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A Situation Analysis of the Center for Information and Counseling on Reproductive Health in Tbilisi, Georgia, as a Response to GFATM's New Funding Model:

A Special Studies Project

By

David Parks

Master of Public Health

Hubert Department of Global Health

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Deborah A. McFarland, MPH, PhD

Committee Chair

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A Special Studies Project

By

David Parks
Bachelor of Arts
University of Colorado
2008

Special Studies Project Committee Chair: Deborah A. McFarland, MPH, PhD

An abstract of a special studies project submitted to the Faculty of the
Rollins School of Public Health of Emory University in partial fulfillment of the requirements for the degree of Master of Public Health in Global Health
2015

Abstract

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By: David Parks

HIV/AIDS continues to be an issue within the country of Georgia and neighboring, high-prevalence countries including Russia and Ukraine.

Historically, local non-governmental organizations (NGOs), dependent on outside international funding such as the funding provided by the Global Fund to Fight AIDS, TB, and Malaria (GFATM), have played a vital role in Georgia's HIV prevention strategies for high-risk, vulnerable populations; but, only one organization is currently serving the country's MSM and FSW high-risk populations with direct health intervention services – the Center for Information and Counseling on Reproductive Health.

In 2013, a strategic shift began to take place within the GFATM resulting in the development of a New Funding Model (NFM) based upon country income rankings assigned by the World Bank. Due to this strategic shift within the GFATM, Georgia will no longer be eligible to receive GFATM funding due to its middle-income ranking after 2016. But before "graduating" from GFATM funding, previous GFATM recipient countries are still eligible for a final round of funding scheduled to take place in April, 2015, under the NFM.

Competition is now intense amongst Georgian HIV/AIDS NGOs, including the Center for Information and Counseling on Reproductive Health, to obtain funding through this final NFM funding round for their respective operations.

The purpose of this SSP is to develop a situation analysis report for the Center for Information and Counseling on Reproductive Health that will inform the national HIV policy dialog currently taking place in Georgia while advocating on behalf of the organization during this final GFATM funding round.

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Acknowledgements

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First and foremost I want to thank my mother and father for their love and continued support over the years and during the development of this project. Thank you both so much for enabling me to find this wonderful path that I am currently on and for your words of encouragement day and night. I hope that my future achievements in this chosen field will be a testament to the love I have felt over a lifetime.

I want to thank Deb McFarland for her leadership and guidance during the course of this project and beyond. Over the last year there were several instances when things seemed truly overwhelming for days or even weeks at a time, only to be made clear by you during a brief conversation. Your knowledge and enthusiasm for Georgia and this subject matter is truly an inspiration. I look forward to our paths crossing in Georgia in the future.

I also want thank the executive director of the Center for Information and Counseling on Reproductive Health – Tanadgoma, Nino Tsereteli. Without a doubt this project would not have been possible without you. Thank you so much for inviting me to your country to work with you and your wonderful organization. I cherish the time we spent working together. Your passion and dedication to Georgia's most vulnerable populations is an inspiration.

I want to thank David Baliashvili and his family for the warm hospitality shown to me while in Georgia and for his continued support of this project over the last year. I am forever in your debt. Your ability to gather crucial, and often random, project information at such off hours saved this project more than once.

I want to thank the founder of Youth for Public Health, Mariam Beridze. Your dedication and drive for a healthier, better Georgia is truly amazing. Thank you for all of your help, support, and encouragement during the course of this project, especially in the translation and understanding of vital documents. I look forward to our lifelong friendship and paths crossing for work around the world.

Finally, I want to thank all of my friends and family for putting up with me during this process. Thank you for your patience with me. I will never forget the kindness shown to me over the last year.

Table of Contents

1. Introduction

HIV/AIDS continues to be an issue within the country of Georgia and neighboring, high-prevalence countries including Russia and Ukraine.

Historically, local non-governmental organizations (NGOs), dependent on outside international funding such as the funding provided by the Global Fund to Fight AIDS, TB, and Malaria (GFATM), have played a vital role in Georgia's HIV prevention strategies for high-risk, vulnerable populations; but, only one organization is currently serving the country's MSM and FSW high-risk populations with direct health intervention services – the Center for Information and Counseling on Reproductive Health.

In 2013, a strategic shift began to take place within the GFATM resulting in the development of a New Funding Model (NFM) based upon country income rankings assigned by the World Bank. Due to this strategic shift within the GFATM, Georgia will no longer be eligible to receive GFATM funding due to its middle-income ranking after 2016. But before "graduating" from GFATM funding, previous GFATM recipient countries are still eligible for a final round of funding scheduled to take place in April, 2015, under the NFM.

Competition is now intense amongst Georgian HIV/AIDS NGOs, including the Center for Information and Counseling on Reproductive Health, to obtain funding through this final NFM funding round for their respective operations.

The purpose of this SSP is to develop a situation analysis report for the Center for Information and Counseling on Reproductive Health that will inform the national HIV policy dialog currently taking place in Georgia while advocating on behalf of the organization during this final GFATM funding round.

Both the overarching SSP and the report are based on firsthand observation as well as analyses of recent national surveys, country and region-specific reports of relevant global health

initiatives, NGO organizational records and reports, and Government of Georgia (GoG) HIV/AIDS policy documents.

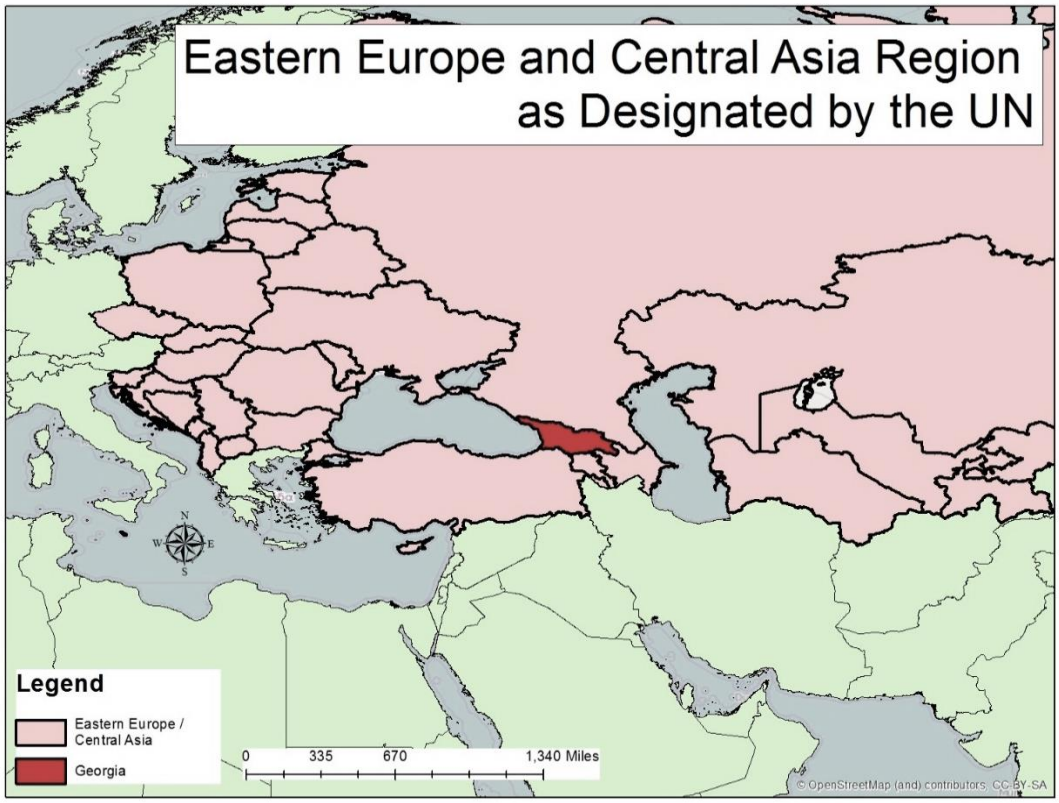
2. Background

The following chapter provides a brief epidemiologic background regarding the current HIV/AIDS situation globally, regionally, and nationally in Georgia. This chapter also provides information on Georgia's national HIV/AIDS response to its current epidemiologic situation while also briefly stating the role of both the GFATM and Tanadgoma in Georgia's national HIV response. Finally, an all-encompassing problem statement for the SSP and the report is contained in this chapter, along with the purpose and objectives of each, in order to convey a clear understanding of the problem being addressed within the SSP and the report.

2.1 Global HIV Burden

As of 2013, there were an estimated 29.2 million people living with HIV globally, 1.8 million of which were estimated to have been infected within the last year.[1] Though these numbers reflect an ongoing wave of human tragedy, the global incidence of HIV and mortality figures attributable to AIDS have been decreasing since 2001 and 2005 respectfully.[1,2] While these prevailing global trends of HIV and AIDS are encouraging, , there are concerning regional and country-specific trends materializing in areas such as Eastern Europe and Central Asia.[2]

Figure 1. Map of UN Eastern Europe and Central Asia region.[3]



In 2013, there were approximately 1.1 million people living with HIV in Eastern Europe and in the Central Asia region, with an estimated 110,000 new HIV infections and 53,000 deaths due to complications from AIDS occurring within the year.[2] From 2005 to 2013 HIV incidence in this region, as well as AIDS-related deaths, increased by approximately 5% each.[2] Located within this grouping of countries lies the Republic of Georgia.

2.2 Georgian HIV Burden

Georgia is a semi-presidential republic with a population of nearly five million. Throughout the country's history, Georgia has been categorized as either an Eastern European or Western Asian country due to its geographical location between Europe and Asia. The country is located on the Black Sea with Turkey and Azerbaijan to its West and East and Russia and Armenia to its North and South. Ukraine, though not sharing a land border with Georgia, lies opposite of

Georgia on the Black Sea and is worth mentioning because the two countries share both strong political and cultural ties resulting in large migrant populations.

Figure 2.Georgia and border countries.[4]

For more than a decade, Georgia has been classified as having a low prevalence of HIV/AIDS but being at a high-risk of an epidemic.[5, 6] The rationale for this classification of high epidemic risk can be attributed to Georgia's geographic position near high-prevalence countries such as Russia and Ukraine; the presence of high-risk, hard-to-reach populations such as people who inject drugs (PWIDs), female sex workers (FSWs), and men who have sex with men (MSM); and large migrant populations, including commercial sex workers (CSWs).[6, 7]

The estimated prevalence of HIV in Georgia is roughly 0.07% amongst the general adult population according to the GoG and USAID.[6, 7] As of December, 2014, there were 4,646 cases of HIV infection registered in the country by Georgia's Infectious Diseases, AIDS, and Clinical Immunology Research Center; however, both the GoG and USAID agree that the estimated total of persons living with HIV may be much higher.[5, 8]

Injection drug use in Georgia was rampant from the fall of the Soviet Union in 1991 until the early 2000s. Nearly 70% of all reported cases of HIV/AIDS during the first decade of Georgia's HIV epidemic were among people who inject drugs (PWIDs).[9] This mode of transmission remained the primary cause of new infections until 2011.

In 2011, PWIDs were no longer the primary driver of Georgia's HIV epidemic and, according to the Government of Georgia (GoG) and USAID, heterosexual transmission of HIV is now the leading route of new infections.[6, 7] The latest HIV/AIDS Country Progress Report published by the government states, "The share of drug use, as a transmission mode among newly registered HIV cases decreased to 43.2 % in 2012, and 35% in 2013 while heterosexual transmission has increased up to 44.8% in 2012 and 49% in 2013."[7] However, the prevalence of HIV in other vulnerable high-risk populations remained, and continues to remain, high.

