



Evaluation of the UNFPA support to the HIV response (2016-2019)

Georgia



COUNTRY CASE STUDY



UNFPA Evaluation Office

2020



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FOREWORD

A founding Cosponsor of UNAIDS, UNFPA is a key partner in the global HIV response. It is a co-convenor (together with other United Nations Funds and Programmes) on HIV prevention among adolescents, youth and key populations, as well as on the decentralisation and integration of SRHR and HIV services. UNFPA also plays a technical role in prevention and condom programming within the Global Prevention Coalition and, as a chair of the UNAIDS Committee of Cosponsoring Organizations, is at the centre of the mechanism for coordinating the global response to HIV and AIDS.

Compared with a decade ago, HIV infections have declined globally, AIDS-related deaths have seen a dramatic reduction and considerable progress has been made towards the 90-90-90 targets. However, the global HIV care continuum is marred by considerable variations with several regions experiencing sharp increases in new infections. It also presents gaps that are greater for men, young people and key populations, while women continue to be disproportionately affected by the epidemic. Across the world, almost 10 million people await treatment and 1.7 million people acquire HIV every year, half of whom are among key populations and their partners.

The purpose of this evaluation is to assess the performance of UNFPA in integrating its approach to supporting the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. As part of this assessment, the evaluation paid particular attention to the contribution of UNFPA to: the prevention of sexual transmission; the linking of HIV with other aspects of SRHR and SGBV; and the promotion of gender equality and human rights in the context of HIV.

The evaluation of the UNFPA support to the HIV response covers the period from 2016 (when the current UNAIDS strategy was rolled out) to 2019 and is structured around a series of regional and country case studies. It also rests on key informant interviews, a comprehensive review of documents and data sets at global, regional and country levels, as well as an online survey of key informants in 59 countries. The case studies were selected to provide an illustrative example of UNFPA work to support the HIV response in very diverse contexts.

The overall evaluation highlights how UNFPA has been able to leverage the UNAIDS Division of Labour to guide its support to the HIV response at global, regional and country levels and has made an important contribution to meeting the needs of the most vulnerable. However, it also indicates that the absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, the key populations, as well as a lack of an explicit strategy for UNFPA support to the HIV response have inhibited UNFPA from fully deploying its capacities to champion the rights of KPs. UNFPA has, however, demonstrated that linking and integrating SRHR, HIV and SGBV services is an effective approach to meeting the needs of the AGYW, other vulnerable groups and KPs. In fact, the evaluation points to the need to develop and strengthen guidance to regional and country offices on piloting and scaling integration at national level.

The overall evaluation also recommends that UNFPA builds on the results it has achieved and develops a strategy for its support to the HIV response. This strategy should detail the role of the Fund at global, regional and national levels and, aligning its responsibilities as a UNAIDS Cosponsor with UNFPA core mandate areas, should seek synergies between the HIV programming and other internal strategies and programmes in support of the transformative results. UNFPA should also continue to assert the critical importance of comprehensive condom programming and extend support to both supply chain strengthening and demand creation, especially among young people.

The present report provides the reader with a summary of the overall evaluation, followed by a presentation of the Georgia case study. Anchored in the Eastern European epidemic and cultural setting, where the majority of new infections are disproportionately among key populations, the Georgia case study results in a rich and detailed account of a UNFPA response tailored for the people in greatest need. It should be read in conjunction with the overall evaluation report and I encourage the reader to compare it with the other case studies (Indonesia and Namibia).

This evaluation would not have been possible without the invaluable inputs and support from a wide range of stakeholders, both within and outside UNFPA. I am deeply appreciative of the considerable time and contributions of colleagues working on the HIV response in UNFPA headquarters, regional offices and country offices who generously shared their knowledge. This evaluation also benefited from the critical insights of all technicians reunited in the Evaluation Reference Group, who co-authored a set of recommendations based on the independent conclusions of the report. Last but not least, I am extremely grateful to the colleagues in regional office in Istanbul, as well as in the country office in Tbilisi for the crucial role they played in facilitating the extensive data collection by the evaluation team for the present case study.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Anti-Retroviral Therapy
ARV	Anti-retro Viral
ASRH	Adolescent Sexual Reproductive Health
BCC	Beahavior Change Communication
BtN	Beyond the Numbers methodology
CCM	Country Coordinating Mechanism
CME	Continuing Medical Education
CO	Country Office
CP	Country Programme
CSB	Commodity Security Branch (of UNFPA)
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DoD	Department of Defense
EC	Emergency Contraception
ECOM	Eurasian Coalition on Male Health
EECA	Eastern Europe and Central Asia
EECARO	Eastern Europe and Central Asia Regional Office
EMTCT	Elimination of Mother-to-Child Transmission
ESA	East and Southern Africa
EU	European Union
EWNA	Eurasian Network of Women with AIDS
GBV	Gender-Based Violence
GHRN	Georgia Harm Reduction Network
GYDEA	Georgian Youth Development and Education Association
HIV	Human immunodeficiency virus
IOM	International Organization for Migration
KAP	Key Affected Population
KP	Key Population
LEPL	"LEPL Children and Youth Development Fund"
LGBT	Lesbian, gay, bi-sexual and transgender
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MEC	Medical Eligibility Criteria
MICS	Multiple Indicator Cluster Surveys
MISP	Minimim Initial Service Package
MNH	Maternal and Newborn Health
MoES	Ministry of Education, Culture, Science, Sport and Youth Affairs
MoH	Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs
MoU	Memorandum of Understanding
MSM	Men Who Have Sex with Men
MSMIT	Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men
NCDC	National Centre for Disease Control
NGO	Non-Governmental Organization

NMCR	Near Miss Case Review
NSP	National HIV Strategic Plan
OB/GYN	Obstetrics and Gynaecology
OHCHR	Office of the High Commissioner for Human Rights
PAAC	Policy and Advocacy Advisory Council
PDO	Office of the Public Defender
PHC	Primary Health Care
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylactic
PTF	Prevention Task Force
PWID	People Who Inject Drugs
RAGSI	Regional Advisory Group on Strategic Information
RFSU	Swedish National Association for Sexuality Information
SGBV	Sexual Gender-Based Violence
SIDA	Swedish International Development Agency
SOP	Standard Operating Procedures
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SW	Sex Worker
SWIT	Implementing Comprehensive HIV and STI Programmes with Sex Workers
The Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
ToT	Training of Trainers
TSMU	Tbilisi State Medical University
UBRAF	Unified Budget, Results and Accountability Framework (UNAIDS)
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organisation
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
UT	Union Tanadgoma
VCT	Voluntary Counselling and Testing
ViC	Virtual Contraceptive Consultation
WHO	World Health Organisation
YFS	Youth-Friendly Services
YKP	Young Key Population

