerns almost all (92%) of them. Moreover, despite the an opportunity of practice of home dosages given in the Ministerial Decree (№01-41/N) of MOHLSA, even in case of health issues affecting 52% of them, high financial burdens from transportation costs (65%), the survey has shown that practice is not accessible to them even in case of conditions described in the decree. The survey participants have mentioned that there are no clear criteria and procedures that would help them to request available services.

Therefore, it is recommended to develop clear criteria and transparent procedures how to implement the right to access to continual service in practice that makes treatment effective. The proposed scheme should work as an incentive for the client and consider the duration of his/her participation in the program, the absence of violation of the program rules and an assessment/report from the doctor and case manager/social worker.

In addition, while discussing the quality of service within OST program, the Service Monitoring Survey has also identified that only 28% are satisfied with the service provided by their doctors. On the other hand, the doctors are the only professionals who speak with them and answer the questions in 80% of cases. Moreover, almost every seventh beneficiary of OST does not get any support from the program staff at all.

Table 13: Responsive OST staff

OST site staff	Percent
Doctors	81%
Social workers	13%
Nurses	7%
None from the Program	15%

Therefore, it is no surprise that almost the same number of beneficiaries (13%) has no idea when and how their therapy assessment/checking takes place. Moreover, more than 37% emphasized that they have no treatment plans at all and additional 25% of beneficiaries say that the plan has not been agreed with them.

Despite the fact, that only 13% of beneficiaries named social workers as a responsive professionals, the need and importance of strengthening case management and social work practice have been identified by 46% of them. Among them, who have ever communicated with program social workers, more than half of beneficiaries (51%) are not happy with the experience.

In overall, more than 25% of the participants have mentioned negative attitude, oppression or rejection from the program staff that also affects their participation in the program. Furthermore, the issue of confidentially is very problematic to them as 35% have an experience of violation of the confidentiality of their personal and health information.

Take into account the fact, that HCV prevention, HIV pre- and post- testing counseling and case management are among of the highly prioritized services and almost one of the third of beneficiaries (32%) requested for psycho-social support, the importance of quality of non-medical services should be emphasized as well, especially considering the facts of malpractice of those professionals.

Considering the needs of beneficiaries and economic analysis**, it is recommended that additionally program should review working procedures, TORs of program medical and non-medical staff, strengthen case management system and diverse quality services based on individual needs of the beneficiaries to ensure sustainability of participation and effectiveness of the program.**

3. Gender sensitive services

It is estimated that 10% of PWIDs are women[32], however only 2% of Harm Reduction program beneficiaries are women[33].Women drug users have indicated that strict national drug strategy and legislation are seen as a barrier for women drug users to seek treatment and receive services (Kirtadze, et al, 2013)[34]. As various studies have revealed, one of the major problems is lack of confidentiality (Kirtadze, et al, 2013, Otiashvili, et al, 2014). As the Service Monitoring Survey (GHRN, 2015) has shown the more than third of beneficiaries (35%) have an experience of distribution of their confidential personal/health information to third parties from the program staff. Moreover, it looks like that engagement of woman drug users in available services creates higher risk that police will be interested in woman beneficiaries and initiate criminal proceedings against them (Step to future, 2012)[35]. The fair of prosecution, stigma and lack of confidentiality, women drug users refrain themselves to contact police even when they become victims of violence (Step to the Future, 2012)[36].

To summarize, according to the assessment of the women-centered substance use disorder treatment in Georgia[37] (Otiashvili, 2014), there are four major issues with undesired impacts on the delivery of effective services for women. These (policy, socio-cultural, programmatic/structural and personal/interpersonal) issues are seen to form a complex and dynamic framework that makes service delivery system ineffective. Moreover, those issues prevent the further advancement of the service provision for this highly marginalized and at-risk population.

Table 14: Issues that present barriers to the development of effective treatment for women substance use disorders[38]

Policy	Socio-cultural	Programmatic/ Structural	Personal/ Interpersonal
Legislation: Criminalization and imprisonment	Stigma and discrimination from their culture, society, family and social networks	Lack of women-specific substance use disorder treatment services	Fear of disclosure of substance use
No guarantee of confidentiality and anonymity	Social roles, norms and expectations	Absence of quality assurance of treatment system in Georgia	Fear of stigma, discrimination, abandonment, violence
Insufficient government funding of comprehensive women-specific services	Prejudice towards substance use disorder treatment	Cost of treatment	Guilt and shame
	Intolerance	Hostile and judgmental service delivery environment	Lack of funds to pay for treatment

32 Sirbiladze. T. (2010) Estimating the prevalence of injecting drug use in Georgia: Consensus report. Bemoni Public Union

33 Kirtadze et al (2013) Twice Stigmatized: Provider's Perspectives on Drug-Using Women in the Republic of Georgia"

34 Kirtadze, et al (2013) Risk and stigma in seeking care and policy implications, 2013 http://www.slideshare.net/IrmaKirtadze/risk-and-stigma-in-seeking-care-and-policy-implications