Men who have sex with men (MSM) in Georgia is a high-risk population with a reported HIV prevalence of 13% according to Georgia's national HIV surveillance system in 2012.[1] And, female sex workers (FSWs) in 2014 were reported to have an HIV prevalence of 0.6% in Tbilisi and 0.8% in Batumi.[5, 7, 10]

This persistently high prevalence of HIV in these high-risk populations, along with the transition to heterosexual transmission as the primary mode of transmission, has resulted in a steady increase of newly registered cases per 100,000 of the population over the last decade.[5, 7] This increase in new cases of HIV per 100,000 is steeper when compared to similar data from the EU or other former Soviet Union countries from 2000-2012 thus requiring a multifaceted response from the GoG.[5, 7]

2.3 Georgian National Response

The leading organization in charge of Georgia's national HIV response is the National Center for Disease Control and Public Health (NCDC).[6] The NCDC is currently responsible for several state health programs including the GoG's HIV/AIDS Prevention and Treatment Program, Post-

Exposure Prevention Program, Opioid Substitution Therapy (OST), the Safe Blood Program, and the Prevention of Mother to Child Transmission Program.[6] The most critical of these programs is the NCDC's HIV/AIDS Prevention and Treatment Program.

Historically, the GoG has been responsible for the treatment side of its HIV/AIDS Prevention and Treatment Program while relying heavily upon local NGOs for the implementation of the prevention side, especially prevention interventions directed towards high-risk vulnerable populations.[5, 6, 7] However, there are currently changes underway that will affect both parts of this vital program as well as Georgia's future national HIV response, Georgian HIV policy, and the funding mechanisms that previously supported the Georgian response.

The Georgian HIV/AIDS Prevention and Treatment Program has always been heavily reliant on local non-governmental organizations (NGOs) for providing the prevention services aspect of its operations.[5, 7, 11] High-risk, vulnerable populations such as men who have sex with men, female sex workers, people who inject drugs, and the incarcerated, are all reliant on these NGOs for disease screenings and HIV intervention services. These local NGOs have been listed as a critical component to the Georgian HIV response in a multitude of studies and program evaluations, but they do not receive funding from the GoG.[5, 11] The way these relevant NGOs have been able to maintain operations is through international funding sources, primarily The Global Fund to Fight AIDS, TB, and Malaria (GFATM).[7]

2.4 GFATM in Georgia

The Global Fund to Fight AIDS, TB, and Malaria (GFATM) is a global health initiative that began its operations in Georgia in 2003. To date, the GFATM has distributed $57,738,873.00 US Dollars for HIV/AIDS interventions and programming in Georgia. Based on this funding amount, the GFATM is presently the most significant organization in terms of funding size and contribution to Georgia's health care system.[5,12]

In 2013, a strategic shift occurred within the GFATM to implement a New Funding Model (NFM) due to various criticisms of its old 'rounds-based' model and as a response to a lessening in financial resources available to similar large-scale health initiatives globally. Under this NFM, Georgia will no longer be eligible for funding after 2016 due to its classification as a middle-income country by the World Bank. However, before Georgia "graduates" from GFATM eligibility, the country is still eligible for a final round of GFATM funding scheduled to take place in April of 2015.

With this shift in funding, the future of programs and organizations dependent on the GFATM is now unclear. It is reasonable to assume that the competition will be intense amongst Georgian HIV NGOs to secure financing for their respective operations during this final GFATM funding round. Therefore, the purpose of this report is to not only inform and encourage the ongoing policy dialog regarding HIV/AIDS in Georgia, but to also advocate on behalf of one of these local NGOs deemed instrumental to the national HIV response: the Center for Information and Counseling on Reproductive Health, commonly referred to as Tanadgoma.

2.5. NGO Tanadgoma

Tanadgoma is a non-profit organization that performs its activities according to the Georgian Constitution and Georgian Civil Code with its headquarters located in Tbilisi, Georgia.[13]

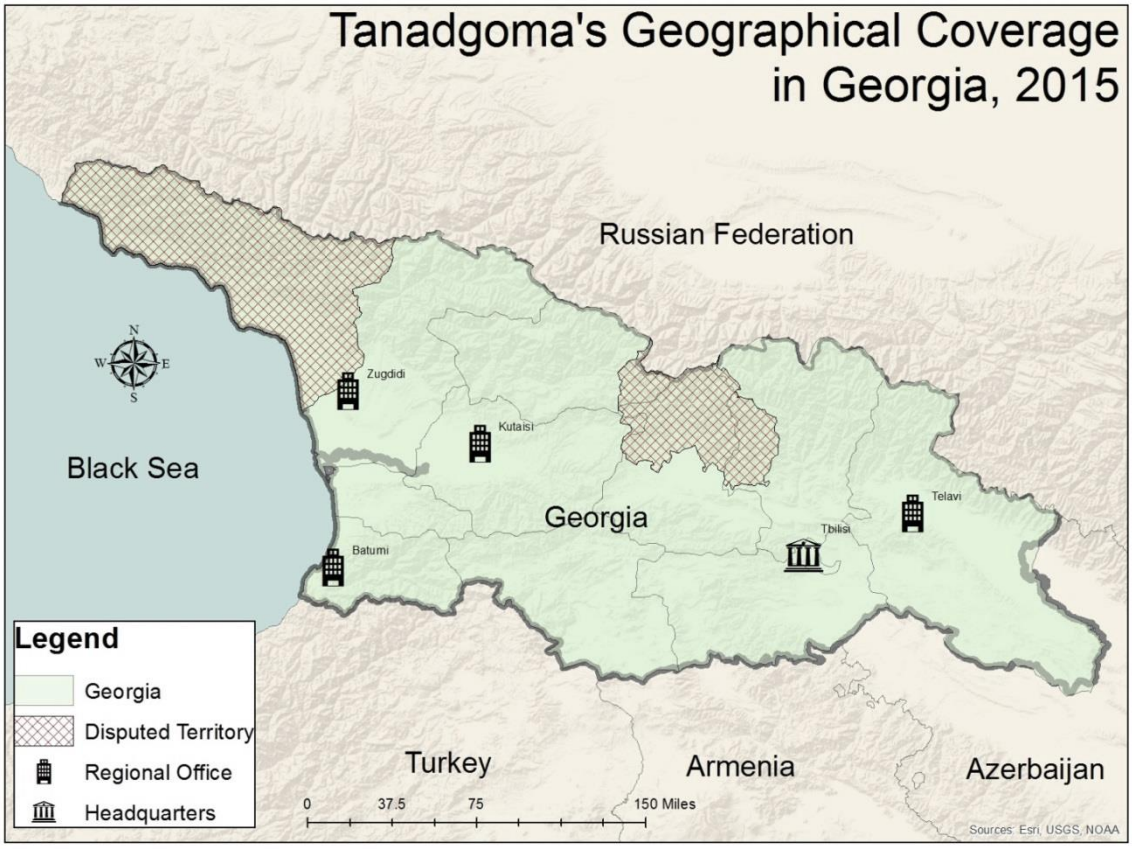
Tanadgoma was created in October of 2000 on the foundation of a preexisting Informational-Counseling Center established by the international humanitarian organization *Medecins Sans* Frontieres (MSF) in 1998.[13] The MSF Center's primary objective during the organization's tenure in Georgia was to improve access to reproductive health information in order to combat reproductive health issues facing the Tbilisi population.[13]

Before completing its mission in 2000, MSF accepted a proposal to turn the MSF Center into a local non-governmental organization called 'Tanadgoma' meaning support in the Georgian language.[13] Tanadgoma's original mission was to ensure the sustainability of ongoing MSF Center

projects while broadening its activities.[13] Tanadgoma took over from MSF on October 16, 2000, and since then, it has continued the programs and activities of the MSF Center while becoming a pillar of Georgia's HIV/AIDS NGO community.

The current mission of Tanadgoma is to improve the physical and mental health of Georgia's vulnerable populations through the implementation of prevention, education, diagnostic, and rehabilitation programs while also advocating for the need of such programs to exist.[13] Tanadgoma also provides technical support and expertise to improve the capacities of relevant organizations, communities, and stakeholders. The organization currently depends on GFATM funding for roughly 60% of its HIV prevention programming budget and herein lies the problem.

Figure 3. Geographical coverage of Tanadgoma operations, 2015.[14]



2.6. Problem Statement

HIV/AIDS continues to be an issue within Georgia and neighboring, high-prevalence countries such as Russia and Ukraine. High-risk, vulnerable populations such as men who have sex with men (MSM), female sex workers (FSW), and people who inject drugs (PWIDs) have been the steady drivers of Georgia's HIV epidemic.[5, 6, 7]

Local non-governmental organizations (NGOs) play a vital role in Georgia's HIV prevention strategies.[5, 6] Only one organization is currently serving the country's MSM and FSW high-risk populations with direct health intervention services – the NGO, Tanadgoma. While other organizations advocate policy change and recognition of these high-risk groups, they do not offer direct health service interventions like Tanadgoma.

A strategic shift has taken place with the GFATM, and, consequently, within the GoG regarding funding sources for HIV/AIDS services and interventions. Due to this strategic shift, competition is now intense amongst Georgian HIV/AIDS NGOs to finance their respective operations during a final round of GFATM funding scheduled to take place in April of 2015.

2.7. Purpose Statements

The purpose of the report, requested by the organization Tanadgoma, is to inform the national HIV policy dialog currently taking place in Georgia while effectively advocating on behalf of the organization. The content of this report is based upon key informant interviews, literature reviews, secondary data sources including financial records, as well as informal and formal surveys.

The objectives of the report are:

> Objective 1: To inform the reader and the key players involved in the national HIV policy dialog currently taking place in Georgia.

Objective 2: To provide a situational analysis of Tanadgoma, including a competitor analysis of HIV/AIDS focused NGOs operating in Georgia, and, more specifically, those working directly with Georgia's high-risk populations.

Objective 3: To provide a situational analysis of Georgia's HIV epidemic including information on its vulnerable high-risk populations, a funding analysis, and a climate (economic, socio-cultural, political) analysis.

Objective 4: To provide recommendations in moving forward for both Tanadgoma and the GoG's national HIV response.

By meeting these key objectives, the report will provide justification for the continuation of funding for Tanadgoma's HIV operations. The report will also highlight the work of Tanadgoma to attract additional funding sources at both the national and international level.

Correspondingly, the purpose of the SSP is to detail the development of the above report for the organization Tanadgoma while also providing a more comprehensive background of the ongoing funding situation. The SSP will seek to accomplish this by a critical review of relevant literature, the methods used in the development of the report, the report and project results, and the conclusion of the entire project. It was deemed necessary to split the report from the SSP because the two documents have different target audiences and due to the use of sensitive organizational data which the organization did not want to be made public. The content of this SSP is also based upon firsthand observation, literature reviews, secondary data sources, and formal and informal surveys.

The SSP has the following objectives:

Objective 1: To inform the reader, particularly those unfamiliar with the subject matter, about the national HIV policy dialog currently underway in Georgia.

Objective 2: To provide a comprehensive understanding of the methods used to develop the requested report for Tanadgoma, including those used in the development of the competitor analysis and client analysis.

Objective 3: To provide a comprehensive understanding of the results of the requested report.

Objective 4: To provide a discussion regarding the strengths and limitations in the development of the report.

By meeting these key objectives, the SPP presented here will provide a detailed understanding into the background, the development process, and the end result of the report requested by Tanadgoma.