GLOSSARY OF TERMS

Term	Definition	Source
Combination HIV prevention	A combination HIV prevention approach provides defined packages of services, including behavioural, biomedical and structural components, tailored to high priority population groups within their specific local contexts. A focus on supporting prevention choices helps to overcome fragmentation of prevention programmes into distinct streams for each prevention tool or intervention, often championed by different agencies and implemented separately. This does imply, however, that local stakeholders – including local governments, local civil society organizations and local communities – are at the centre of their own responses.	UNAIDS (2018) <i>HIV Prevention 2020 Road Map</i>
Key populations	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere - they are key to the epidemic and key to the response. The term “key populations at higher risk” also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment.	UNAIDS (2015) <i>Terminology Guidelines</i>
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV and certain behaviours create, increase or perpetuate risk. Avoid using the expressions “groups at risk” or “risk groups” - people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.	UNAIDS (2015) <i>Terminology Guidelines</i>
Sexual and reproductive health package	This term refers to programmes, supplies and multi-integrated services to ensure that people are able to have not only a responsible, satisfying and safer sex life, but also the capability to reproduce and the freedom to decide if, when and how often to do so. It is particularly important that this decision be free of any inequality based on socioeconomic status, education level, age, ethnicity, religion or resources available in their environment. A sexual and reproductive health package aims to guarantee that men and women are informed of, and have access to, the following resources: safe, effective, affordable and voluntary acceptable methods of birth control; appropriate health-care services for sexual and reproductive care, treatment and support; and comprehensive sexuality education.	UNAIDS (2015) <i>Terminology Guidelines</i>
Sexual gender-based violence	This is now the terminology that is increasingly being used in all contexts, as this is one of the most common forms of violence encountered, including in intimate partner relationships as well as against those who have different sexual orientations.	
Vulnerability	Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their	UNAIDS (2015) <i>Terminology Guidelines</i>

	<p>control. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human-rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.</p>	
Vulnerable populations	<p>Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. These guidelines do not specifically address vulnerable populations, but much of the guidance can apply to them.</p>	<p>WHO (2014) <i>HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines</i></p>
Young people, youth and adolescents	<p>Child: a person under 18 years of age, as defined by the United Nations. Adolescent: a person aged 10 to 19 years, as defined by the United Nations. Young person: a person between 10 and 24 years old, as defined by the United Nations. Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes, but respects national and regional definitions of youth.</p> <p>Children: According to Article 1 of the Convention on the Rights of the Child, “a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier”. Adolescents: Individuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services. Youth: This term refers to individuals between the ages of 15 and 24. Young people: This term refers to those between the ages of 10 and 24.</p>	<p>UNESCO (2018) <i>International technical guidance on sexuality education: An evidence-informed approach</i></p> <p>WHO (2014) <i>HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines</i></p>
Linkages and integration	<p>Linkages refer to bi-directional synergies in policy, systems and services between SRHR and HIV. It refers to a broader human rights-based approach, of which service integration is a subset. Integration refers to the service delivery level (whether at a facility or in the community) and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).</p>	<p>Interagency Working Group on SRHR and HIV Linkages (2017) <i>SRHR and HIV Linkages: Navigating the work in progress 2017</i></p>

EXECUTIVE SUMMARY OF THE OVERALL EVALUATION OF THE UNFPA SUPPORT TO HIV RESPONSE (2016-2019)

Purpose and scope of the evaluation

UNFPA is a key partner in the global response to the human immunodeficiency virus (HIV). It works at global, regional and national levels and advocates for sexual and reproductive health and rights (SRHR), scaling up integrated SRHR services, intensifying HIV prevention, supplying male and female condoms and lubricants, and tackling gender inequalities. UNFPA is a founding cosponsor of UNAIDS and, in the UNAIDS Division of Labour, is a co-convenor (with UNDP) on HIV prevention among key populations (KPs). UNFPA is also a co-convenor on HIV prevention among adolescents and youth (with UNICEF and UNESCO), and the integration of SRHR and HIV services (with WHO).

The purpose of this evaluation is to assess the performance of UNFPA in integrating its support to the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. The evaluation covers the period 2016-2019 and all types of interventions and responses to HIV supported by UNFPA at global, regional and national levels.

Methodology

The evaluation aims to identify the contribution made by UNFPA and adopts a theory-based approach with analysis of the intended results of UNFPA support. It also analyses the contextual factors related to the nature of the HIV epidemic and the response. The evaluation team developed a theory of change for all aspects of UNFPA support and, ultimately, detailed evaluation questions, which set out the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around two regional and five country case studies supported by a wide range of methods: key informant interviews, a review of all relevant documents and data sets at global, regional and country level, and an on-line survey of key informants in 59 countries.

Main findings

The UNAIDS Division of Labour has served as an organizing framework to guide UNFPA efforts to promote HIV prevention and to link and integrate sexual reproductive health and rights/HIV/sexual gender-based violence (SRHR/HIV/SGBV) programming and services. Some UNFPA regional offices and country offices studied have been able to match their respective capacities, comparative advantages and mandates to their assigned role in HIV support, often with minimal resources. Country offices in Eastern Europe and Central Asia (EECA) and East and Southern Africa (ESA) have benefited from technical assistance, coordinated advocacy and programmatic support from regional offices: a level of support which may not be available in other UNFPA regions. For UNFPA overall, there is a tension between the role UNFPA has assumed under the UNAIDS Joint Programme, and the perceived diminished priority of HIV within the UNFPA strategic plan 2018-2021 (with reduced human and financial resources allocated to HIV dedicated programming). This has limited the ability of UNFPA to fulfil its expected leadership roles.

UNFPA has directed considerable effort towards promoting the rights of the most vulnerable, including adolescent girls and young women (AGYW), other young people at risk and KPs. This includes identifying crucial issues for policy and advocacy, and supporting efforts to improve the legal and policy environment for young people and key populations. However, these efforts are hindered by the fact that the transformative results in the UNFPA strategic plan 2018-2021 do not refer

specifically to the rights of young people and key populations in relation to HIV prevention, testing and treatment (although the ESA Regional Office has adopted a fourth transformative result: The elimination of sexual transmission of HIV and sexually transmitted infections). Another constraint to effective rights promotion has been the limitations UNFPA has experienced in basing its groundwork for rights policy and advocacy on an understanding of the challenges faced by the most vulnerable at the point of service delivery.

UNFPA has demonstrated a commitment to promoting linkages and supporting the integration of SRHR/HIV/SGBV services to improve access for marginalized, at-risk persons and key populations.

UNFPA has also contributed to achieving quality, client-centred services at country level, especially in ESA, with strong support from the regional office, effective regional partners, and access to multi-year/multi-country funding for support to linkages and integration. However, efforts to scale integration of SRHR/HIV/SGBV services to national level face significant institutional and operational challenges. UNFPA has gained important experience at the regional and national level in ESA, but this does not yet sufficiently inform advocacy at global level. There is also a gap in UNFPA support to supply chain management for condoms and, in general, support to comprehensive condom programming (CCP) in the countries studied.

UNFPA has been active in forging partnerships and working with networks on critical aspects of the HIV response.

At regional and country level, UNFPA has demonstrated an ability to foster strong relationships with organizations and networks led by adolescents, youth and key populations to support their capacity to engage meaningfully in national dialogue and action. At global level, a lack of common understanding within the organization on the priority assigned to the HIV response impairs UNFPA capacity to execute its mandate for leadership on HIV prevention. For instance, UNFPA has not yet maximized its comparative advantage and taken a lead role in revitalizing condom programming and SRHR/HIV/SGBV integration in response to the ECHO trial that highlighted the need to integrate HIV prevention, including condom programming, into family planning services.

UNFPA is an active and respected participant in mechanisms for coordinating support to the HIV response at global, regional and national levels.

At global level, UNFPA staff participate actively in mechanisms and processes for budgeting and accountability of the UNAIDS Joint Programme and play a central role in the UNAIDS Committee of Cosponsoring Organizations (CCO) and the Global HIV Prevention Coalition. At both regional and country levels, UNFPA has supported efforts to improve sustainability and encourage national investment alongside its United Nations partners and other sources of financial support. However, many countries remain highly dependent on external sources of finance for HIV prevention.