35 Union "Step to future", Violence in families of drug dependent women in Georgia. Georgia-Gori, 2012.

36 Union "Step to future", Violence in families of drug dependent women in Georgia. Georgia-Gori, 2012.

37 Otiashvili et al (2014). Comprehensive women-centered treatment for substance use disorders in Georgia: current status and future directions

38 Modified from Otiashvili et al (2014) Comprehensive women-centered treatment for substance use disorders in Georgia: current status and future directions

5% of survey participants are women and all of them have mentioned the needs of gender specific services included:

- Sensitive staff and procedures
- Specific entrance and/or different schedule

According to the data, all women participating in the survey have mentioned that infrastructure and rules/procedures regulating their local OST prevent them to participate in and/or drop-out from the program.

Moreover, they all have mentioned that the opinion of others/stigma also plays a significant role in their decision whether or not to participate in the treatment. The recent research found that over 80% of women who use drugs have suffered violence in their homes[39]. Domestic violence against women who use drugs is most often justified due to "nontraditional" and "unacceptable" conduct, which might be tolerated in case of men, they are seen as fallen and unworthy women and are abused and cast away, even by their families[40]. The GHRN survey has revealed that, 25% of women OST program beneficiaries have been experienced physical violence (6% of men beneficiaries). Thus it is not surprising that all women ask for a gender sensitive program or at least specific entrance and/or alternative service hours for them.

In terms of satisfaction of the quality of provided services, it turns out that men feel more supported than women in every respect. Only one woman has mentioned that she is satisfied with the medical personnel counseling. Furthermore, one third of women (35%) say that in they have not got any support from the program staff, twice as much as in case of men (17%). Considering stigma, confidentiality issues and non-responsive and insensitive professionals at the service, it is not surprising that 35% of them have no questions about the program and services at all. Even in terms of outside support, men have been able to get support more frequently (see the table below).

Table 15: OST staff response rates

OST Beneficiaries	Doctor	Nurse	Social Worker	Had NO questions	Got support from others	Nobody helped
Female	60%	0%	5%	35%	5%	30%
Male	82%	7%	14%	5%	10%	7%

Considering the evidence, **it is recommended to implement women specific programs (trained staff, women specific medical services, rehabilitation services for victims of violence), encourage more women to seek support and improve infrastructure and procedures to meet the specific needs of women.**

Needles and Syringe Program (NSP)

Exclusively funded by GFATM, there are 14 NSP/Voluntary Counseling Testing (VCT) centers (4 in Tbilisi, and rest per each city-Rustavi, Telavi, Gori, Kutaisi, Samtredia, Poti, Zugdidi, Batumi, Ozurgeti, Sokhumi) operating, among them 4 new sites were opened in 2013 and mobile (bus) sites opening is expected in 2015 (GHRN, 2015).

GHRN reaches out on average to over 12 000 PWIDs per year and plays crucial role in HIV/AIDS prevention among the key affected populations (KAP). Harm reduction activities covered by GFATM include: the distribution of injecting equipment, condoms, information materials; voluntary counseling and testing (VCT) on HIV, HBV, HCV and syphilis; peer-to-peer education; raising awareness among people who inject drugs; and advocacy activities for policy reform facilitating provision of harm reduction services[41]. Based on site census, the coverage of the NSPs was 7,592 (2012) and 13,253 (2013) beneficiaries (GHRN, 2015).

According to the Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (WHO, 2008) coverage of NSP and VCT programs should be considered as low if less than 20% of PWIDs are covered and as average if 20-60% are covered. The same guide suggests that 200 and more syringes should be distributed per year per PWID to ensure effective coverage. GHRN (2015) has calculated that 3,573,405 syringes have been distributed through NSP in 2014 covering up to 37,195 PWIDs (including number of covered PWIDs, who received at least only syringe, as service), meaning that number of syringes and needles distributed per 1 client is 96.07 (GHRN, 2015). Therefore, the full potential of this otherwise effective HIV prevention intervention is not utilized still.

In Georgia, in addition to giving out of syringes, NSP distributes condoms, and informational materials; provides voluntary counseling and testing (VCT) on HIV, HBV, HCV and syphilis and peer-to-peer education. The program also works on raising awareness among PWIDs. According to the Service Monitoring Survey (GHRN, 2015), the program beneficiaries prioritized the services:

Table 16: Services prioritized by NSP beneficiaries

High priority	Medium priority	Low priority
Needles and syringe distribution	Case management	Spoon, injection water
Overdose prevention	TB screening and diagnostics	Disinfection means
STDs treatment including HCV & HBV	Peer education	
Medical consultancies	Condom distribution	
Social work services		
Women sensitive services		
HIV testing and Pre- and Post- consultancies		

Economic analysis of services (GHRN, 2015) has shown that the weighted unit cost of NSP services per client per year was 396.10 GEL for 2012-2013. The same report indicates that only 39.8% have got the highly prioritized services.