2.8. List of Acronyms

AFEW	AIDS Foundation East-West
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
Bio-BSS	Behavior Surveillance Survey
Caritas	Caritas Czech Republic
CCM	Country Coordinating Mechanism
CIF	Curatio International Foundation (Curatio), local Georgian NGO
CSW	Commercial Sex Worker
EU	European Union
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
GFATM	The Global Fund to Fight AIDS, TB, and Malaria
GHPP	Georgia HIV Prevention Project
GoG	Government of Georgia
HCT	HIV Counseling and Testing
HIV	Human immunodeficiency virus
IDU	Injection Drug User
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NSPA	National Strategic Plan of Action on HIV/AIDS
PWID	People Who Inject Drugs
RFSU	*Riksförbundet för Sexuell Upplysning*, Swedish Assoc. for Sexuality Education
RTI	RTI International
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

3. Key milestones in HIV/AIDS in Georgia

To clearly understand the pivotal role Tanadgoma plays within Georgia's HIV/AIDS prevention and control landscape, the current funding changes that have taken place within the GFATM, and the ensuing dialog concerning the future of Georgia's HIV response, one must clearly understand the relevant events leading up to the present day.

Therefore, in the following section designated as this SSP's literature review, the framework used will be that of a timeline to properly illustrate the historical events relevant to HIV in Georgia and the national response over the last thirty years to set the context for the events underway in Georgia.

3.1. 1980s

After being identified due to unusual clustering of disease in New York and California, the HIV and AIDS epidemic began to take shape during the early 1980s within in the United States and abroad. The Georgian Soviet Socialist Republic (present day Georgia), while still part of the Soviet Union, was one of the first countries globally to initiative HIV surveillance in 1984.[9] Five years later the first case of HIV was identified and diagnosed in 1989, two years before the country gained independence from the Soviet Union in 1991.[9]

3.2. 1990s

After the collapse of the Soviet Union in 1991, a system-wide breakdown of the state was followed by a costly civil war in Georgia. The results of the war effectively crippled most government institutions and the national health care system. In 1995, stability returned to Georgia and government reforms began to take place, including health care system reforms and the creation of the National AIDS Treatment Program.[9] However, the country was in a dire economic position and could no longer maintain the state-funded, Semashko model health care system it had during the Soviet era.[9] In response, the GoG turned toward a market-driven health system that has gone through many permutations over the last 20 years.

In 1996, the government institutionalized another state HIV program to address the newly-emerging pandemic. Known as the Governmental Commission on HIV/AIDS and Socially Dangerous Diseases, or "The Commission,"[11] this entity would serve as Georgia's national HIV response coordination structure until 2003 when it was then converted into GFATM's Country Coordination Mechanism (CCM).[9]

In 1997, Georgia began its Blood Safety Program requiring mandatory screening of blood donors for syphilis, HIV, and hepatitis B and C, eventually reaching 100% of all blood donors in the country.[9, 15]

In 1998, the MSF Center, or the Informational-Counseling Center, was established by the international humanitarian organization MSF in Tbilisi, Georgia. The MSF Center was the precursor of Tanadgoma.

In 1999, Georgia had a cumulative number of 128 reported HIV/AIDS cases.[9] Roughly 70% of these reported cases were attributable to people who inject drugs (PWIDs).[9] This mode of transmission was the primary cause of new infections for the next decade.[7]

Information on Georgia's other populations at high-risk for HIV, such as MSM, FSW, and prisoners, were not readily available at this time and what little information was known was suspected of being drastically underreported by USAID.[16]

3.3. 2000s

In September 2000, representatives and leaders from 189 countries gathered in New York to adopt the United Nations Millennium Declaration.[17] This UN Millennium Declaration and its objectives would later become known as the Millennium Development Goals (MDGs). These 8 goals had various targets including the reduction of global poverty by half, reducing maternal mortality by three-quarters, achieving universal primary schooling, and halting and then reversing the spread of HIV by 2010 and 2015 respectfully.[17] MDG number six, the Millennium

Development Goal focused on HIV/AIDS, also had a secondary objective: to achieve universal access to antiretroviral treatment therapy (ART) for those living with HIV/AIDS by 2010.[18] These goals were incredibly ambitious and to achieve these objectives by their allotted deadlines required the mobilization of health and development resources on a global scale not previously seen.

In response to this rapid mobilization of resources and funding, several large-scale global health initiatives (GHIs) were developed. GHIs are organizations that involve the private sector, philanthropic trusts, and civil society to develop a public-private partnership focusing on a small number of fatal diseases such as TB, Malaria or HIV.[16,19] Focus is given to a limited number of diseases that disproportionally burden the health care systems of low and middle-income countries.[19] By alleviating the burden of a few select diseases, GHIs aim to free up resources within the recipient health care system for capacity building and health system strengthening. Ideally, the recipient country will eventually take ownership of a GHI's health intervention(s) targeting specific diseases within the country and sustainability will be achieved. This practice of allocating funds, from large-scale GHIs, for disease-specific control and prevention projects is known as vertical funding. In comparison, a horizontally funded approach seeks to strengthen the recipient country's health care system as a whole.

Vertical funding practices by large-scale health initiatives are not a new occurrence in global health. Such practices have been in existence and argued over since the advent of global health. Disease-specific immunization and eradication campaigns are seminal examples of the vertical approach. However, due to the creation of the MDGs, nearly 100 GHIs were developed to capitalize on the seemingly unlimited resources newly available and this, in turn, revived debates about the effects of vertical funding on recipient health care systems.[16]

In October 2000, The Center for Information and Counseling on Reproductive Health, Tanadgoma, became an official NGO in Tbilisi, Georgia.[13] As was mentioned before, Tanadgoma was founded upon the basis of the MSF Center in Tbilisi.[13] This counseling center focused on

reproductive health and was established by the humanitarian organization "Medecins Sans Frontieres" (MSF), in 1998.[13] Nearing the end of its mission at the start of 2000, MSF agreed to turn the center over to Tanadgoma to maintain ongoing projects. Chief among these projects was the newly implemented Female Sex Worker Outreach Project which aimed to promote healthy lifestyles, safe sex, and contraception to sex workers.[7]

In January 2002, one of the largest of GHIs in terms of funding size and global reach of operations was formed, The Global Fund to Fight AIDS, TB, and Malaria (GFATM). After its foundation in 2002, GFATM went on to become the world's largest financier of HIV/AIDS, TB, and Malaria health intervention programs by approving the funding for 22.9 billion USD in support worldwide over the next decade.[20] Due to its large scope of operations, GFATM immediately became one of the primary GHIs mentioned during vertical funding debates.

In 2003, to address growing concerns about the effects of large-scale GHIs on recipient health care systems, and, in particular the effects of GFATM funding, international organizations and varying task forces were developed to investigate the operation of the GHIs and to assess the implications of their dominance in the global health space. In the meantime, GFATM began its operations in Georgia with one of its first acts being the conversion of the previously mentioned, "Commission," into the Country Coordination Mechanism (CCM) for GFATM funding.[11, 16] This newly formed CCM was the primary HIV/AIDS national coordination structure for Georgia's response to the disease for the following decade.

The original GFATM CCM structure had 46 members in total, with several ministries being represented by multiple members and was seen as ineffective due to its size and inability to discuss technical matters.[11, 16] But, before changes could be made to the CCM body to address these issues, a seismic change took place within the government.

At the end of 2003, the 'Rose Revolution' took place in Georgia ousting President Shevardnadze. Georgia's economic problems, as well as growing discontent with the

government due to political and police corruption, were seen as a few of the contributing factors leading to this bloodless revolution.

In January 2004, President Mikael Saakashvili was elected to office following the previous events of the revolution. President Saakashvili promised reform to counter rampant corruption within the government and a zero-tolerance stance towards drugs. These promises would later translate to President Saakashvili implementing new drug policies resulting in harsher sentencing guidelines and increased imprisonment of drug users.[21] Later, these harsh sentencing guidelines would become abhorred by the international community as a violation of human rights due to lengthy sentencing practices (7 years minimum) and the dire conditions of the Georgian prison system.[21] These strict penalties for drug users, more specifically people who inject drugs (PWIDs), would also make it more difficult for NGOs to implement interventions such as syringe exchanges for fear of government reprisal in the coming years.[21]

After the changing of government, GFATM – Georgia revived its operations and the following actions took place relevant to GFATM funding: GFATM funding enabled the GoG to begin universal access to ART for all patients in need, an achievement only Georgia was able to reach and maintain out of all other Eastern European countries; and, a GFATM funding study was implemented to examine the effects of the GFATM on Georgia's health care system development.[6, 7, 16]

In the initial stages of the GFATM funding study, a baseline survey was conducted at the national and sub-national level to examine CCM functionality, local NGOs relevant to GFATM activities, healthcare providers, and the policy environment.[16, 22] Initial results of the baseline survey indicated that those involved with the CCM process believed it to be too large, unmanageable, ineffective, and with little representation from the private sector.[11]

To alleviate this initial problem, the CCM installed the First Lady of Georgia, Ms. Sandra Roelofs as its Chairperson. Once Ms. Roelofs became the Chairperson of the CCM, a number of changes

were immediately made to the CCM body, including the reduction of representatives from 46 to 30 in order to improve efficiency and functionality.[11]

In the meantime, the Georgian GFATM funding study to examine the effects of GFATM on Georgia's health care system development continued until 2007 and the results of studies examining GFATM's effects elsewhere were also beginning to be published.

In 2005, a number of reports examining the effects of GHIs and GFATM vertical funding became available. As mentioned earlier, the development of the MDGs and the subsequent GHIs to cater to these goals had revived debates about the effects of vertical funding on recipient health care systems. During the first years of the new millennium, a number of studies were conducted to examine these effects and to address these growing concerns. These reports and studies would later become incorporated into Georgia's ongoing GFATM funding study scheduled to end in 2007.

Syntheses of these prior reports illustrated a number of the problems found globally with GHIs and GFATM funding practices including lack of donor harmonization, lack of coordination and planning, multiple funding channels, and an inability to absorb or distribute funds.[22] But, it was at the national policy implementation level that most of the negative effects were overwhelmingly felt due to the development of varying coordinating bodies operating parallel to, or in competition with, the pre-existing national HIV responses.[22] However, as each country's interaction with GHIs and GFATM was situationally different, the GoG and its GFATM CCM were prepared to wait for the results of their own study before making any changes to the funding procedures.

In the meantime, the strengthening of the existing national response to HIV was underway with GFATM funding a large-scale project aimed at implementing effective prevention, control, and treatment of the disease. Tanadgoma was selected along with the GoG's Infectious Diseases, AIDS and Clinical Immunology National Research Center and Institute of Dermatology and

Venereology to initiate prevention interventions against STIs and HIV/AIDS for vulnerable, high-risk populations.[23]

In 2007, Georgia's study examining the effects of GFATM funding on its national health care system concluded. The final results, published by Curatio International Foundation, indicated that there appeared to be little evidence of harm caused by GFATM's vertical funding practices on Georgia's health care system since the baseline survey.[16] The report noted that there was even an improvement in regards to the coordination and decision-making processes due to the appointment of the First Lady of Georgia as the CCM's Chairperson.[11, 16]

However, the study did acknowledge that funds received by GFATM did little to improve the overall quality or general access to care within Georgia's health care system.[16] The report findings also showed a drop in government spending and commitment towards HIV/AIDS prevention and control interventions.[2, 16] This decline in government funded prevention interventions indicated a possible dependency on GFATM financing beginning to take shape, if not already in place, according to Curatio.[7, 16]

The study results concluded by comparing the problems found globally in similar studies from 2005 and beyond to those found in Georgia. In these studies, the influx of resources from GFATM were burdening the national recipient health care systems.[16] The Curatio report found that Georgia did not share in this problem due to a surplus of health care providers and an ability to absorb resource influxes.[13] Another important point expressed in this study, and one often found in the reports of outside health observers, was the importance of local HIV NGOs to Georgia's national response.[5, 7, 16] The report specifically stated that, "NGO(s) are the principal agencies to work with high-risk groups (People Who Inject Drugs, Commercial Sex Workers, Men Who Have Sex with Men) who are not reached by government services." [19]

Due to a lack of evidence involving specific negative effects of GFATM vertical funding, GFATM – Georgia and the GoG continued to operate the same way for an additional six years.