Conclusions

1. UNFPA has been able to utilize the UNAIDS Division of Labour to guide its support to the HIV response in a manner consistent with its comparative advantages. However, strategic plan 2018-2021 does not explicitly recognize the central role UNFPA should play in preventing sexual transmission of HIV and realizing the rights and meeting the needs of key populations. As a result, there is an imbalance between the outward-facing ambition of UNFPA to fill a leadership role in the global HIV response and the inward-facing attention and priority paid to this responsibility. This imbalance, combined with the lack of an agreed UNFPA HIV strategy supported by a theory of change, and the necessary financial and human resources, has limited the ability of UNFPA to use advocacy to shape the global agenda and ensure prioritization of comprehensive HIV prevention. In countries where external resources are limited and the allocation of UNFPA core resources is constrained by the UNFPA business plan, these factors have contributed to an insufficient level of attention to HIV prevention in family planning and a lack of prioritization for comprehensive condom programming.

2. UNFPA has made important contributions to realizing the rights and meeting the needs of the most vulnerable, including adolescent girls and young women and key populations. However, a number of factors inhibit the capacity of UNFPA to play its expected role in championing their rights and the ability of country offices to engage on sensitive issues in order to reform the broader legal and policy framework. The absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, key populations, and the lack of an explicit strategy for UNFPA support to the HIV response, diminish the focus required for more effective action on rights. This is further limited by a UNFPA business model that does not foresee service delivery as a mode of engagement in many countries, hence constraining the capacity of country offices to address the ability of the most vulnerable and key populations to access quality services in HIV prevention, testing and treatment free from discrimination. These are often countries (as in EECA) where the pace of HIV infection is rising and is concentrated among key populations. Yet, support to rights promotion and meeting the needs of the most vulnerable is of limited effectiveness when not rooted in efforts to improve access to rights-based services.

3. UNFPA support has demonstrated that linking and integrating SRHR/HIV/SGBV programmes and services is an effective approach to meeting the needs of adolescent girls and young women, other vulnerable groups and key populations. UNFPA has also responded effectively to the proven link between sexual and gender-based violence and HIV infections among adolescent girls and young women by extending the integration agenda to include SGBV. UNFPA has made an important contribution to achieving quality, integrated services in SRHR/HIV/SGBV, especially in countries taking part in the 2gether 4 SRHR programme in ESA. This can be attributed to access to consistent financial support for this large multi-country project focused on linkages and integration, combined with a strong regional partnership with the Southern Africa Development Community (SADC), and sustained advocacy and technical support by UNFPA staff. However, the understanding, level and nature of support to integration varies widely across UNFPA regions and countries. Furthermore, the relative absence of UNFPA support to comprehensive condom programming in many countries can undermine some of the results obtained through linkages and integration of SRHR/HIV/SGBV.

4. UNFPA has effectively forged partnerships and worked with networks at regional and country level to promote meaningful participation of adolescent girls and young women, key populations and other vulnerable groups in the policy process. UNFPA has also contributed to the effectiveness of networks and civil society organizations (CSOs) led by adolescents, youth and key populations. However, empowering these partners requires adequate and sustained investment over time in order to build their capacity to engage in advocacy and policy-making to improve the HIV response, broader SRHR policies and the overall legal framework. Yet, UNFPA support to networks is currently constrained by a lack of guidance on how to extend participation beyond the stages of programme design and implementation into accountability by partner governments for effectively realizing the rights of young people, key populations and other vulnerable groups.

5. UNFPA participates actively in platforms and mechanisms for coordinating actions in support of the HIV response at global, regional and national levels. These platforms have successfully avoided duplication of efforts and conflicting messages from the United Nations country teams in host countries. UNFPA participation in coordinating mechanisms does, however, require a significant investment of time and resources. In addition, coordination among partners with a view to increasing and sustaining investments in HIV prevention, testing and treatment has been limited. This is despite the fact that the need is particularly acute in countries transitioning to upper-middle income country (UMIC) status, where resource-allocation models for large-scale programmes can result in abrupt reductions in multilateral support. Reliance on external funding for key aspects of the HIV response by many countries presents a continuing risk to the sustainability of progress made.

Recommendations

1. Clarifying the role and strategic orientations of UNFPA on HIV

While the UNAIDS 2018 Division of Labour helps to guide UNFPA interventions, it cannot replace a clear statement from UNFPA senior management regarding the roles and responsibilities of the organization in the HIV response. UNFPA, as a matter of organizational priority, should develop and adopt a strategy for its support to the HIV response. This strategy should include the appropriate level of human and financial resources, setting priorities, and accommodating the flexible application of the business model. It should be supported by a theory of change detailing the role of UNFPA at global, regional and national levels, aligning UNFPA responsibilities as a UNAIDS cosponsor with UNFPA core mandate areas, and seeking synergies between UNFPA HIV programming and other internal strategies and programmes, in support of the transformative results of the strategic plan 2018-2021.

2. Meeting the needs of those left behind and promoting their rights

UNFPA needs to take steps to close the gap between rhetoric and action regarding human rights-based approaches in SRHR. To this end, it should develop tools for operationalizing the UNFPA commitment to rights in different technical areas, including in contributing to the HIV response. This should include explicit programming tools placing the promotion of rights - including the rights of adolescent girls and young women, key populations and other vulnerable groups - as a core strategic pillar of UNFPA work in support of the HIV response. It should also include efforts to promote rights literacy among UNFPA staff, service providers and communities. Finally, it should encompass the strengthening of accountability mechanisms or other components related to the identification (and follow-up) of potential violations of rights, especially in relation to access to quality SRHR services.

3. Linking and integrating SRHR/HIV/SGBV

Linking and integrating SRHR/HIV/SGBV services is key to an effective and sustainable national response to HIV. There is a need for UNFPA to build on lessons learned from the ECHO trial results, as well as from the experiences in EECA, ESA and other regions, to develop and strengthen guidance to regional and country offices on piloting and scaling linkages and integration at national level. This guidance should take stock of the diversity of contexts in which UNFPA operates, and should be communicated across all regional and country offices. The intent is to ensure that UNFPA maintains strong leadership on linkages and integration, and that country offices can be effective in supporting related programmatic action at country level, with regional offices providing the advocacy and technical support as needed.

4. Asserting leadership in comprehensive condom programming

UNFPA should continue to assert the critical importance of comprehensive condom programming and promoting its role in championing triple protection (prevention of HIV, other sexually transmitted infections (STIs) and unintended pregnancies). This should include providing support to condom programming (male and female condoms and lubricants) that is comprehensive and covers both supply and demand. Important elements of a comprehensive approach should include, in particular, further integration of condom programming into UNFPA support to family planning programmes. It should extend to strengthening supply chains (including in countries that do not currently benefit from the UNFPA Supplies Programme) and bolstering demand creation, especially among young people. A comprehensive approach to condom programming should also foresee the reinforcement of public-private-people partnerships for increasing access to, and uptake of, condoms and lubricants.

5. Forging partnerships and supporting networks

UNFPA should increase support to the development of the community of regional and national networks by leveraging and allocating resources to strengthen the capacity of CSOs (particularly those catering for or led by KPs, adolescent girls and young people) to engage effectively in policy dialogue, and to access funding from national and international sources. UNFPA should also promote linkages between global, regional and national networks for advocacy and engagement of KPs, AGYW and other young people. Finally, UNFPA should explore collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria to support grant applications and the implementation of HIV prevention programmes, especially for programmes focused on AGYW and KPs.