41 Georgian Harm Reduction Network GFATM funded project "Increasing coverage and quality of preventive interventions targeted at MARPS";

Table 17: Utilization of NSPs and cost per client per year(GEL)

Hierarchy of activity priorities	NSP beneficiaries receiving service, %	Direct unit cost	Indirect unit cost	Total unit cost
High	100%	139.5	42.1	181.6
Medium	60.34%	293.7	61.6	355.3
Low	0.00%	0.0	0.0	0.0
* Weighted average unit cost a year			396.10 GEL*	

Moreover, as the data have shown, the largest share of expenses was under other direct costs associated with transportation/travel, small medical supplies, peer education, case management and publishing of informative leaflets and brochures etc.

Table 18: Cost of NSP service per client per a year (GEL)

Categories	High priority	Medium priority	Low priority
Direct personnel	92.5	30.5	0.0
Medical supplies	44.0	0.4	0.0
Medical equipment	0.7	0.2	0.0
Other direct	2.4	262.7	0.0
Total direct	**139.5**	**293.7**	**0.0**
Indirect personnel	7.0	14.8	0.0
Non-medical equipment	4.5	4.5	0.0
Overhead	19.9	19.9	0.0
Total indirect	**31.5**	**39.3**	**0.0**

The same report of economic analysis of NSPs has revealed that medium prioritized services such as case management, TB screening and diagnostics, peer education, condom distribution have been funded/budgeted for only 16.7% of beneficiaries, while the same services have been used by 24.2% of beneficiaries (GHRN, 2015).

The importance of employ full capacity of harm reduction programs in Georgia is additionally accentuated in terms of financial cost-effectiveness perspective. As Craig et al (2014)[42] has concluded the programs targeting the general public are not so much cost-effective or not cost-effective at all to compare with programs targeting at KAPs. Specifically, Wilson (2012)[43] has shown that NSPs are generally effective and bring significant benefits to Georgian society in terms of preventing new HIV and HCV cases, reducing mortality related to these infections and ultimately saving health care costs that otherwise are allocated to provide relevant health services to people infected. Moreover, the same report suggests that initial quality and effectiveness of the services are supposed to be improved over time and thus NSP investments in 2000-2010 will be able to produce +246% return in investment over the 2000-lifetime perspective (see the table below).

42 Craig et al (2014) Spending of HIV resources in Asia and Eastern Europe: systematic review reveals the need to shift funding allocations towards priority populations. Journal of the International AIDS Society. For its summary, refer to the study mapping report.

43 Evaluating the cost-effectiveness of needle-syringe exchange programs in Georgia (Wilson, 2012)

Table 19: Funding scenarios for NS Programs

Maintain current levels	4.46m	105,285	15,244	19,187	15,018,179	671	0 (Ref)
NSP investment	Change in NSP spending * ($ mil)	Change in QALYs	Change in infections (infections averted)**		Return *** ($)	Lives saved	ICER ****
			HIV	HCV			
50% reduction	-2.23	-11 163	-13 276	-5 986	-7 816 922	-386	199
25% reduction	-1.11	-6 735	-7 914	-3 786	-4 454 377	-222	164
25% increase	1.11	5 599	5 620	3 595	3 069 952	152	198
50% increase	2.24	9 555	8 794	6 381	4 891 851	241	234
100% increase	4.5	13 114	11 043	9 041	6 296 277	308	338
200% increase	8.54	14 296	11 669	9 952	6 716 614	327	597

* Assuming costs scale linearly with current implementation costs (undiscounted)** Cumulative number of incidence (2011-2020)