In 2009, Spicer et al. published a study that synthesized previous national and subnational studies examining the effects of GHIs and GFATM on health care systems, including Georgia's results.[11] While the authors did agree with the previous analysis of Georgia's CCM membership being too large in the beginning and the beneficial role the First Lady of Georgia had played as the Chairperson of the CCM, they disagreed that there was a lack of evidence regarding the negative impact of GFATM funding on the local health care system.[11]

The Spicer et al. study found that in Georgia, Kyrgyzstan, and Ukraine there had been a rapid development and specialization of care in areas concerning HIV and not in other areas of these countries' health care systems, thus leading to 'siloed' care and an inability to interact between departments.[10] These findings were similar to those found in other major study reports such as the Biesma et al. (2009) study, which questioned the overall benefits and long-term sustainability of GHIs such as GFATM.[11, 22]

3.4. 2010s

January 2010 began with 2,236 HIV cases registered in Georgia with most of these cases occurring in people between the ages of twenty five and forty-five.[15]

By 2011, the GoG had developed its national strategic plan for HIV, 2011 – 2016. This national strategic plan for the coming years emphasized enhanced national coordination and advocacy while improving upon preventative treatment interventions including access to ART therapies.[4] These scheduled improvements to the Georgian response would be made possible due to GFATM funding and GFATM funded activities.

However, changes also began to take shape in 2011 within GFATM's previous funding model. In response to a decade of funding frustrations, criticism about the negative effects of such funding styles, and a drop in overall global funding resources available, the GFATM developed a New Funding Model (NFM) as part of its own GFATM 2012 – 2016 Strategy.[24] The organization's

rationale for the change was to make the GFATM funding process simpler while better aligning the country specific GFATM missions with their recipient country's health priorities and doing more with less funding.[24]

In October 2012, elections were held in Georgia, and President Saakashvili was ousted by the opposition leader Giorgi Margvelashvili. Later, in November, the NFM developed by GFATM was approved by the organization's board to begin taking shape in 2013. The NFM's primary objective, as briefly mentioned above, was to get the most value for both the recipient country and the donor due to an overall reduction in funding resources now available to GHIs and the GFATM.[24] In other words, the new mandate from the GFATM was to direct or push resources to those countries in most dire need, countries with the highest disease burden and the lowest ability to pay.[24] As a result of this NFM, Georgia, as well as other Eastern European and Central Asian countries, would now be considered the lowest-priority for GFATM funding due to their middle-income World Bank ranking.[24] This low-priority ranking and the subsequent changes in funding available for the coming years was, and continues to be, concerning since Georgia and other Eastern European and Central Asian countries remain one the few areas globally where the incidence of HIV is rising.[2, 7, 24]

In 2013, President Margvelashvili was inaugurated. Afterward, the former First Lady of Georgia, Ms. Roelofs was forced to resign as the Chairperson of the CCM, followed by various other ministers and cabinet members within government agencies, effectively creating a new CCM. In the absence of a Chairperson, the Minister of Health directed the CCM while in this transitional period during which GFATM's NFM began to come into effect in Georgia. [25]

In response to the NFM changes, a Georgian-based NGO known as the Georgia Union of People Living with HIV launched an online petition to inform, raise awareness, and develop support concerning the predicted funding vacuum that could take place due to the NFM.[23] This campaign was primarily concerned about the rising HIV prevalence in Georgia and the region, as well as the prevention and harm reduction organizations targeting vulnerable high-risk

populations dependent on GFATM funding; those pivotal to the Georgian response.[2, 7, 26]
As of 2014, the Global Fund to Fight AIDS, TB, and Malaria has distributed $57,738,873 for HIV/AIDS interventions to Georgia.[5] And, in March of 2014, an additional 33.9 million USD was earmarked for Georgia under the NFM to continue supporting these interventions while GFATM attempts to phase out its funding role in Georgia by 2016.[25]

In May 2014, Georgia's National Center for Disease Control and Public Health (NCDC) became the new Principal Recipient of all GFATM funding. This means that all GFATM funding will now flow through the state, something that many local NGOs are concerned about.[25] In June 2014, Georgia's CCM voted in a new Chairperson to fill the vacant spot left by the resignation of First Lady Roelofs. David Sergeenko, who is currently the Minister of the Ministry of Health, Labour and Social Affairs, became the CCM chairperson. [27]

Following the appointment of David Sergeenko as the new CCM Chairperson, several formal concerns were voiced regarding the Minister's conflict of interest. These concerns are due to the NCDC being a government agency currently operating under the Ministry of Health, Labour and Social Affairs and therefore already under David Sergeenko's jurisdiction.[27]
As 2014 ended, the CCM began planning to rectify this conflict of interest while taking steps towards developing its final NFM HIV concept note due by April, 2015, to GFATM.[27] A series of forums were also scheduled to take place beginning in mid-January of 2015. These forums will be used to aid in the development of the final concept note by allowing relevant NGOs, community stakeholders, and GoG ministry representatives an opportunity to consult on the process.

Presently, in 2015, Georgia is preparing to submit its GFATM HIV concept on the 20th of April. Since January, a number of forums have taken place organized by the CCM that have included the Principal Recipient, NCDC, previous GFATM funding sub-recipients such as Tanadgoma and Curatio International, and a number of other local NGOs and stakeholders.[28] As was mentioned earlier, the goal of these forums was to allow for the opportunity to consult on the concept

development process.[28] The first of several forums took place on January 25 and featured a two panel discussion involving local NGOs (including Tanadgoma), people living with HIV/AIDS, the NCDC, and CCM representatives.[28] And, as the deadline for GFATM's NFM HIV concept note approaches, Georgia is still engaged in this process. Therefore, the objective of Tanadgoma's report is to inform this current HIV policy dialog taking place while advocating on behalf of the organization during this last round of GFATM funding.

4. Methods

The following chapter describes the methods and processes used in the development of the situation analysis report for the organization Tanadgoma. Both the development processes and the report were informed by relevant literature including organizational records and national surveys, government policy documents concerning HIV, and selected global health initiative country reports.

4.1. Motivation for the Report

The request for a situation analysis report came from the administration of Tanadgoma and its community stakeholders. The rationale for the request was motivated by the anticipated significant changes in funding patterns, the subsequent elevated level of competition amongst relevant NGOs for the remaining GFATM funds, and the need to seek out and secure other modes of funding so as to not be solely reliant on one particular funding source. The aims and objectives of the report were developed in concert with the executive director of Tanadgoma before the investigator left Georgia in August 2014. Because the funding environment is fluid, there was concern that it might be difficult for the investigator to keep abreast of key events from the U.S. To alleviate this concern, the executive director of Tanadgoma pledged to continue to provide support and input.

4.2. Data Collection

Mixed methods research and data collection were used to create both the report requested by Tanadgoma (Appendix A) and this SSP.

The methods that were used for both include:

Firsthand Observational Experience – During the summer of 2014, the investigator for this SSP and the subsequent report was allowed to participate in a variety of health intervention activities including HIV outreach, prevention interventions and population size estimations of vulnerable populations. During this time, the investigator was able to observe Tanadgoma's place within the Georgian HIV NGO landscape during multiple community stakeholder meetings and international conferences on HIV/AIDS in Georgia including the *US-Georgia* Program-Development *Workshop on HIV*/AIDS, *Tuberculosis* (*TB*) and *Hepatitis; and, USAID/RTI International's Georgia HIV Prevention Project – End of Project Conference*.

Client Satisfaction Survey – The investigator developed and implemented a client satisfaction convenience survey in order to assess current staff performances as well as to gauge client levels of satisfaction with current services in June 2014. Over a period of two weeks, 240 unique clients were given a ten-question survey completed at Tanadgoma offices and during Tanadgoma outreach activities. (See Appendix B for an example of the survey instrument used.)

MSM and FSW Size Estimation Surveys – During the summer of 2014, two separate population size estimation surveys were conducted in both Batumi and Tbilisi to estimate the sizes of Georgia's MSM and FSW population sizes. These studies each used a variety of different size estimation methods and triangulation in order to obtain the most plausible population estimates in Georgia. The investigator, during the implementation of these surveys, was able to assist in various methods used by the organizations Tanadgoma and Curatio International including: mapping and census exercises during daytime and nighttime outreach, capture-recapture methodology, and the implementation of a relatively new size estimation methodology known as the

Dombrowki method, which is a modified capture-recapture method based on network sampling.

Georgian NGO Comparison Survey – The investigator developed and implemented an online English and Georgian language survey directed towards Georgian NGOs focusing on HIV/AIDS that had received, or were currently receiving, GFATM funding in the last year. Over a period of three weeks in December 2014, NGOs matching the above criteria were asked to participate by filling out a fourteen-question online survey regarding the size and scope of their organizations HIV/AIDS programming and activities.

Literature Reviews – An extensive review of all relevant literature was conducted in order to develop an adequate foundation and understanding of the current situation pertaining to HIV/AIDS in Georgia and neighboring countries; current treatment, prevention, and control programs; relevant international and domestic actors and organizations both past and present; the GoG response over the last three decades; the history of Tanadgoma as well as current activities and the organization's targeted populations; and the role the GFATM has played in Georgia's HIV/AIDS response. The most up-to-date information available was used in order to develop a report as current and relevant as possible with the understanding that though the target audience might be familiar with the subject matter, they will most likely not be familiar with the latest figures (e.g. MSM and FSW population size estimation figures from the above mentioned surveys).

Informal Consultations – During the development of this report for Tanadgoma, the investigator was able to consult with persons directly involved with the ongoing changes and happenings taking place in Georgia relevant to the final round of GFATM funding.

Correspondence between the investigator and the organization Tanadgoma regarding the most recent developments and processes relevant to GFATM funding and the organization were also vital to both the development of the report and this SSP.

4.3. Target Audience for the Report and Project

The intended audience for Tanadgoma's report is the leadership of Tanadgoma and its primary partners. The intended secondary audience includes any persons or organizations Tanadgoma deems essential to the GFATM funding process or that would benefit from a better understanding of the organization. The intended tertiary audiences for this report are future partners or donors selected by the organization to receive this report as a marketing tool in order to develop new funding streams.

4.4. Situation Analysis Report

A 5C analysis was used as the analytical framework for the Tanadgoma report.[29] The objective of this type of analysis is to illustrate the internal and external factors affecting Tanadgoma and by extension the national HIV situation in Georgia.

The 5Cs of the analysis framework are:

Company Analysis. A company analysis was conducted using Tanadgoma's organizational records and financial data to demonstrate the strengths and weaknesses of the organization. These same data sources also allowed for a funding analysis to be conducted of the company.

Client Analysis. A Tanadgoma client analysis was conducted using the organization's latest client records. These records were able to demonstrate the total number of unique clients per each high-risk population currently served by the organization. Also, a previous assessment conducted by Tanadgoma was analyzed. This client assessment, conducted by Tanadgoma in 2014, examined the overall client satisfaction levels with the organization's health services and therefore was relevant to this client analysis.