6. Coordination and sustainability

UNFPA should take action to address risks to the sustainability of the HIV response as part of its role as a UNAIDS Cosponsor participating in the Joint Programme at global, regional and country levels. UNFPA should also advocate and collaborate with other development partners to promote sustainable HIV programming, including transition from external funding and integration of HIV into national and sector development programmes. It should advocate for increased emphasis on prevention within HIV responses under national stewardship and support national strategies and plans for incorporation of the essential package of SRHR interventions, including on HIV/STIs, into universal health coverage mechanisms. UNFPA should also consider technical assistance to national authorities developing proposals for external funding for the HIV response and ensure that the support to capacity development of health-care providers for family planning and other SRHR services does incorporate rights-based HIV prevention, testing and links to treatment.

Read the **evaluation report** of the UNFPA support to the HIV response (2016-2019) [here](#)



1 INTRODUCTION OF THE CASE STUDY

This note presents the results of the field country case study of Georgia, undertaken for the evaluation of United Nations Population Fund (UNFPA) support to the HIV response 2016-2019. It is one of three field country case studies carried out during the evaluation (Georgia, Indonesia and Namibia). These case studies are complemented by desk-based country case studies for Turkey and Zambia, and desk-based regional case studies for Eastern and Southern Africa (ESA) and Eastern Europe and Central Asia (EECA) regions.

1.1 The evaluation of UNFPA support to the HIV response (2016-2019)

The purpose of the evaluation is to assess the performance of UNFPA in integrating its approach to HIV within the broader context of sexual and reproductive health and rights (SRHR), population dynamics, gender equality and human rights. As part of this assessment, the evaluation will pay particular attention to the contribution of UNFPA to:

- The prevention of the sexual transmission of the human immunodeficiency virus (HIV)
- The linking of HIV with other aspects of SRHR
- The promotion of gender equality and human rights in the context of HIV

The **objective of this evaluation** is two-fold:

1. To **assess** how the framework set out in UNFPA Strategic Plans, 2014-2017 and 2018-2021 and in the United Nations Joint Programme on HIV and AIDS (UNAIDS) Unified Budget Results and Accountability Framework (UBRAF) 2016-2021 and further specified in thematic strategies and programmes (for example, UNFPA strategies for Adolescents and Youth and for Family Planning as well as for the UNFPA Supplies Programme) has guided the programming and implementation of UNFPA interventions in relation to HIV.
2. To **facilitate learning** and to derive good practices from UNFPA experience in supporting efforts to address HIV across a range of key programmatic interventions in the three above-mentioned overlapping and mutually reinforcing thematic areas and in differing regional and national contexts.

1.1.1 Evaluation questions

The evaluation examines six major evaluation questions.

Table 1: Evaluation questions by area of investigation

Evaluation criteria, areas of investigation and evaluation questions
<p>Area of Investigation 1: UNFPA support to linking SRHR, HIV and SGBV, including integrated SRHR, HIV and SGBV service delivery</p>
<p>Evaluation Question: To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between SRHR, HIV and SGBV and to integrating SRHR, HIV and SGBV service delivery? (Relevance, Effectiveness, Sustainability)</p>
<p>Area of Investigation 2: UNFPA support to the HIV response corresponds to the needs of the at-risk and the most vulnerable, the marginalized and key populations (KPs)</p>
<p>Evaluation Question: To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of the at-risk, most vulnerable and marginalized people, especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities? (Relevance, Effectiveness, Gender Equality)</p>
<p>Area of Investigation 3: UNFPA support to the promotion of human rights and gender equality in the context of HIV</p>
<p>Evaluation Question: To what extent has UNFPA support contributed to engage and empower communities (including, but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to SRHR, HIV and SGBV services? (Relevance, Effectiveness, Gender Equality)</p>
<p>Area of Investigation 4: UNFPA efforts to act as a broker to forge partnerships and facilitate meaningful participation of a broad spectrum of partners in the HIV response</p>
<p>Evaluation Question: To what extent has UNFPA been effective at global, regional and country levels in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including programme design, planning and implementation? (Effectiveness, Gender Equality, Sustainability)</p>
<p>Area of Investigation 5: UNFPA efforts to optimize its comparative advantage within UNAIDS Division of Labour</p>
<p>Evaluation Question: To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS Division of Labour? (Effectiveness, Coordination, Efficiency, Sustainability)</p>
<p>Area of investigation 6: UNFPA efforts to support coordination of actions and resources to strengthen national leadership</p>
<p>Evaluation Question: To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV, especially at national level? (Efficiency, Coordination, Sustainability)</p>

1.1.2 Region and country case studies

A key feature of the evaluation is the completion of a series of field and desk-based regional and country case studies.

Table 2: Case studies

Desk regional case studies	Field country case studies	Desk country case studies
Eastern and Southern Africa (ESA)	Namibia	Zambia
Eastern Europe and Central Asia (EECA)	Georgia	Turkey
	Indonesia	

The evaluation team also conducted visits to UNFPA regional offices for ESA and EECA in support of the regional desk studies.

1.2 Objectives of the field country case studies

The field-based country case studies aim to provide insights into the evaluation questions and a comprehensive nuanced picture of programme actions and their results. They allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies. The country case studies are not individual programme evaluations at country level. Their objectives are to:

- Provide input for answering the evaluation questions and causal assumptions
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

1.3 Approach and methodology

Each field country case study uses a theory-based evaluation approach based on the theory of change and causal assumptions developed for UNFPA activities related to the HIV response. The theory of change is described in detail in the Inception Report of the evaluation.¹ The causal assumptions form the basis of the Evaluation Matrix (Annex B) and allow, for each evaluation question, to determine the contribution of UNFPA to the HIV-related outcomes in the theory of change.

The data collection methods used in each field country case study are:

- Identification and review of core documents at country level, including country programme documents and annual work plans, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, minutes of coordination meetings and documents produced by other bilateral and multilateral agencies supporting the HIV response
- Review of financial data regarding programme investments
- Key informant interviews with a wide range of stakeholders at national level (Annex C)
- Site visits to programme and service delivery sites, including interviews with service providers, social workers and counsellors
- Interviews and group discussions with individuals accessing sexual and reproductive health and rights (SRHR)² and/or HIV services supported by UNFPA

¹ UNFPA, 2019. *Inception Report*: p. 12-16.

² **Nota Bene:** During the evaluation period, documents describing national programmes and UNFPA support to the HIV response in Namibia have evolved in their use of terminology. In 2016, many documents refer to reproductive health (RH)

- Debriefing workshop with UNFPA country office (CO) staff to present preliminary findings and receive feedback on any gaps in the data used or factual errors or misrepresentation.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all elements of the UNFPA response to HIV.