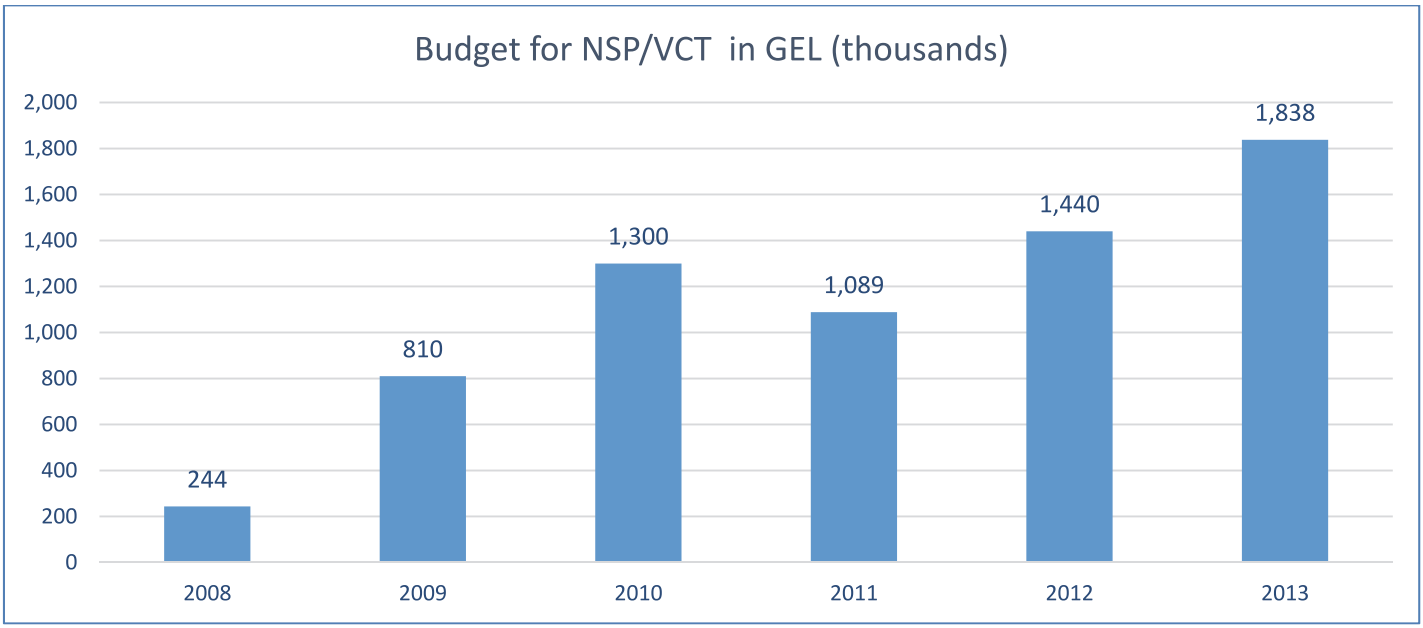
*** Health costs saved (2011-2020)

****Incremental cost-effectiveness ratio (ICER) = (NSP1 – NSP0) / (QALY1 – QALY0)

The incremental cost-effectiveness ratios between alternative scenarios were estimated by dividing the incremental net cost of the scenarios by the incremental QALYs gained or lost.

However, investments into health initiatives targeting KAPs are in scarce globally due to marginalization of the most-at-risk populations (Craig et, al, 2014). In Georgia, there are no public funds available to finance NSP/VCT programs still. Exclusively funded by GFATM NSP/VCT program costs for 2008-2013 looked the following[44]:

Figure 5: Budget for NSP/VCT in GEL (Thousands)



44 Georgian Harm Reduction Network - Financial Department;

Furthermore, economic analysis of NSP for 2012-2013 (GHRN, 2015) has shown that the funding deficit is expected for 2016-2018 to cover the services such as case management, peer education, TB screening, condom distribution etc., the services that are shown to be very effective for this particular group in prevention of HIV and HCV transmission (Wilson, 2012, Craig et al, 2014).

Considering the financial/economical estimations, the role of NSPs in prevention of HIV and HCV infections and number of possibly saved lives, **the advancement of measures to amplify outreach capacities and the number of covered beneficiaries of the programs and the development of mechanisms enabling the handover of these services to the government is urgently required** as up till now all NSPs remain fully funded by GFTAM.

Recommendations for Needles and Syringe Programs in Georgia:

Based on the findings from the Service Monitoring Survey and Economic Analysis of HRP in Georgia, GHRN proposes to advance the Needles and syringe program in terms of:

1. Build Legal foundation for the service

Despite the fact the services have been operating since 2002, there is no legal framework regulating the activities within Needles and Syringe Programs (NSPs). According to Georgian legislation, the administrative sanctions might be imposed for only the first episode of positive drug test with a very high fines (500 GEL/250 EUR) and/or even administrative confinement - up to 15 days (Code of Administration violation, Article 45) and there is a possibility of a criminal charge for illicit drug use (Criminal Code, Article 273) that is widely used in practice. 4,003 persons prosecuted in 2014; among whom 24,3% got imprisoned, 52% - conditional sentence and 20.1% paid fines (data from the Institute of Development of Freedom of Information[45], 2015). In case of doubt that might be set off by being caught with any syringe or just being around the NSP, the people might become a subject of forced urine drug testing randomly; impose to violation their human rights (Kiknadze & Otiashvili, 2007) and to even heavy fines and/or imprisonment. Therefore, the clients of NSPs pay a lot of attention to security measures to prevent any contacts with police.

As a result, safety for the beneficiaries is one of the main concerns of NSPs and thus, the services are provided through different options (office, mobile/field work, outreach worker etc.). However, despite the facts that the clients are able to enjoy the program anonymously (95%) and most of them believe that their private information will not be shared with the third party (92%), it appears that the 23% of them anyway do not always feel safe Furthermore, 44% of beneficiaries have felt a threat due to nearby policemen and almost third of them (32%) have experienced some kind of oppression from the police side. All these factors challenge the NSP to increase coverage and reach the clients in need of assistance (GHRN, 2015).