Competitor Analysis. An assessment of local Georgian NGOs working specifically with HIV/AIDS was conducted using a Georgian and English Language NGO survey to examine HIV intervention programming, programming funding, and high-risk populations served. The assessment was developed with the use of an online survey tool in both English and Georgian. NGOs were selected to participate in the survey if they had received or were currently receiving GFATM funding for HIV/AIDS programming. A copy of the survey instrument can be found in Appendix B.

This type of sampling technique was also necessary due to the sensitive focus of the survey, organizational and programming budgets regarding HIV interventions. In Georgia, detailed financial records are not commonly kept by Georgian NGOs working with HIV/AIDS or any other disease. Also, what financial and budgetary records that are kept are not often shared with persons outside of the organization. The survey sample was by necessity a convenience sample.

The survey asked a series of questions in order to gauge the size of the respondent's NGO operations, organizational size, budget, interventions offered, and their target populations. The resulting data was then used to develop a competitor analysis of HIV NGOs operating in the Republic of Georgia.

Collaborators Analysis. A future collaborators analysis was planned to identify relevant organizations for partnerships with Tanadgoma moving forward. However, due to Tanadgoma's unique position within the Georgian NGO landscape, the high level of dependence these NGOs share on international donor funding, the very personal nature of NGOs operating within Tbilisi, and the uncertainty of the current changes underway, it was decided to strike this portion of the analysis so as to not offend current or future collaborators.

Climate Analysis. Within this section, a brief breakdown of the current economic situation facing Georgia is presented. This analysis should be used to inform the reader about the economic environment in which Tanadgoma operates and the HIV policy changes taking place. The second part of this climate analysis is an observation of the current socio-cultural and political environments in regards to HIV, high-risk populations, and HIV policy. This analysis draws upon current events, policy changes, firsthand observational data, and newspaper articles published in the last few years relevant to this situation.

These 5Cs are all presented within the context of Georgia's current epidemiologic situation concerning HIV.

To develop this epidemiologic context, a separate analysis was developed using a variety of studies and reports prepared by organizations such as Curatio International Foundation, Tanadgoma, the GoG's NCDC, USAID, and RTI International. The goal of this section is to inform the reader about HIV/AIDS in Georgia by using the most up-to-date data available. Various prevalence estimations are presented from differing populations as well as information on the latest population size estimations of two high-risk population groups. Also, a funding analysis is presented in order to demonstrate the past, current, and future cost of HIV in Georgia.

4.5. IRB Approval

This SSP did not meet the IRB definition of research and thus did not require IRB approval.

5. Results

The following chapter describes the results of both the situation analysis report prepared for Tanadgoma and the comprehensive SSP results that could not be included within the report due to the organization's desire to keep sensitive information private.

5.1. Situation Analysis Report Results

A preliminary report was submitted to Tanadgoma so that staff, along with interested and vested community partners, could confirm the accuracy and cultural appropriateness of the report's findings. During this time data determined to be private or seen as too self-praising were removed. Also, because of the close personal environment in which Georgian NGOs operate, it was deemed prudent to not isolate or alienate Tanadgoma, or any other organization, during the competitor and collaborator assessments for fear of future reprisal.

The report also purposely remains broad in regards to GFATM funding in order to not limit the scope of its future use by Tanadgoma. During the development process of this report it became clear that Tanadgoma needs to secure another funding source in the immediate future since Georgia is set to "graduate" from the GFATM in 2016. This report, while initially commissioned to advocate on Tanadgoma's behalf during this final round of GFATM funding, can now be used as a business marketing tool to advocate on the organization's behalf to other international donors.

Finally, during the development of this report, the investigator encountered a barrier when trying to obtain detailed financial records from Tanadgoma and relevant HIV/AIDS NGOs in Georgia. It is the investigator's understanding that such records are not commonly kept by Georgian NGOs as was previously identified by Curatio International in 2008.[8] The limited financial records that were obtained were considered to be sensitive information by these NGOs and therefore not suitable for publication.

Despite these drawbacks, the finalized report was submitted to Tanadgoma on March 26, 2015. The national dialog regarding national HIV/AIDS policy for the coming year(s) is ongoing and the report will be useful for Tanadgoma in its deliberations with the HIV/AIDS community and decision makers. However, the objective of the investigator was only to write a report to inform the national HIV/AIDS policy dialog while advocating for the continued funding of the organization Tanadgoma. By completing this report, and submitting it for review, this objective

has been achieved.

5.2. SSP Results

This SSP's objective was to educate those unfamiliar with the background of HIV in Georgia, the GFATM, the GFATM's role in Georgia's HIV response, and Tanadgoma so that a better understanding can be obtained concerning the report prepared for Tanadgoma. A comprehensive discussion as to the strengths and limitations of this SSP and report follows in the next chapter.

6. Discussion

Over the next few years most Georgian NGOs focusing on HIV/AIDS will likely close their doors due to changes that have occurred and will occur regarding GFATM funding. However, a select group of NGOs are the only existing organizations that target Georgia's vulnerable, high-risk populations. HIV prevalence remains high within these populations and the expertise of the NGOs that have concentrated on these populations deserve special consideration from the GoG's NCDC, the Principal Recipient of the final GFATM funds and the organization that now controls how these funds are allocated.

By focusing on the situation of Tanadgoma the investigator sought to facilitate and inform the national dialog currently taking place regarding these issues. The investigator also strove to develop a report that can be used by the organization to inform those unfamiliar with the organization's activities, structure, and role within the Georgian national HIV response and to be used as a market tool after GFATM funding is no longer available.

6.1. Strengths

There were several strengths to this SPP and the report but most notable is the collaboration and support received from Tanadgoma, its stakeholders, and individuals dedicated to the improvement of Georgia's public health.

A secondary strength of this project is the utilization of the most up-to-date data available to Tanadgoma in order to advocate on its behalf. The end results, it is hoped, will benefit Georgia's high-risk, vulnerable populations that are served by the organization. Ideally, not only will Tanadgoma's services continue to be funded in the coming final round of GFATM funding, but additional resources, along with targeted interventions, will be developed due to the awareness raised by this report.

6.2. Limitations

There are a variety of limiting factors and unknowns applicable to this project, including the fact that the report mostly focused on two out of several of the high-risk, vulnerable populations identified. This is due, in part, to the volume of information available concerning HIV/AIDS in Georgia and also due to the scope of Tanadgoma's operations. Also, the data available on these vulnerable, high-risk populations is often limited as was seen here in the SSP's results chapter regarding MSM and FSW population size. Nevertheless, while Tanadgoma works with all of Georgia's vulnerable populations, the organization's health interventions for MSM and FSW are what make it unique when compared to the other organizations operating in Georgia.

An additional, and key, limiting factor was the lack of available data, and specifically the lack of detailed financial records, kept (or shared) by Tanadgoma and similar NGOs. As was mentioned above, this problem has been identified before by Curatio International in 2008.[8]

Finally, because of the funding changes literally taking place as this report was being developed, it is impossible to know exactly when and how this report will be used. Therefore, the reason this report remains a broad situation analysis of Tanadgoma, and does not narrow in on GFATM or other GoG entities, is due to a desire to remain relevant and to stay above the fast paced changes currently underway in Georgia.

6.3. Recommendations

To counter the limitations of this study, one could increase the amount of human resources available for conducting and analyzing research. An increase in human resources could also aid in the development of a subsequent report. Typically, when situation analyses are conducted, there are teams of specialists from a variety of backgrounds coming together to focus on one topic. With more persons working on this report and/or this special study project, the data presented here could have been taken in countless directions given the relevant subject matter.

Conversely, there are only a few recommendations available when dealing with the limited availability of vulnerable population(s) country data. Therefore, the overarching recommendation is to continue implementing and funding studies focused on obtaining this sensitive information.

The primary objective of this project was to aid the national dialog *currently* taking place. To wait for things to stabilize would subtract from this report's impact. However, there are certain things that could be done to ease these changes in information and direction. One purposed idea is the implementation of human resources on the ground in Georgia solely for the development of this report in order to cover the directional changes in real time and thus elimination the previous delay in the dissemination of information.

7. Conclusion

Due to the constant support of Tanadgoma, and having developed strong relationships with Tanadgoma staff during my summer practicum experience, the investigator believes this SSP and report served, and will continue to serve, a vital purpose moving forward.

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9. Appendix A

Center for Information and Counseling on

Reproductive Health – Tanadgoma

Tbilisi, Georgia

A Situation Analysis of Tanadgoma, 2015

Acknowledgements

The author's views expressed in this report do not necessarily reflect the views of Tanadgoma.

The author is thankful to Nino Tsereteli, executive director of Tanadgoma, for her technical support and guidance; David Baliashivili of the National Center for Disease Control & Public Health; and Mariam Beridze of Youth for Public Health, Georgia.

Special thanks are also extended to: Kakhaber Kepuladze, Lela Kurdgelashvili, Kakhaber Akhvlediani, Giorgi Lomidze, Ketevan Tchelidze, Khatuna Khazhomia, Vazha Kasrelishvili, Beka Gabadadze, Nino Kipiani and Koba Bitsadze – for their input into the inner workings of Tanadgoma, MSM and FSW target specific health interventions, and their overall expertise on previous as well as current Tanadgoma/GFATM funding procedures.

Contents

1. Introduction

HIV/AIDS continues to be an issue within the country of Georgia and neighboring, high-prevalence countries such as Russia and Ukraine. High-risk, vulnerable populations such as men who have sex with men (MSM), people who inject drugs (PWIDs), and female sex workers (FSW) have been the steady drivers of Georgia's HIV epidemic but, in 2011, heterosexual transmission emerged as the leading route of transmission.[1]

Local non-governmental organizations (NGOs), like Tanadgoma, play a vital role in Georgia's HIV prevention strategies.[1,2] Recently a fundamental shift has taken place in Georgia regarding funding sources for HIV/AIDS services and interventions. Due to this shift in funding on the part of the Global Fund to Fight AIDS, TB, and Malaria (GFATM), the competition is intense amongst Georgian HIV/AIDS NGOs to maintain and increase funding for their HIV/AIDS operations. The purpose of this report is not only to inform and encourage policy dialog regarding HIV/AIDS in Georgia, particularly from the perspective on civil society, but also to advocate on behalf of the Center for Information and Counseling on Reproductive Health – Tanadgoma.

This report is based on analyses of national surveys, selected global health initiatives' country and region-specific reports; Tanadgoma organizational records and reports; and Government of Georgia (GoG) HIV/AIDS policy documents.

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2. Tanadgoma

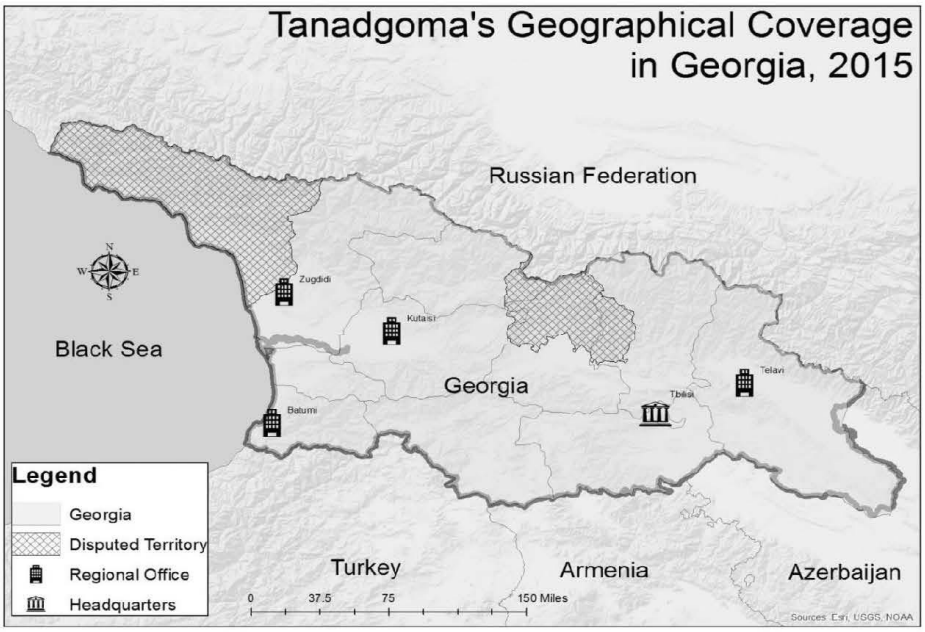
Tanadgoma is a non-profit organization that performs its activities according to the Georgian Constitution and Georgian Civil Code with its headquarters located in Tbilisi, Georgia.