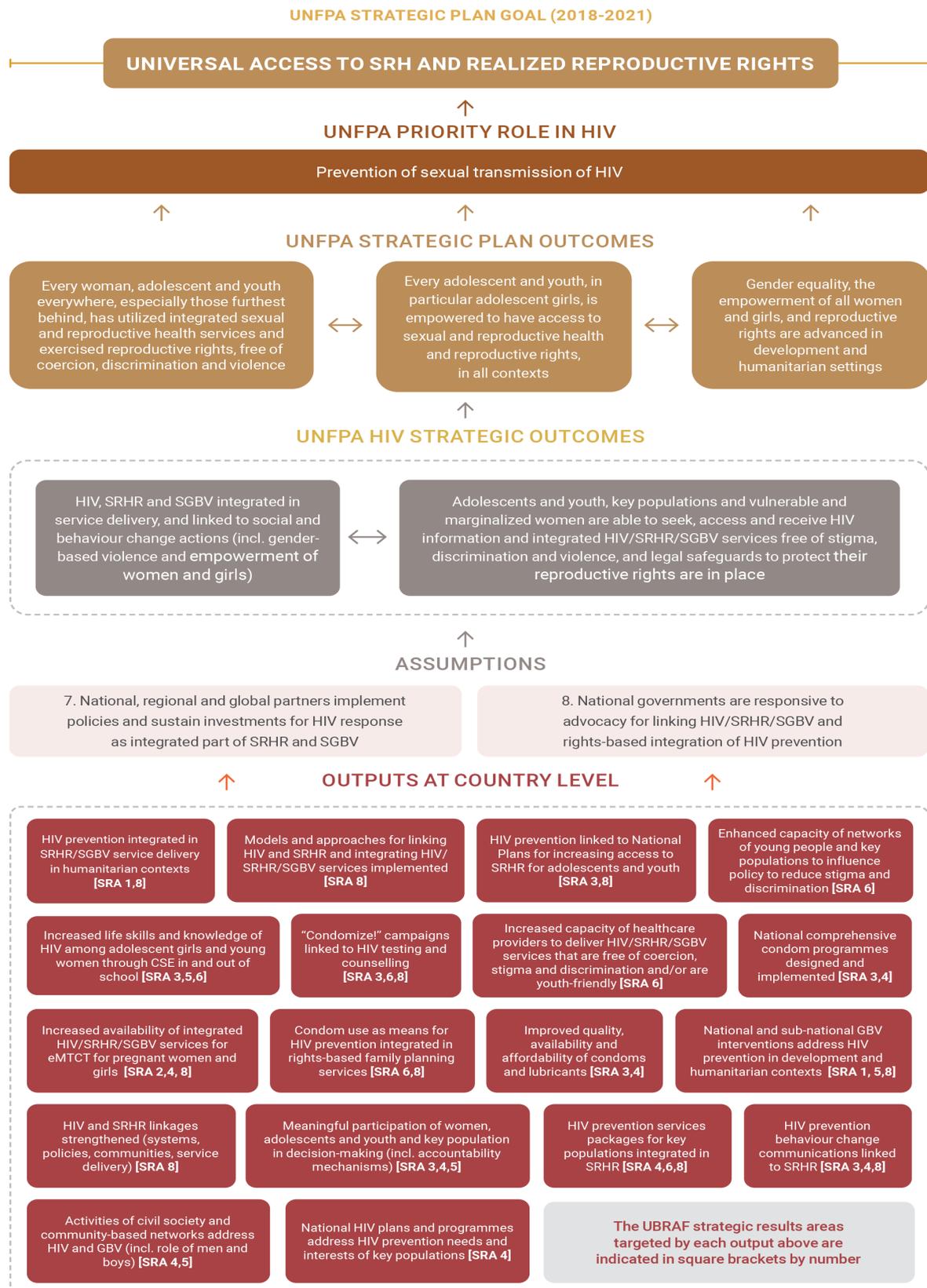
1.4 Overall theory of change

This section presents the **overall** theory of change for UNFPA support to the HIV response as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to capture **all** of the different ways in which UNFPA currently supports the response to HIV, in **vastly differing contexts** and at **different levels** (global, regional and national). **In this sense, nowhere has the evaluation team seen this theory of change implemented in its entirety.**

In fact, the theory of change encompasses a wide range of activities and a multi-layered chain of results, which are difficult to effectively implement and sustain given the current staffing and financial resources available to UNFPA for the HIV response.

or sexual and reproductive health (SRH). By 2018, most documents refer to sexual and reproductive health and rights (SRHR). There was a similar shift from references to gender-based violence (GBV) to sexual gender-based violence (SGBV). The shift from GBV to "SGBV" stems, in part, from the increasing work of UNFPA in humanitarian settings and on the women, peace and security agenda. "SGBV" was, inter alia, taken up by the Special Rapporteur on violence against women, its causes and consequences in a 2009 report, positioning sexual violence and rape as an explicitly (gendered) tool of conflict and war. "SGBV" is now the terminology that is increasingly being used in all contexts as this is one of the most common forms of violence encountered, including in intimate partner relationships as well as against those who have different sexual orientations. These shifts towards the concepts of SRHR and SGBV have not yet occurred in Georgia, in part because of its more conservative environment. However, the Georgia country report is a case study in the overall evaluation of UNFPA support to the HIV response and, for consistency, the present report uses "SRHR" and "SGBV" throughout, unless quoting from a document.

Figure 1: Overall theory of change



ASSUMPTIONS



UNFPA ACTIVITIES AND INVESTMENTS



Coordination and strengthening/sustaining political commitment and funding
(Note: This is transversal and reinforces/acts as multiplier for the activity clusters above)



PROBLEM

Almost four decades into the epidemic, and despite substantial progress, the number of people newly HIV-infected remains high. The nature of the epidemic has also been evolving with more than half of all new HIV infections (in 2018) occurring among key populations – sex workers, people who use drugs, gay men and other men who have sex with men, transgender people and prisoners – and their partners, while, in some regions, girls and young women continue to face disproportionate HIV risks. Structural factors contributing to HIV vulnerability include gender inequalities and violence, limited livelihood options, stigma and discrimination, gaps in knowledge of HIV status and lack of access to adequate health facilities.

External factors: Political developments – increasing discrimination – international HIV and SRHR financing trends – conservative attitudes towards key populations

Guiding principles: Human rights and gender equality – meaningful participation of affected populations – focus on groups left behind, most at-risk and most vulnerable – actions tailored to context – evidence-informed approach

1.5 Carrying out the HIV field-based case study in Georgia

1.5.1 Data collection activities

The country case study mission was carried out by a team of two evaluators, one international and one national consultant, from 8-15 May 2019. The case study mission was preceded by a review of relevant documents provided by the Georgia CO. These documents were supplemented by documents gathered during the mission from key informants. For a list of documents referred to in the case study see Annex D.

The evaluation team carried out extensive interviews with key stakeholders for UNFPA activities related to SRHR and HIV. The key informants included:

- The UNFPA Georgia CO, including the Country Representative and programme and technical advisors
- Senior managers at the Ministry of Labour, Health and Social Affairs; the Ministry of Education and Science, Culture and Sport (MoES); National Centre for Disease Control and Public Health (NCDC), Infection Diseases, AIDS and Clinical Immunology Research Centre (National AIDS Centre); Office of the Public Defender (PDO)
- Staff of non-governmental implementing partners, including youth representatives
- Staff of development partners supporting the health sector in the HIV response (World Health Organization (WHO), United Nations Children's Fund (UNICEF), UN Women, Coordinator for the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) grant HIV component)
- Group interviews with social workers and service providers.

1.5.2 Limitations

The evaluation team did not visit service delivery sites, nor did it have the opportunity to interview or conduct focus groups with individuals receiving services as is generally conducted in country case study missions. UNFPA Georgia does not directly support service delivery activities as per the current UNFPA business model, which prioritizes support for policy and advocacy work (Section 2.2). Nevertheless, the team was able to access all the identified key informants and this limitation does not undermine the validity of the findings reported in Chapter 3. The evidence for all findings is presented in the evaluation matrix in Annex B.