In addition, the focus group discussions revealed that not only program beneficiaries, but also outreach workers do not feel safe while working for the NSP, leading to high turnover among them (GHRN, 2015).

Furthermore, there is no legal commitment (policy papers, strategies, action plans, etc.) from the state how to handover the NSP programs when the donor is leaving the country. Moreover, it is required not only to continue the programs but also to scale up them to meet the needs of the beneficiaries.

It is recommended to develop a legal framework to decriminalize the consumption drugs to ensure efficient implementation of NSP services in Georgia.

2. Individual needs based services

Drug situation in Georgia indicates that homemade stimulants and poly-substance consumptions are the major challenges for the professionals working in the field of Harm Reduction in Georgia (Kirtadze & Otiashvili, 2014). Moreover,

45 Statistical Information on Drug Crimes in Georgia. https://idfi.ge/ge/statistical-information-on-drug-crimes-in-georgia

as there are no flexible schemes to adjust commodities on a regular basis, the system becomes unprepared for the shifting patterns of substance consumption reality and thus the changing needs of PWIDs (GHRN, 2015). According to WHO Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014)[46], injecting equipment should be appropriate to the local context, taking into account such factors as the type and preparation of drugs that are commonly injected. The same WHO guidelines indicate that an implementation of needle and syringe programs providing syringes for distribution to PWIDs should be as a key public health measure along with offering the rapid hepatitis B vaccination regimen with incentives to increase uptake and completion of the hepatitis B vaccine schedule. Moreover, it appears that peer interventions to PWIDs to reduce the incidence of viral hepatitis are much more efficient than professional psychosocial interventions to reduce the incidence of viral hepatitis[47].

However, according to GHRN (2015), it turns out that the clients of NSP often faced issues related to corresponded commodities in the previous (2010 - 2013) years.

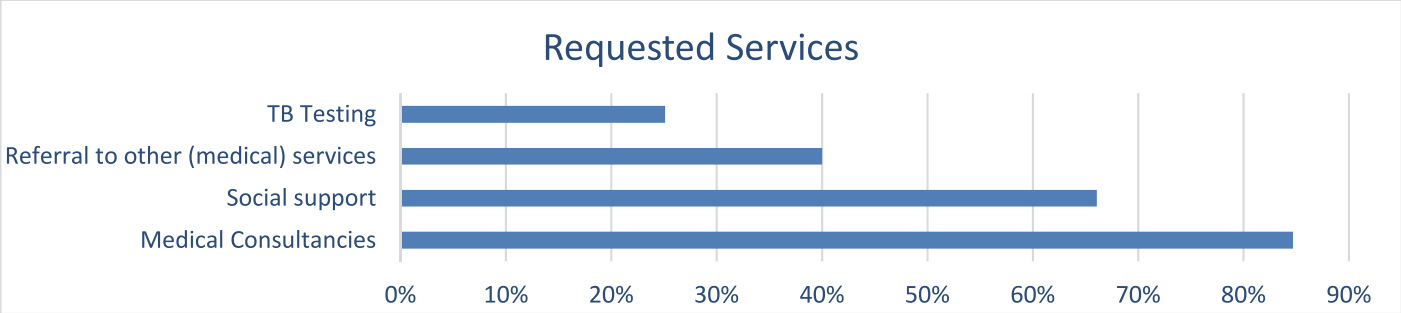
Table 20: lack of necessary commodities

Lack of necessary commodities	
Water for injection	69%
Filters	60%
Spoons	57%
Napkins	30%
"Tourniquets"	26%
No experience of scare materials	25%

Furthermore, there are some geography (25%) and time constrain (47%) issues related to access to amenities as well.

While evaluating the NSP, the beneficiaries of the program have listed the services available/used at their NSP site. It looks like that most often people approach the program for medical consultancies (85%) and social support (65%) (see the graph below):

Figure 6: Requested services



46 WHO Consolidated guidelines on HIV Prevention, Diagnosis, Treatment, and Care for Key Populations (2014. Geneva). http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