2.1. Brief History of Tanadgoma

Tanadgoma was created in October of 2000 on the foundation of a preexisting Informational-Counseling Center established by the international humanitarian organization *Medecins Sans* Frontieres (MSF) in 1998.[13] The MSF Center's primary objective during the organization's tenure in Georgia was to improve access to reproductive health information in order to combat reproductive health issues facing the Tbilisi population.[13]

Before completing its mission in 2000, MSF accepted a proposal to turn the MSF Center into a local non-governmental organization called 'Tanadgoma' meaning support in the Georgian language.[13] Tanadgoma's original mission was to ensure the sustainability of ongoing MSF Center projects while broadening its activities.[13] Tanadgoma took over from MSF on October 16, 2000, and since then, it has continued the programs and activities of the MSF Center while becoming a pillar of Georgia's HIV/AIDS NGO community.

Figure 1. Geographical coverage of Tanadgoma operations, 2015.[3]



2.2. Vision and Mission

The current mission of Tanadgoma is to improve the physical and mental health of Georgia's vulnerable populations through the implementation of prevention, education, diagnostic, and rehabilitation programs while also advocating for the need of such programs to exist. Tanadgoma also provides technical support and expertise to improve the capacities of relevant organizations, communities, and stakeholders.

[3] *Georgia and Neighboring Countries*. Scale: 1:3,000,000. In: Parks, David. "A Situation Analysis of the Center for Information and Counseling on Reproductive Health in Tbilisi, Georgia, as a Response to GFATM's New Funding Model: A Special Studies Project." SSP, Emory University, April 20, 2015, Figure 1.

3. HIV/AIDS Epidemiologic Context

For more than a decade, Georgia has been classified as having a low prevalence of HIV/AIDS but at high-risk of an epidemic.[1,2] The rationale for this classification of high epidemic risk can be attributed to Georgia's geographic position near high-prevalence countries such as Russia and Ukraine; the presence of high-risk, hard-to-reach populations such as people who inject drugs (PWIDs), female sex workers (FSWs), and men who have sex with men (MSM); and large migrant populations including commercial sex workers (CSWs).[2,4]

The estimated prevalence of HIV in Georgia is roughly 0.07% amongst the general adult population according to the GoG and USAID.[2,4] As of December, 2014, there were 4,646 cases of HIV infection registered in the country by Georgia's Infectious Diseases, AIDS, and Clinical Immunology Research Center; however, both the GoG and USAID agree that the estimated total amount of persons living with HIV to be much higher.[2,5]

Injection drug use in Georgia was rampant from the fall of the Soviet Union in 1991 until the early 2000s. Nearly 70% of all reported cases of HIV/AIDS during the first decade of Georgia's HIV epidemic were among PWIDs.[6] This mode of transmission would remain the primary cause of new infections until 2011.

In 2011, PWIDs were no longer the primary driver of Georgia's HIV epidemic and, according to the GoG and USAID, heterosexual transmission of HIV is now the leading route of new infections.[2,4] The latest HIV/AIDS Country Progress Report by the government states, "The share of drug use, as a transmission mode among newly registered HIV cases has decreased to 43.2 % in 2012, and 35% in 2013 while heterosexual transmission has increased up to 44.8% in 2012

[4] USAID. (2014). Georgia HIV Prevention Project: Challenges, Opportunities, and Recommended Actions. Policy Brief. Retrieved from http://bemonidrug.org.ge/wp-content/uploads/2014/07/GHPP_-Policy-Brief_-July-2014.pdf

[5] Infectious Diseases, AIDS, and Clinical Immunology Research Center (Dr. Otar Chokoshvili, National HIV/AIDS Database Manager). HIV Data. Retrieved from http://aidscenter.ge/epidsituation_eng.html

[6] Tkeshelashvili-Kessler A et al. Int J STD AIDS.2005 Jan; 16(1):61-7. *The Emerging HIV/AIDS Epidemic in Georgia*. Retrieved from http://std.sagepub.com/content/16/1/61.long

and 49% in 2013."[4] However, the prevalence of HIV in other vulnerable high-risk populations remained, and continues to remain, high.

MSM in Georgia is a high-risk population with a reported HIV prevalence of 13% according to Georgia's national HIV surveillance system in 2012.[1] And, FSWs in 2014 reported an HIV prevalence of 0.6% in Tbilisi and 0.8% in Batumi.[1,4,7]

3.1. Men Who Have Sex with Men

Homosexuality is not a crime in Georgia; however, it is not socially acceptable thus causing high levels of disgrace, discrimination, and a very real risk of violent repercussions for being associated with homosexual behavior. As a result, this stigmatized group is difficult to identify in order to obtain accurate population size estimates.

Nevertheless, one GFATM MSM size estimation survey was completed by Curatio International Foundation and Tanadgoma during the summer of 2014 in Tbilisi and Batumi.[8] This population size estimation survey found, when taking into account certain assumptions about the general population, that they could extrapolate their findings from these two cities to the remainder of Georgia's population. Therefore, the survey results estimate that there are approximately 17,200 MSM in Georgia, with a range between 11,700 and 27,600. This translates to roughly 1.32% (0.89-2.11) of the adult male population in Georgia.[8] However, more population size estimation data is still needed in order to triangulate multiple size estimations for a more accurate result.

3.2. Female Sex Workers

A FSW population size estimation survey also took place in the summer of 2014. This survey

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[7] Curatio International Foundation, Center for Information and Counseling on Reproductive Health—Tanadgoma. (2014). HIV risk and prevention behaviors among Female Sex Workers in two cities of Georgia. Bio-behavioral surveillance survey in Tbilisi and Batumi. Study Report. Tbilisi: CIF & Tanadgoma.

[8] Curatio International Foundation, Center for Information and Counseling on Reproductive Health—Tanadgoma: *Population Size Estimation of Men Who Have Sex With Men in Georgia, 2014*. (August, 2014). Study Report. Retrieved from http://www.curatiofoundation.org/uploads/other/0/255.pdf

was again funded by GFATM and implemented by Curatio International and Tanadgoma. The study estimates that the prevalence of FSW in Tbilisi at 1.03% (0.99-1.07) and 2.42% (2.36-2.53) in Batumi.[9] Thus, there are approximately 3,910 (3,758-4,062) FSW currently working within the capital Tbilisi and 1,001 (976-1,046) FSW working in the port city of Batumi.[9]

Again, this population size estimation survey found, when taking into account certain assumptions about the general population, that they could extrapolate their findings from Georgia's key cities to the remainder of the population. The survey estimates that there are approximately 6,525 FSW living and working in Georgia, with a total population no smaller than 6,286 and no larger than 6,785.[9]

Regional recommendations provided by UNAIDS indicate that these estimates are within range for the region though the study does note that these estimates represent "all types of FSWs" and therefore were not limited to street and facility-based survey methods.[9]

However, much like Georgia's MSM population, reliable information on Georgia's FSW population size is difficult to obtain, and triangulated estimates are currently not available.

3.3. Funding Analysis of HIV/AIDS in Georgia

In Georgia, the most significant organization in terms of funding size and contribution to Georgia's health care system has been The Global Fund to Fight AIDS, TB, and Malaria (GFATM). As of 2014, this global health initiative has distributed $57,738,873 for HIV/AIDS interventions in Georgia.[10] And, as of December 2014, a total of 4,646 HIV/AIDS cases were registered with Georgia's Infectious Diseases, AIDS, and Clinical Immunology Research Center since the beginning of HIV/AIDS in Georgia.[5]

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[9] Curatio International Foundation, Center for Information and Counseling on Reproductive Health—Tanadgoma: *Population Size Estimation of Female Sex Workers in Tbilisi and Batumi, Georgia 2014*. (August, 2014). Study Report. Retrieved from http://www.curatiofoundation.org/uploads/other/0/252.pdf

[10] Global Fund to Fight AIDS, TB, and Malaria – Georgia Profile. (2014). Retrieved from http://portfolio.theglobalfund.org/en/Country/Index/GEO on December, 2014.

"Historically GFATM has covered approximately half of all country expenses for HIV/AIDS (57.9% in 2012 and 47.8% in 2013)," according to USAID and RTI International.[4] This has included the entirety of universal ART cost. However, in 2013, the GFATM changed its funding model to facilitate a more horizontal approach. For Georgia's health care system, these changes started going into effect in 2014 and will be completed by 2016. As of August, 2014, USAID no longer provides funding for HIV prevention interventions in Georgia which previously totaled 5 million USD between 2010 – 2014.[2] As a result there is likely to be a significant financial gap for HIV prevention service interventions as well as possible funding gaps in the current services offered.

Currently the GoG has allocated 3.5 million Lari (GEL) towards the Georgian HIV/AIDS -- 2015 program budget, roughly 1.8 million USD.[11] The current cost of antiretroviral medication for people living with HIV/AIDS in Georgia alone is roughly 430 USD per person per year.[11] In 2013, there were 2,092 persons on ART living in Georgia (>90% coverage) costing roughly 855,628 Euros or 1.1 million USD according to 2013 exchange rates.[2,11] And, in August of 2014, there were 2,311 persons on ART living in Georgia costing roughly 993,730 Euros or 1.3 million USD according to 2014 exchange rates.[12]

Georgia is the only Eastern European country to have achieved and maintained universal antiretroviral therapy coverage. GFATM has been the principal support for ART since 2004.[2,4] Since the number of those living with HIV in Georgia has increased since 2013, and because of the shift in funding practices taking place effectively halting GFATM's funding of ART in 2016, one can see why there is growing concern and policy dialog currently underway about HIV/AIDS in Georgia.

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[11] National Center for Disease Control and Public Health (David Baliashvili, Specialist, personal communication, February, 2015).

[12] Vardiashvili, Manana. (2014). *Concern About Future of Georgian HIV Funding*. CRS Issues 749. Retrieved from https://iwpr.net/global-voices/concern-about-future-georgian-hiv-funding

4. Company Assessment

Tanadgoma periodically conducts needs assessment surveys in order to identify the health needs and demands of its current clients and target populations, with the most recent assessment taking place during the summer of 2014.

4.1. Current Programs

There are two programs currently in progress at Tanadgoma that are scheduled to continue until 2016:

1. **Sexual and Reproductive Health and Rights Program**

   Sexual and reproductive health and rights are a cornerstone of Tanadgoma programming and have been since the organization's inception. However, in the coming years, Tanadgoma plans to strengthen certain components of its ongoing program in order to create a richer and more focused effort. These components, related to sexuality education and health rights, will strike a balance between service provision and advocacy in the coming years.