2 COUNTRY CONTEXT AND PROGRAMME RESPONSES

2.1 Overview of the HIV epidemic

2.1.1 HIV data and trends

Georgia is a country of 3.7 million people in the Caucasus region of Eurasia, bordered by Russia, Turkey, Armenia, Azerbaijan and the Black Sea. Following the fall of the Soviet Union in 1991, Georgia emerged as an independent state. Since that time it has gone through armed conflicts with separatist regions of Abkhazia and South Ossetia in 1992-1993, the Rose Revolution (a peaceful, pro-Western change of power) in 2003, and an armed conflict with Russia in 2008 over the "breakaway" territories of Abkhazia and South Ossetia where tensions remain high. Currently, 20 per cent of Georgian territory is out of government's jurisdiction.

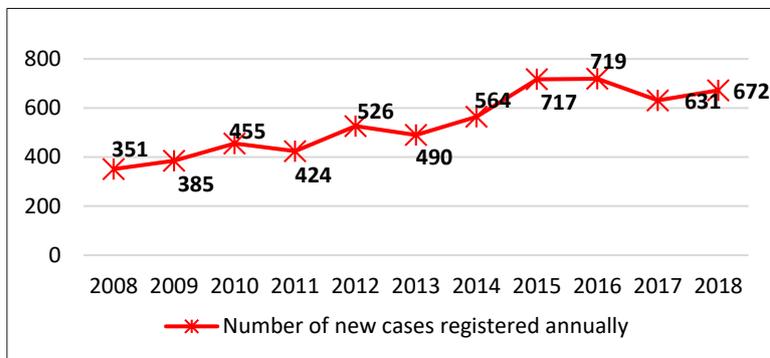
Figure 2: Administrative regions of Georgia



- | | | |
|--------------------------|---------------------------------|---------------------|
| 1 Abkhazia | 5 Racha-Lechkhumi-Kvemo Svaneti | 9 Mtskheta-Mtianeti |
| 2 Samegrelo-Zemo Svaneti | 6 Imereti | 10 Kvemo Kartli |
| 3 Guria | 7 Samtskhe-Javakheti | 11 Kakheti |
| 4 Adjara | 8 Shida Kartli | 12 Tbilisi |

The first case of HIV in Georgia was detected in 1989. Since then, the country has been actively monitoring the epidemic and has achieved significant progress, although HIV and/AIDS remains a significant public health issue. According to the National AIDS Centre, as of May 2019, a total of 7660³ HIV cases are registered. Majority of infected persons are males (5737), within the age group of 29 – 40 at the time of diagnosis; 4007 patients have developed AIDS, 1564 have died. In 2018, in total, 672 new cases were registered. The highest annual number of new HIV cases (n=719) was observed in 2016 (see figure below). The estimated number of people living with HIV (PHLIV) in Georgia is estimated to be 10,500.

Figure 3: Number of new HIV cases registered annually (2008 - 2018) ⁴



Nevertheless, HIV prevalence remains low in Georgia, estimated at 0.4 per cent (400 per 100,000 population), with concentrated epidemics among men who have sex with men (MSM), people who inject drugs (PWIDs), female sex workers and their sexual partners. From the early years of the epidemic, injecting drug use was the major transmission route; however, over the last few years, sexual transmission has been on the rise. Despite the low prevalence in the general population, there are a growing number of new cases among key populations (KPs), especially PWIDs and MSM, including young key populations (YKPs). According to the National AIDS Centre, in recent years, heterosexual and homo/bisexual contacts together are responsible for the majority of cases, followed by injecting drug use.

³ https://aidscenter.ge/epidsituation_eng.html

⁴ National AIDS Center. https://aidscenter.ge/epidsituation_eng.html

2.1.2 Key challenges and issues

The biggest challenge for the National HIV Strategic Plan (NSP) for the period 2019-2022 is to improve early HIV detection and the presentation of PLHIV for treatment. The low detection of PLHIV and late diagnosis remain significant challenges. Over the last three years more than half (51 to 55 per cent) of newly diagnosed persons presented to care late. Individuals who do not know their status continue to engage in high-risk behaviours and unknowingly transmit the virus fuelling the growth of the epidemic. Late diagnosis is the leading cause of death in Georgia and also requires additional resources to treat advanced disease, otherwise preventable with timely diagnosis. In general, testing uptake in Georgia is low within the general population and among KPs. Analysis of surveillance data from the NCDC shows that in 2017, in total, 19,109 individuals were tested for HIV in the country. Out of 631 positive cases, the majority were detected in medical facilities. It is presumed that, due to stigma, representatives of KP's are reluctant to self-identify themselves as drug users or MSM and prefer seeking HIV testing in general medical facilities rather than MSM/PWID's focused testing facilities.⁵

Although Georgia has made significant progress in adopting antidiscrimination legislation and policies in support of human rights, stigma and discrimination related to sexual orientation and against PLHIV remains a key challenge in Georgia and is especially acute for PWIDs, MSM and transgender individuals. It contributes to suppressed reporting of legal, health and social rights violations. Access to healthcare services is constrained if their HIV positive status is revealed outside HIV specialized clinics.

Given the privatized nature of healthcare services and the lack of a supervisory and regulatory oversight of providers, quality of care is an important issue with challenges related to adherence to standards and the lack of a comprehensive and systematic way for continuing medical education. Poor quality is exacerbated due to the aforementioned stigma and discrimination, resulting in lower access to and uptake of HIV prevention services especially by adolescents and YKPs.

Gender stereotypes also continue to dominate within society and contribute to challenges towards the achievement of gender equality and women's and girls' empowerment. Violence against women is a recognized concern yet it is generally framed in terms of domestic violence, making it easier for doctors and law enforcement to ignore as a "family concern." Sexual gender-based violence (SGBV) is not only a serious violation of human rights, but it also contributes to an increased risk of HIV infection.

2.1.3 Policy and health system response

The Georgian Law on HIV and AIDS defines the responsibility of the Government of Georgia (the Government) to ensure the implementation of effective interventions for HIV prevention and treatment; additionally, the Georgia Law on Public Health emphasizes the role that the Government should play in creating a solid framework for the national HIV response and supporting implementation.⁶

The Government places HIV at a high level of its political and health agenda. In 2018, the country developed a new *National Strategic Plan for HIV/AIDS (2019-2022)* to provide guidance towards achieving the UNAIDS 90-90-90 targets with corresponding funding requirements. According to the most recent NSP, in 2017 analysis of fast track 90-90-90 targets show that only 48 per cent (n=5,090) of the estimated number of PLHIV are aware of their status; 81 per cent (n=4,144) of those diagnosed are on anti-retroviral therapy (ART) and, of these 89 per cent (n=3,703) are virally

⁵ Chkhartishvili N, Chokoshvili O, Bolokadze N et al. *Late presentation of HIV infection in the country of Georgia: 2012-2015. PLoS One. 2017;12:e0186835.*

⁶ Government of Georgia, 2018. *Georgia HIV/AIDS National Strategic Plan 2019-2022*

suppressed.⁷ Diagnosis is the primary challenge; however, the Government's implementation of a "treat all" policy in 2015 has contributed to approaching the fast-track targets for ART and viral suppression.