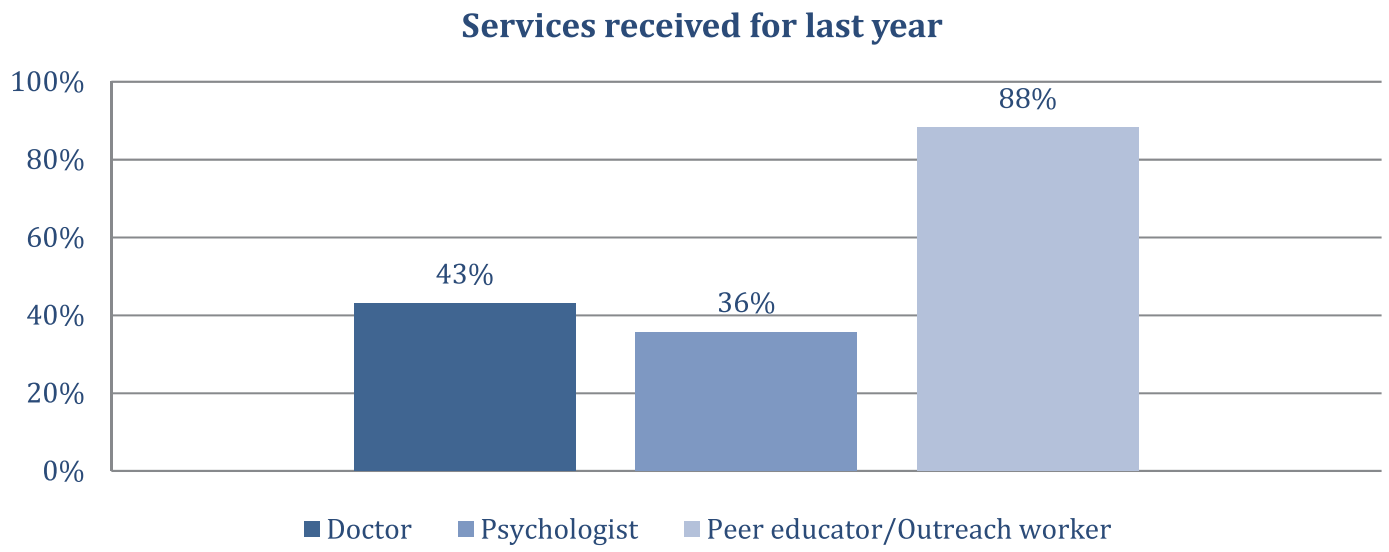
47 Guidance on prevention of viral hepatitis B and C among people who inject drugs (WHO, 2012)

The beneficiaries of NSP have emphasized the importance of implementation of gender sensitive and overdose prevention services along with needles and syringe distribution, medical services (HIV testing, consultancies, and STDs including HVC and HBV screenings and treatment, TB screening etc.), condom distribution, peer education, strengthen social work and case management, etc. (See table: Services prioritized by NSP beneficiaries).

As the effectiveness of the program heavily depends on the outreach work, GHRN has also checked the utilization of the service of outreach workers. It appears that almost two third (67%) of respondents use outreach workers' services on regular basis.

In general, it looks like that the beneficiaries have received the various services. For the details see the graph below:

Figure7: Services received for last year



In addition, it appears that 78% of clients have a request for professional social work assistance and medical check-ups and screenings as well. For instance, while HIV testing is available to all of them, TB testing has been available to only 74% of clients who expressed the need of such services.

Table 21: Screening tests and their availability

In need of Testing		Completed tests
TB	34%	74%
HIV	68%	100%
Medical Check-ups	26%	-

Considering the crucial role of NSPs in prevention of HIV, HCV and HBV not only among PWIDs, but in general population, it is important not only meet the needs of the beneficiaries and provide the services based on the their need in accordance of changing drug situation, but also scale-up the programs both in terms of number of covered people but also in terms of diversification of services.

Therefore, **it is recommended to review the composition of commodities on a regular basis in order to ensure that NSPs provide all required supplies; strengthen social support/work services; develop gender sensitive services and medical referrals/services for all beneficiaries and safeguard funding sources to provide quality services to ensure sustainability of the NSPs in the future.**

NSP/OST program activity areas and funds allocated in Georgia 2016-2018:

Table 22: NSP/OST program activity areas and funds allocated in Georgia 2016-2018:

Strategic Priority/ Activity area	Indicative			Unit cost, USD			Number of units			Total cost, USD		
	Imple-menting partners	Financing Sources (detail)	Unit descrip-tion	2016	2017	2018	2016	2017	2018	2016	2017	2018
[HIV Prevention and Detection]												
Prevention and detection of HIV among PWIDs										**2,307,839**	**2,426,081**	**2,764,112**
Delivery of basic prevention services (including VCT, HCV and syphilis testing) from stationary service delivery units	GHRN	Global Fund	per person per year	101.16	108.92	117.59	15,300	15,300	15,300	1,540,791	1,658,990	1,791,081
Outreach and delivery of basic prevention services (including VCT, HCV and syphilis testing) from mobile service delivery units	GHRN	Global Fund	per person per year	61.65	50.82	52.88	10,350	12,600	14850	635,269	637,473	781,770
Reaching and engaging new clients (hidden segments of PWIDs) through peer-driven interventions (PDI)	GHRN	Global Fund	per person per year	26.06	23.25	22.12	2,800	2800	2800	72,652	64,820	61,659
Implementation of interventions targeting sexual partners of PWIDs, as well as to ensure timely detection of HIV in these groups with follow-up access to vital care and treatment services	GHRN	Global Fund	per person per year	48.03	47.70	47.80	769.5	837	904.5	36,795	39,747	43,044
Increasing early TB detection (question-naire-based screening for TB), referrals and surveillance among PWIDs at harm reduction sites	GHRN	Global Fund	per person per year	0.26	0.27	0.29	7000	7000	7000	1,833	1,916	2,009
STI (syphilis) diagnostics and treatment	GHRN	Global Fund	per person per year	1.35	1.52	1.71	15,300	15,300	15300	20,498	23,135	26,064
HIV, HBV, HCV tests procurement	GHRN	Govern-ment	per person per year			0.60			104650.65	0	0	58,486
Opioid Substitution Treatment (OST) and other forms of treatment and rehabili-tation										**4,367,360**	**6,345,838**	**6,997,672**
Inpatient detoxification and rehabilitation	IMHPA	Govern-ment	per pa-tient per month	952.38	952.38	952.38	401	0	0	379,926	393,742	407,557
OST and delivery of pharmaceutical products in Tbilisi and Regions Purchase, transportation security escorts of Pharmaceuticals for OST (Procurement of methadone, tests for illicit drugs, tests for HIV, HBV and HCV and other pharmaceuticals)	IMHPA	Govern-ment	per patient per year	635.71	960	960	2400	3600	4000	1,519,216	3,440,599	3,822,888
Estimated patients contributions to the state program (co-funding)	IMHPA	Private	per patient per year	628.57	628.57	628.57	2,300	3,500	3,900	1,439,272	2,190,196	2,440,504
OST and delivery pharmaceutical products in Tbilisi and Regions Purchase, transportation security escorts of Pharmaceuticals for OST (Procurement of methadone, tests for illicit drugs, tests for HIV, HBV and HCV and other pharmaceuticals)	IMHPA	Global Fund	per patient per year	1022.86	0	0	700			712,809	0	0
OST treatment for PLHIV (co-funding from Government program)	IMHPA	Govern-ment	per patient per year	628.57	628.57	628.57	100	100	100	62,577	62,577	62,577
Psychosocial rehabilitation of PWIDs	IMHPA	Global Fund	per patient per year	352.38	352.38	352.38	250			87,703	0	0
Psychosocial rehabilitation of PWIDs	IMHPA	Other interna-tional	per patient per year	352.38	352.38	352.38		250	250	0	87,703	87,703
Implementation of methadone detoxification program in prisons	IMHPA	Govern-ment	per patient per year	628.57	628.57	628.57	100	100	100	62,577	62,577	62,577
Social Bureau for former prisoners, proba-tioners (included drug users)	Tanad-goma	Other interna-tional	per person per year	952.38	952.38	952.38	800	800	800	103,280	108,444	113,866

Table 23: Projected Gap based on prioritized services for 2016-2018 USD

Harm Reduction Program	2016			2017			2018		
	required	planned	deficit	required	planned	deficit	required	planned	deficit
NSP									
High priority	827,603.84	1,561,289.62	733,685.78	900,242.77	5,269,718.02	4,369,475.25	827,603.84	1,561,289.62	733,685.78
Medium priority	972,770.76	74485.06	-898,285.70	1,058,025.65	66,735.91	-991,289.74	972,770.76	74485.06	-898,285.70
Low priority	0	0	0	0	0	0	0	0	0
Deficit	1,800,374.61	1,635,774.68	-164,599.92	1,958,268.42	5,336,453.93	3,378,185.51	1,800,374.61	1,635,774.68	-164,599.92
OST									
High priority	4,497,292.61	3,733,874.45	-763,418.16	5,065,960.97	5,693,373	627,411.55	4,497,292.61	3,733,874.45	-763,418.16
Medium priority	124,948.01	0	-124,948.01	140,732.65	0	-140,732.65	124,948.01	0	-124,948.01
Low priority	46,482.61	0	-46,482.61	52,327.13	0	-52,327.13	46,482.61	0	-46,482.61
Deficit	4,668,723.24	3,733,874.45	-934,848.78	5,259,020.76	5,693,373	434,351.76	4,668,723.24	3,733,874.45	-934,848.78
Total	**6,469,098**	**5,369,649.14**	**-1,099,448.71**	**7,217,289.18**	**11,029,826.45**	**3,812,537.27**	**6,469,098**	**5,369,649.14**	**-1,099,448.71**

It appears that funds will be not properly distributed as while some activities will be in surplus.