   Moving forward in the coming years, the basic directions under this program will include:

   - Educating high-risk behavior groups such as sex workers, MSM, prisoners, LGBT persons, people who inject drugs, and youth most at risk on sexual and reproductive health and rights. This is done by Tanadgoma in a variety of ways including individual and group counseling, outreach, peer education, training, educational meetings, and mobilization events.
   - Educating the general population, specifically men and women of reproductive age, youth between the ages of 14-25 years of age, and the internally displaced on sexual and reproductive health and rights. The thematic areas covered will include but not limited to: family planning, prevention of abortions, sexuality, sexual and reproductive rights, HIV infection and STIs, viral hepatitis, safe sexual practices with the promotion of condom use, gender, and puberty. Tanadgoma

will also provide psychological counseling in addition to the above topics in case there are psychological problems related to the topics listed above. However, it should be noted, that the organization does practice a proactive approach when working with youth. This direction implies working with intermediate target groups such as representatives of the education and healthcare sectors, as well as parents of young people. Awareness raising and dissemination of the thematic materials among these representative groups therefore is critical to the efforts of Tanadgoma regarding its proactive youth approach.

- Preventing HIV infection, viral hepatitis, STIs amongst Georgia's general population and its high-risk behavior groups. HIV infection, STI and viral hepatitis prevention interventions are similar to those interventions mentioned above: individual and group counseling, outreach, peer education, training, educational meetings, mobilization events, etc.

2. Mental Health Program

Over the last three years, Tanadgoma has been developing and strengthening the direction of its mental health program. As a result, a psychosocial rehabilitation component has emerged that shows real promise for Tanadgoma's clients and the organization moving forward. This mental health program, and subsequent psychosocial rehabilitation component, includes the rehabilitation of women with oncological diseases, prison inmates, people who inject drugs, and people living with HIV. Descriptions of each are as follows:

- Psychosocial rehabilitation of women with oncological diseases includes the organizing and conducting of a special rehabilitation course for the women with oncological diseases of reproductive system.
- Psychosocial rehabilitation of prison inmates includes a case management approach, used by the organization, and aims at meeting the needs of the recently incarcerated.

- Psychosocial rehabilitation of people who inject drugs includes a "12 steps" rehabilitation program for drug users. Tanadgoma is the only organization to offer such a program outside of Georgian penitentiary establishments.
- Psychosocial rehabilitation of people living with HIV takes place through self-support groups for HIV positive prison inmates enabled by Tanadgoma.

Primary drug prevention is also included within this direction of Tanadgoma programming but can be found in other modules as well that target at risk youth.

4.2. Services and Methodologies

Hotline and In-person Counseling. During Tanadgoma voluntary counseling and/or testing sessions, the counselor provides health information, answers questions, and addresses attitudes and behaviors of the client regarding his or her health. The purpose of these confidential counseling sessions is to raise awareness, improve risky behavior, and enable problem-solving as well as referrals.

Outreach. Outreach, when used by Tanadgoma, is the term used to designate any activity that involves contacting target populations while providing information or services. Past projects requiring outreach implemented by Tanadgoma have targeted Georgian youth, teachers, parents, IDP, policemen, MSM, sex workers, Boarder Guards, and PWIDs. Outreach also includes counseling sessions in the schools, universities, IDP camps, police departments, streets, saunas, brothels, Boarder Guard Subdivisions, and prisons.

Arguably outreach is the most critical step in implementing effective and targeted interventions. Therefore, an important principle is to involve core group members of the targeted populations in the design and implementation of services from the start.
Tanadgoma uses the peer outreach approach while:

- Providing information to representatives of high-risk, vulnerable populations (PWIDs, Sex Workers, MSM, and the incarcerated) about STIs, HIV/AIDS, Hepatitis B and C, safe sex practices, while also carrying out VCT in the field.
- Distributing information, educational materials, lubricants, and condoms.
- Conducting outdoor counseling for representatives of different groups of populations on the following issues: STIs, HIV/AIDS, Hepatitis B and C, safe sexual relations, drug-related harm reduction, modern methods of contraception, abortion, reproductive rights, and patients' rights.

Peer Education. Peer education occurs in a variety of settings and includes many different activities. Peer education has been effectively used to organize certain high-risk groups of the population, including MSM and sex workers, to raise awareness about STIs and HIV, as well as other health issues, while promoting preventative health behavior. Peer educators play an important role in creating new opportunities for their peers. Tanadgoma actively implements peer education within its target populations, namely by:

- Conducting training in Peer Education techniques as well as Training for Trainers (TOT) on Peer Education for youth.
- Conducting peer education trainings for representatives of high-risk, vulnerable populations.

Voluntary Counseling and Testing for HIV. Voluntary Counseling and Testing (VCT) is a cornerstone of prevention. Tanadgoma targets its VCT interventions towards populations that are or might be at higher risk of contracting HIV. Tanadgoma also aims to raise public awareness and provide VCT for HIV with the use of mobile laboratories in Tbilisi, Batumi, and Kutaisi.

Primary Screening for STIs and HIV. Primary screening for HIV and the most common STIs (including Hepatitis B and C) are performed as a part of outreach activities. Screening activities are directed towards the most vulnerable populations (PWIDs, MSM, sex workers, and the

incarcerated). Screening is also available for those who lack the ability to undergo testing elsewhere due to financial reasons or due to the absence of medical services.

Qualitative/Quantitative Research. Tanadgoma has extensive and diverse experience conducting qualitative and quantitative research in Georgia.

Qualitative Research: Focus Group Discussions (FGD) and In-Depth Interviews (IDI) are conducted by Tanadgoma in order to explore and understand the attitudes, motivations, opinions, feelings, and behaviors of the target populations.

Survey Research: Tanadgoma, in close collaboration with other partner organizations (e.g. Curatio) periodically carries out Integrated Bio-Behavior Surveillance Surveys on vulnerable high-risk populations (MSM, FSWs, prisoners) to collect data on the knowledge and risk behaviors of these target groups. Recently Bio-BBSS have been conducting jointly with the population size estimation surveys.

4.3. Organizational Analysis

The analysis provided within this subdivision examines the organizational strengths and weaknesses identified by the organization Tanadgoma (Table 1.).

Table 1. Strengths and weaknesses of Tanadgoma.

Organizational Strengths and Weaknesses of the Georgian NGO Tanadgoma, 2015.	
Strengths	Weaknesses
• Organizational experience (15 years) • Well-known and has a good reputation amongst target populations and collaborators • Broad network of partners (i.e. strategic partnerships with similar organizations and government entities) • Qualified personnel • Access to target populations • Innovation-oriented and organizationally transparent • Material and technical resources owned by the organization • Wide geographical coverage	• Total dependence on donors for program funding • Rarely renewed human resources (e.g. expressed levels of burnout amongst long-term staff) • Multifunctional personnel (e.g. staff is thinly stretched and therefore individuals often are responsible for multiple roles within the organization) • Inexperience and practice in public relations • Inexperience in advocacy when compared to service delivery

4.4. Funding Analysis

As of right now, Tanadgoma employs 50 professional staff as well as 14 administrative employees operating in 5 offices throughout Georgia. Tanadgoma's primary donors, to date, have been GFATM, USAID/RTI, RFSU, Caritas Czech Republic, UNFPA, European Union and AIDS Foundation East-West. In 2013, GFATM funding accounted for roughly 60% of Tanadgoma's project budget or 504,780 USD, with all other funding equaling 384,380 USD.

5. Client Assessment

In February of 2015, a current client assessment was conducted using Tanadgoma's latest client records. These records were able to demonstrate the total number of unique clients per each high-risk population currently served by the organization 2014. A previous assessment, conducted by Tanadgoma in 2013, is also presented as a comparison.

Table 2. Tanadgoma's clients in 2013.

Number of Tanadgoma clients per HIV target population reached, 2013.	
Men who have Sex with Men	1,500
Prisoners	5,100
Sex Workers	2,200
Injecting Drug Users	600
General Population	500
Total Clients	**9,900**

Table 3. Tanadgoma's clients in 2014.

Number of Tanadgoma clients per HIV target population reached, 2014.	
Men who have Sex with Men	1,738
Prisoners	5,653
Sex Workers	1,719
Injecting Drug Users	938
General Population	300
Total Clients	**10,348**

5.1. Client Satisfaction

As recently as June, 2014, Tanadgoma assessed its current staff performance as well as gauged client levels of satisfaction with current services using a client satisfaction survey instrument (Appendix C).

This client satisfaction survey instrument, in the form of a ten-question survey, was administered to 240 unique clients over a two week period in June, 2014. At the end of the survey period, 98% of survey respondents were found to be either "satisfied" or "very satisfied" with Tanadgoma overall. And, with respect to the client's last interaction with Tanadgoma, 98.8% rated their experience as either "good" or "very good." These were the two main indicators for this 2014 assessment; however, it is also important to note how long and how often clients reported using Tanadgoma services.

Of these 240 unique respondents, 35.8% had used Tanadgoma services for less than a year while 48.8% of respondents had been with Tanadgoma from 1 to 5 years. 9.6% survey respondents had used Tanadgoma services from 5 to 9 years, and 5.8% had been with Tanadgoma since the "beginning," or 10 to 14 years.

When asked about the frequency of use of Tanadgoma services, 19.2% responded that they use services weekly including accessing the "healthy cabinet" for sexual health pamphlets, condoms and lubricants. Nearly 56% stated that they used Tanadgoma services 1-2 times a month. And finally, 16% of respondents claimed to only use Tanadgoma services 3-4 times a year while 8.8% answered less than 3-4 times a year.

6. Competitor Assessment

Starting in 2014, funding sources for HIV/AIDS became more limited for reasons mentioned above and due to the four year USAID HIV prevention project ending during which time 5 million USD was allocated towards the prevention and control of HIV in Georgia. With funding now flowing through the GoG, and the state wanting to take on more of a role within the

prevention and control response, the competition for these funds is intense amongst other non-governmental organizations.

Tanadgoma is the only organization within Georgia's crowded HIV/AIDS NGO network that offers HIV prevention interventions for MSM, FSW, and the incarcerated. Other organizations advocate for policy changes, or for the rights of MSM and LGBT, but only Tanadgoma offers health interventions to these two vulnerable high-risk populations.

7. Collaborators Assessment

Due to the heavy reliance on international donors and the current shift in funding taking place in Georgia, the sustainability of Georgia's HIV/AIDS NGOs is being called into question. These local NGOs do not readily receive funding from the GoG, and, therefore, these NGOs will need to seek additional funding, or they will perish.[4] It is difficult to assess which organizations will be available for Tanadgoma to collaborate with, or to seek funding from, within the coming year(s).

8. Climate Assessment

As already mentioned, starting in 2014, funding sources for HIV/AIDS became more limited for local Georgian NGOs with activities focusing on HIV/AIDS. These local HIV/AIDS NGOs have frequently been identified by outside observers, including the USAID, as playing a vital role in the delivery of HIV prevention interventions, especially for vulnerable high-risk populations.[1,4,13] The limited international funding still available will now flow through the state, and, as a result, the competition for this funding is very high amongst other non-governmental organizations.

There are also concerns about the new funding structure itself and how it will be affected by Georgia's political, economic, and cultural environment in regards to HIV prevention

[13] Curatio International Foundation: Effects of GFATM on Georgia's Health System Development. (February, 2008). Study Report. Retrieved from http://www.curatiofoundation.org/uploads/other/0/154.pdf

interventions for vulnerable high-risk populations.