The overall goal of the current NSP is to reverse the HIV epidemic in Georgia through targeted and sustainable interventions of KPs and their sexual partners and to improve the quality of services and treatment outcomes. Objectives include:

- Scale up of HIV preventive services to ensure timely detection and progression to care
- Ensure universal access to quality treatment, care and support
- Ensure sustainability of HIV response through enhanced government commitment and greater involvement of civil society.⁸

Although the HIV epidemic is concentrated among KPs, the elimination of mother to child transmission (EMTCT) is a high priority for the Government. A National EMTCT Board was created in 2017 to lead the elimination process. At present, all pregnant women have access to antenatal care (ANC) HIV testing and all HIV positive mothers and their children have access to ART prophylactic and/or full treatment.

The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoH) is responsible for oversight and regulation of health services. The healthcare system in Georgia is extensively privatized and decentralized; most primary and secondary providers are private, for-profit entities in terms of management and ownership.

The NCDC is accountable to the MoH and is responsible for the prevention and control of communicable and non-communicable diseases, including the development of national standards and guidelines, health promotion, disease surveillance and management of public health emergencies. It implements ten vertical state programmes for public health protection and health promotion covering early detection and screening for diseases, surveillance, blood safety, prevention of occupational diseases, TB management, HIV and AIDS management, maternal and child health (MCH), immunization, health promotion and Hepatitis C management.

The PDO is the national institution responsible for human rights observance and monitoring. It analyses the nation's laws, policies and practices to see how they align with international standards and advises the Government with relevant recommendations.

Civil society organizations (CSOs) are explicitly noted in the NSP for specific competencies to contribute to the overall HIV response in Georgia, i.e., in reaching out to vulnerable populations, mobilizing communities and developing effective service delivery models. Their involvement is seen as an important component for achieving desired outcomes. However, there are regulations that make it difficult for non-governmental organizations (NGOs) to offer direct HIV testing and services., i.e., testing with rapid tests can be provided if the NGO has at least one nurse on staff. NGOs can provide preventive services and social assistance, but cannot offer treatment. Further, although mechanisms exist for the Government to contract with NGOs for social services, these have not yet been used for HIV prevention.

⁷ Ibid, p. 11

⁸ Ibid, p. 15

2.1.4 Financing for HIV and AIDS

The Government enacted a universal health care programme in 2013 which signalled a significant shift in the way health care is financed and purchased in the country. As a result, publicly funded entitlements were extended to the entire population to cover a package of services with a variable depth of coverage depending on household income. In 2017, those with an income of USD 20,000 or higher were excluded and are assumed to be covered by private insurance package⁹. Although the overall share of health spending in the government budget has been increasing (8.8 per cent in 2018), it is still relatively low compared with other countries in the European region and the fragile economic situation may limit the Government's ability to increase further investments in health, including for the HIV response.

HIV and AIDS is a one of the priority communicable diseases along with Hepatitis C and TB. Georgia continues to be eligible for Global Fund resources for the 2020 to 2022 funding cycle. In 2015, the public share out of the total AIDS spending was estimated at 55 per cent (and had increased from 32 per cent in 2013). The Government resolution in July 2016 that legally endorsed the NSP confirmed Government commitment to sustaining funding for HIV control. While specific programmes are covered by the state, e.g., PMTCT, Blood Safety and Opioid Substitution Therapy, there is concern that some portion of anti-retroviral (ARV) treatment costs, a substantial portion of HIV prevention and care, and surveillance are dependent on the Global Fund.¹⁰

United States Agency for International Development (USAID) was a major donor for health and HIV activities but phased out assistance by 2014, including its

support for Population Services International social marketing of condoms for HIV prevention. Its current portfolio is focused on democracy and governance activities. No other major bilateral donors are active in the HIV response in Georgia.

UN agencies active in Georgia during this period include UNFPA, UNICEF, WHO, World Bank, UN Women and United Nations Development Programme (UNDP) and United Nations Office for Project Services (UNOPS), United Nations High Commissioner for Refugees (UNHCR), Office of the High Commissioner for Human Rights (OHCHR), International Organization for Migration (IOM). UNAIDS does not have a presence in the country. UNFPA chairs the HIV and AIDS Theme Group and represents UN in Policy and Advocacy Advisory Council (PAAC), which operates under the NCDC/the Global Fund, in addition, UNFPA is the member of Country Coordinating Mechanism (CCM).

2.2 UNFPA HIV-related activities in Georgia

2.2.1 Financial allocations

According to the current business model in the 2018-2021 UNFPA Strategic Plan, Georgia is in the yellow quadrant which supports capacity development for an enabling environment and institutional level, partnerships and coordination, knowledge management, and advocacy, policy dialogue and advice (but not service delivery).¹¹

⁹ World Bank. *Georgia Public Expenditure Review - Building a Sustainable Future*. Report No: 114062-GE. June 2017

<http://documents.worldbank.org/curated/en/630321497350151165/pdf/114062-PER-P156724-PUBLIC-PERFINAL.pdf>

¹⁰ Ibid, p. 17.

¹¹ United Nations Population Fund. *UNFPA strategic plan, 2018-2021*. Annex 4.

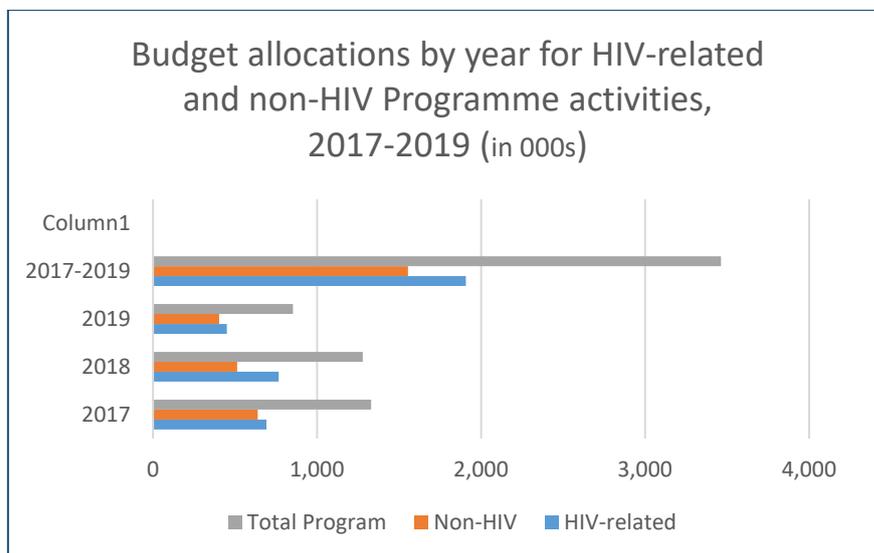
Data available from UNFPA Georgia show an overall programmatic portfolio valued at USD 3.46 million for the period 2017-2019 under the third country programme for Georgia. Over this three-year period, the Georgia CO identified seven projects that they considered to be HIV-related. In this context “HIV-related” tag is given to a range of activities that include an HIV component, generally within a broader SRHR. activity. The table below provides a brief description of project activities that were tagged by the Georgia CO as HIV-related and indicates source(s) of funding and total budget allocation from 2017-2019.