Funds allocated to meet the needs of the NSP/OST/ART coverage indicators in Georgia for 2016-2018:

Table 24: Funds allocated to meet the needs of the NSP/OST/ART coverage indicators in Georgia for 2016-2018:

Full demand in selected HIV services	2016	2017	2018
Needle and syringe program (NSP):			
(a) Number of clients to be covered to reach 50% HIV transmission reduction among PWID	a) 25,650	a) 27,900	a) 30 150
(b) Financial resource needed	b) 2,307,839 USD	b) 2,426,081 USD	b) 2,764,112 USD
Opioid substitution treatment (OST):			
(a) Number of clients to be covered to reach 50% HIV transmission reduction among PWID	a) 4300	a) 4900	a) 5400
(b) Financial resource needed	b) 4,367,360 USD	b) 6,345,838 USD	b) 6,997,672 USD
HIV treatment:			
(a) Number of patients to receive HIV treatment	a) 3800	a) 4300	a) 4800
(b) Financial resource needed	b) 10,341,326 USD	b) 6,447,902 USD	b) 7,390,384 USD
Available funding			
NSP financed from domestic sources:	0	0	
(a) Absolute ($)			a) 58,486
(b) % of the full demand			b) 2.1%
international donor programs:			
(a) Absolute ($)	a) 2,307,839 USD	a) 2,426,081 USD	a) 2,705,626 USD
(b) % of the full demand	b) 100%	b) 100%	b) 97.9%

OST financed from domestic sources: (a) Absolute ($) (b) % of the full demand **international donor programs:** (a) Absolute ($) (b) % of the full demand **Out of pocket** (a) Absolute ($) (b) % of the full demand	a) 2,024,296 USD b) 46% a) 903,792 USD b) 21% a) 1,439,272 USD b) 33%	a) 3,959,495 USD b) 62,6% a) 196,147 USD b) 3% a) 2,190,196 USD b) 34,4%	a) 4,355,599 USD b) 62% a) 201,569 USD b) 3% a) 2,440,504 USD b) 35%
HIV treatment financed from domestic sources: (a) Absolute ($) (b) % of the full demand **international donor programs:** (a) Absolute ($) (b) % of the full demand	a) 7,619,972 USD b) 74% a) 2,721,354 USD b) 26%	a) 5,646,209 USD b) 87,6% a) 801,693 USD b) 12,4%	a) 6,857,688 USD b) 92,8% a) 532,696 USD b) 7,2 %
Strategies to fill in the resource gap and increase efficiencies			
For NSP – specify: (a) Potential funding sources (b) Legislation/policy revision required	a) N/A b) YES	a) N/A b) YES	a) N/A b) YES
For OST – specify: (a) Potential funding sources (b) Legislation/policy revision required	a) N/A b) YES	a) N/A b) YES	a) N/A b) YES
For HIV treatment – specify: (a) Potential funding sources (b) Legislation/policy revision required	a) N/A b) YES	a) N/A b) YES	a) N/A b) YES

Transition plan from donor to national funding:

Up till now, public funds are available to cover number of Harm Reduction services in Georgia. It finances only OST services and even these services are funded partially, as there is co-financing principle at OST sites running by state and still there are some sites fully funded by GFTAM providing services free of charge. Moreover, all 14 NSPs are fully funded by GFTAM.

Considering the number of potential beneficiaries (45,000 drug users, among them 3,000 women), prevalence of HIV (3-9%) and HCV (70% - 80%) among PWIDs and coverage of the harm reduction services (5-10%), the importance of increasing of coverage of the programs is not doubtful. Moreover, as the GFTAM indicates to leave the country in the coming years, it is crucial not only to increase the number of sites of the harm reduction programs, but also ensure sustainably of existing services through allocation state funds.

To make transition smoother, it is important to make sure that HIV prevention strategy and HVC state program puts appropriate emphasis to harm reduction services in prevention and treatment of HIV and HCV. Furthermore, the implementation of handover measures and mechanisms should be started in the nearest future to prevent any gaps in service provision.

This process should be used to implement the practice taking into account the lessons learnt during GFTAM funding and make the programs and services even more flexible and diverse both in terms of service provision and funding/ procurement mechanisms to make sure that there is no break in service provision.

Moreover, the legal framework should be reviewed to protect beneficiaries while they are in treatment and decrease drop-out rates through offering services with various schemes (mobile services, home-in dosages, support with transportation costs etc.). In addition new outreach measures and gender sensitive services should be employed to increase number of beneficiaries.

The role of service provider NGOs is to propose various procurement mechanisms and ensure that the State is fully aware of the needs of the program beneficiaries and allocates funds accordingly

Based on the Table N22 "NSP/OST program activity areas and funds allocated in Georgia 2016-2018" p36 in order to sustain the relatively the same coverage of NSP/OST beneficiaries the following amount of state funding should be allocated for the years 2019-2020[48] and keeping the same trends beyond for sustainable HR provision.

48 Estimations made based on the scaling up trends for 2016-2018 that might be different for upcoming years

Activities	2019	2020
Decriminalization of 273 Article of the Criminal Code	+	+
NSP Coverage	32.400	34,650
Make services flexible	+	+
Allocation of the domestic funding needed (USD)	3,140,000	3,480,000
OST Coverage	5,900	6,400
Make services flexible	+	+
Precise the criteria and introduce of practice of home-in dosages	+	+
Review service delivery and site procedures	+	+
Allocation of the domestic funding needed (USD)	7,650,000	8,300.000

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