8.1. Economic Environment

In 2014, Georgia's economy grew by 4.7% leading Georgian financial analysts to predict a 5% increase in economic growth for 2015.[14] However, since November, 2014, a rapid inflation of the Georgian Lari (GEL) against the US Dollar has occurred, and, as of March, 2015, the Georgian Lari currently is 2.18 GEL to 1 US Dollar, an increase of roughly 26%.[15] The cause of such rapid inflation is due to the unrest in Ukraine, the resulting tense geopolitical situation, the plummeting Russian ruble, and the strength of the US dollar.[16] Georgia is now predicting a more conservative growth of a little more than 4% for 2015 according to Georgia's Finance Minister Nodar Khaduri in February of 2015.[14]

This financial instability, most notably the instability of the GEL/USD exchange rate, has also made it difficult to effectively plan a budget for the coming years at both Tanadgoma and within various departments of the NCDC including those now responsible for GFATM funding and HIV/AIDS response.[11] Fluctuating exchange rates make it difficult to effectively budget the response when diagnostic tools and medicines are procured abroad and therefore susceptible to the global economy.

8.2. Sociocultural and Political Environment

HIV-associated stigma and discrimination are a major challenge and a real threat to HIV control and prevention intervention success.[2] Since the fall of the Soviet Union, the Georgian Orthodox Church has rebounded in size and political power. The Church's influence appears to be at an

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[14] Antidze, Margarita. (2015, Feb 5). UPDATE 1 – Georgia May Cut 2015 Economic Growth Forecast. *Reuters*. Retrieved from http://www.reuters.com/article/2015/02/05/georgia-gdp-idUSL6N0VF3CB20150205

[15] Bloomberg: USD to GEL Exchange Rate. (2015). Retrieved from http://www.bloomberg.com/quote/USDGEL:CUR on March, 2015.

[16] Bloomberg—Marton Eder. *Ex-Soviet Republics Feeling Putin's Ruble Pain Now*. (2015). Retrieved from http://www.bloomberg.com/news/articles/2015-03-10/ex-soviet-republics-feeling-putin-s-ruble-pain-now on March, 2015.

all-time high, and it called for annual national days of protest against homosexuals and those it deemed a threat to Georgian society in 2013 and 2014.[17]

To combat these discriminatory attitudes, the Georgian Parliament passed an antidiscrimination law aimed at all forms of discrimination on May 2, 2014.[2] This law, it is hoped, will add to a previous HIV/AIDS law which sought to protect those with HIV against discrimination while legally exempting certain HIV interventions for the national response.

9. Summary

In summary, over the next few years most Georgian NGOs focusing on HIV/AIDS will most likely shut down due to changes that have occurred in regards to international funding and the overall funding structure. It is imperative that the GoG continues funding a selected group of HIV NGOs due to their expertise and skill set regarding Georgia's high-risk, vulnerable populations and because HIV prevalence within these populations remains high. As stated in the beginning, the intention of this report is to facilitate and inform the national dialog currently taking place regarding this issue and to inform those unfamiliar with Tanadgoma of its role in Georgia's national response to HIV.

10. Recommendations

As a response to situation illustrated above, the following recommendations should be considered as the discussion of the future of HIV/AIDS organizations and funding evolves in Georgia for both strategic non-domestic and domestic actors and/or agents.

10.1. Recommendations for Non-Domestic Actors or Agents

The Global Fund to Fight AIDS, TB, and Malaria (GFATM). Due to the implementation of GFATM's New Funding Model (NFM), Georgia and countries within Eastern Europe and Central

[17] BBC—Damien McGuinness. *Thousands Protest in Georgia over Gay Rights Rally*. (2013). Retrieved from http://www.bbc.com/news/world-europe-22571216 on March, 2015.

Asia are no longer eligible for funding from the organization due to their middle-income statuses despite continued domestic issues surrounding HIV/AIDS. Therefore the following recommendations are made to the GFATM in the spirit of continuing collaboration and partnership:

- NFM Reevaluation – By end of 2016, the GFATM should reevaluate the criteria the organization uses to determine a country's funding eligibility.
- Fundraising Campaign – By the end of 2016, the GFATM should develop a new marketing department within the organization. This new marketing department will be responsible for attracting new sources of financing while combating donor fatigue for HIV/AIDS, TB, and Malaria.

10.2. Recommendations for Georgian Actors or Agents

Tanadgoma. Due to the funding changes currently underway, Tanadgoma's dependence on external international donors has been exposed. The organization should begin immediately to identify new sources of funding and develop strategies to reduce cost. Therefore the following recommendations are to be implemented in order to alleviate donor dependence and/or a reduction in services:

- Fundraising – The organization should conduct fundraising activities with a special focus on attracting new, nontraditional donors with the first of these fundraising events to have taken place no later than December 2015. This will be achieved by developing a new position within the organization that is to be responsible for identifying nontraditional donors and with the planning and implementation of fundraising events. This position will be developed and filled no later than September, 2015.
- Compensation – Tanadgoma should reevaluate its compensation package for staff until the security of their current activities and services can be guaranteed for a period of three years or more. This temporary salary reduction should take the form of a 2% total decrease over six pay periods.

- Staff Training – Tanadgoma should develop its MSM and LGBT advocacy abilities by the end of December, 2015, so that the organization is more attractive to GoG agencies for future supporting roles in large-scale projects. This should be done by developing a new position by July, 2015, whose sole purpose is to mobilize Tanadgoma resources towards events and activities that advocate on behalf of Georgia's MSM and LGBT populations.
- Service Cuts – Tanadgoma should suspend services at its regional branch locations by the end of 2016, with the exception of its Batumi branch, if client services funding has not been secured for a period of three years.
- Dissolve Assets – Tanadgoma should sell the regional branch offices, their contents, and vehicles that are owned by the organization, with the exception of its Batumi branch, by the end of 2016 if services funding has not been secured for a period of three years.

National Center for Disease Control and Public Health (NCDC). The GoG's NCDC is now the Principal Recipient of all GFATM funding that remains to be allocated, and, therefore, it is the GoG agency in charge of how these funds will be spent in the coming years. Due to this responsibility, the following recommendations should take place in order to maintain current HIV/AIDS prevention and control services:

- Outsourcing – The NCDC should outsource HIV prevention and control program/projects to Tanadgoma that are targeted towards MSM and FSW populations after GFATM funding ends in 2016.
- Capacity Building – The NCDC should conduct internal organizational training by the end of 2015 with Tanadgoma staff in Tbilisi on reproductive and sexual health topics for MSM and FSW populations.
- Funding – The NCDC should lobby the GoG for an increase in state funding to be provided by the government so as to prevent a lapse in current prevention and control services by the end of 2015. The rational for this increase being the

continued cost of universal ART coverage and the additional cost of prevention programs previously provided by Georgia's HIV NGOs.

10. Appendix B

Georgian HIV/AIDS NGO Online Survey Instrument

Please fill out as accurately as possible using your organization's 2012-2013 fiscal year or your organization's fiscal year that corresponds to the calendar year for 2013. (გთხოვთ, შეიტანოთ მაქსიმალურად ზუსტად თქვენი ორგანიზაციის 2012-2013 წლის ფისკალური წლის შესაბამისი ინფორმაცია ან, იმ შემთხვევაში, თუ ფისკალური წელი კალენდარულს ემთხვევა, 2013 წლის ინფორმაცია):

1. **Organization Name (ორგანიზაციის სახელი):**

2. **Legal Status (იურიდიული სტატუსი):**

3. **Position of Respondent (რესპოდენტის პოზიცია):**

4. **Number of Professional Staff (თანამშრომლების რაოდენობა):**

5. **Number of Administrative Staff (ადმინისტრაციული პერსონალის რაოდენობა):**

6. **Main Field of Activity (ძირითადი საქმიანობა):**

7. **Types of Services (მომსახურების სახეები):**

8. **Target Populations and/or Groups (სამიზნე მოსახლეობა და / ან ჯგუფები):**

9. **Number of Clients from Target Populations Reached (კლიენტების რაოდენობა სამიზნე პოპულაციიდან):**

MSM-ჰომოსექსუალური ურთიერთობების მქონე მამაკაცები:

CSW-კომერციული სექს მუშაკები:

FSW-კომერციული სექსის მუშაკი ქალები:

IDU-ნარკოტიკების ინექციური მომხმარებელი:

General Population-ზოგადი პოპულაცია:

10. Primary Donors (ძირითადი დონორები):

11. Minimum Budget of Non-GF Projects (in USD) (არასამთავრობო-გლობალ ფონდის პროექტების მინიმალური ბიუჯეტი (აშშ დოლარი)):

12. Maximum Budget of Non-GF Projects (in USD) (არასამთავრობო-გლობალ ფონდის პროექტების მაქსიმალური ბიუჯეტი (აშშ დოლარი)):

13. GFATM Project Budget (in USD) (გლობალური ფონდის პროექტის ბიუჯეტი (ათასი აშშ დოლარი)):

14. Budget Spent on Harm Reduction (ზიანის შემცირებაზე დახარჯული ბიუჯეტი):

Condoms (პრეზერვატივის):

Lubricants (საპოხი მასალები):

Sterile Syringes / Sharps Containers

(სტერილური ნემსი / ინსტრუმენტების კონტეინერი):

HIV and/or HCV Testing and Counseling

(აივ ან / და C ჰეპატიტის ვირუსის ტესტირებისა და კონსულტირების):

11. Appendix C

Center for Information and Counseling on Reproductive Health - Tanadgoma

Tanadgoma staff fills out this section:

Tanadgoma office: □ Tbilisi □ Batumi □ Kutaisi □ Zugdidi □ Telavi

Target group: □ A □ B □ C □ D □ E

Questionnaire filled: **Date** _____/_____/_____

□ At TG office □ During outreach day / month / year

Client satisfaction survey

Please, mark or circle your answer:

1. How long have you been using Tanadgoma services?

□ 1 წელზე ნაკლები □ 1-დან 5 წლამდე □ 5-დან – 9 წლამდე □ 10-დან - 14 წლამდე

2. How often have you been using Tanadgoma services?

□ Once a week □ 1-2 times a month □ 3-4 times a year □ Less than 3-4 times a year

3. Please remember your last visit to Tanadgoma or the last time, when Tanadgoma workers approached you. How would you assess the services that you received then?

__1_____2_____3_____4_____5_____

Very bad Bad Neither bad nor good Good Very good

4. Are you satisfied with the attitude of Tanadgoma counselors and social workers towards you?

____1_____2_____3_____4_____5_____

Very unsatisfied Unsatisfied Neither satisfied nor unsatisfied Satisfied Very satisfied

5. If you are not satisfied with the attitude of Tanadgoma counselors and social workers towards you, what exactly don't you like?

Please specify: _____

_____

_____

10. Primary Donors (ძირითადი დონორები):

11. Minimum Budget of Non-GF Projects (in USD) (არასამთავრობო-გლობალ ფონდის პროექტების მინიმალური ბიუჯეტი (აშშ დოლარი)):

12. Maximum Budget of Non-GF Projects (in USD) (არასამთავრობო-გლობალ ფონდის პროექტების მაქსიმალური ბიუჯეტი (აშშ დოლარი)):

13. GFATM Project Budget (in USD) (გლობალური ფონდის პროექტის ბიუჯეტი (ათასი აშშ დოლარი)):

14. Budget Spent on Harm Reduction (ზიანის შემცირებაზე დახარჯული ბიუჯეტი):

Condoms (პრეზერვატივის):

Lubricants (საპოხი მასალები):

Sterile Syringes / Sharps Containers

(სტერილური ნემსი / ინსტრუმენტების კონტეინერი):

HIV and/or HCV Testing and Counseling

(აივ ან / და C ჰეპატიტის ვირუსის ტესტირებისა და კონსულტირების):