Table 3: UNFPA Georgia HIV-related project activities

Project name	Fund source	Total USD 2017-2019
Support improved sexual and reproductive health (SRH) quality of care through continuing medical education (CME) at Tbilisi State University	UNFPA	8,000
Healthcare response to domestic and gender-based violence (GBV)	Other	105,708
Support for healthy lifestyles and SRH education	Other	62,688
Strengthened gender equality and reproductive rights	UNFPA, Other	694,672
Georgia Multiple Indicator Cluster Surveys (MICS) (2017-2018) under UNICEF execution	UNFPA, Other	112,598
Country inquiry into SRH and well-being (PDO)		64,150
Strengthened policy and mechanisms for SRH services	UNFPA, Other	788,292
Joint UN Programme on HIV and AIDS (includes policy/advocacy, capacity building and YKP advocacy)	UBRAF	71,237

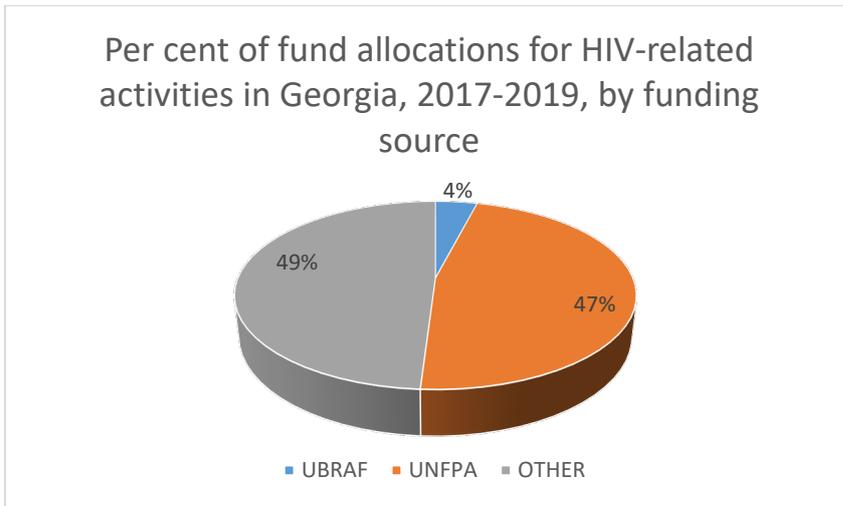
Budget allocations for these HIV-related projects account for approximately USD 1.9 million or 55 per cent of the total programme.

Figure 4: UNFPA Georgia budget allocations dedicated to HIV activities



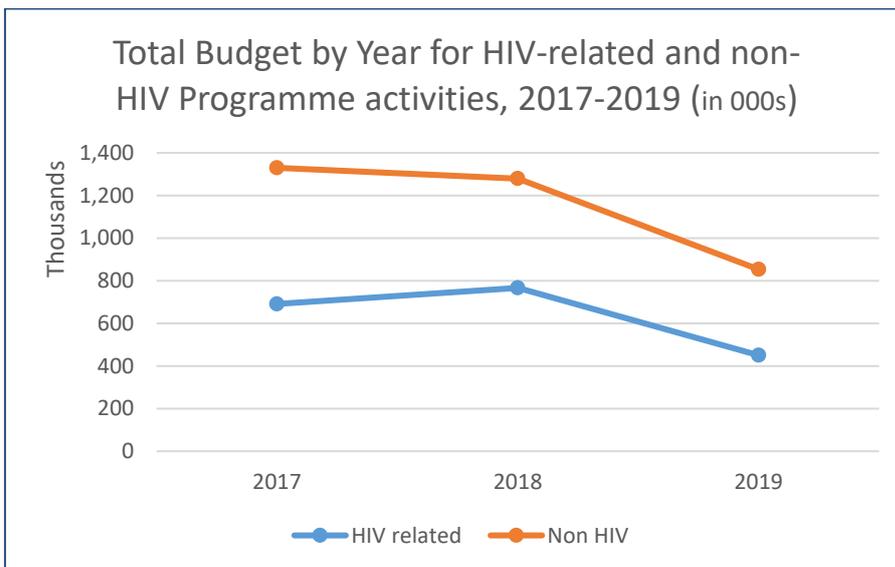
There are three categories of funds available to support HIV-related activities in Georgia, including UBRAF funds allocated from the Joint Programme, UNFPA core funds, and funds mobilized from donors such as the European Union (EU) and Swedish International Development Agency (SIDA) for specific activities. UBRAF funds make up a very small part of the budget for HIV-related programming as seen in the figure below.

Figure 5: Per cent of fund allocations for HIV-related activities in Georgia by source of funds



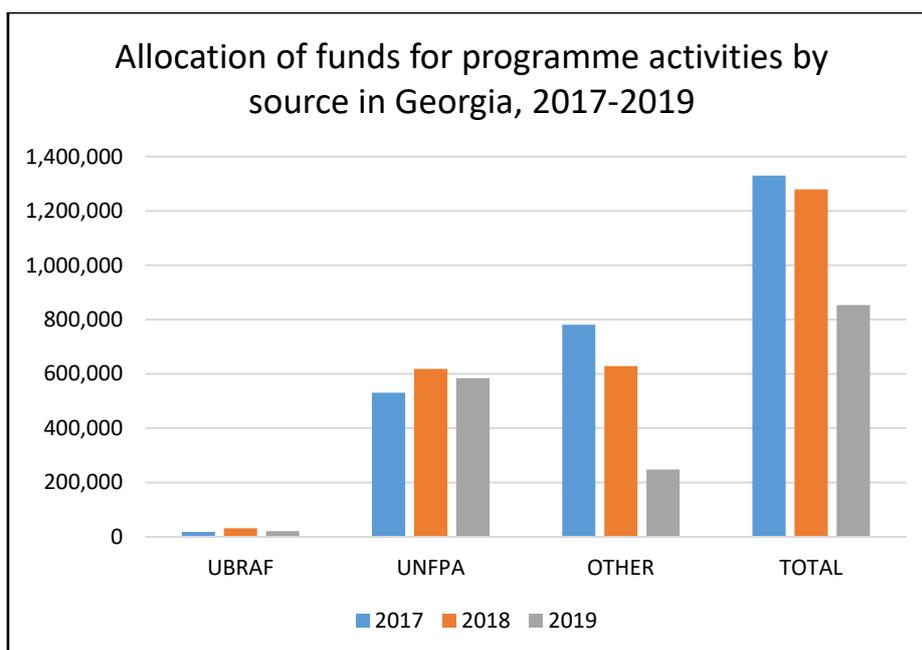
In general, funding allocations for Georgia decreased between 2017 and 2019 for all programming, whether HIV-related or not. The figure below indicates that there was a slight increase in budget allocations for HIV-related activities between 2017 and 2018, the amount dropped over 40 per cent between 2018 and 2019.

Figure 6: Trends in total budget allocations for HIV related and non-HIV activities, 2017-2018



When looking at in the totality of the overall programme budget for all activities (HIV-related and non-HIV), UBRAF funding is practically negligible as compared to the other sources of funding through the three years. The aforementioned dip in funding between 2018 and 2019 is the result of a decreased allocation in the “other” category, i.e., in SIDA funding.

Figure 7: Programme fund allocations by source in Georgia



2.2.2 Key implementing partners

UNFPA is operating under its third country programme for the five-year period 2016 to 2020 to achieve strategic plan outcomes in SRH, gender equality and women’s empowerment and population dynamics. HIV-related activities are integrated within the SRH and gender equality and empowerment portfolios. UNFPA works with both governmental and non-governmental partners to address HIV-related activities. A summary of key implementing partners and the programme areas supported by UNFPA are described in the table below.

Table 4: Key partners and implementing partners of UNFPA Georgia

Partners and implementing partners	Areas of programme support
Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (MoH)	<ul style="list-style-type: none"> Standards and protocol development for EMTCT, cervical cancer Screening, SRH and HIV prevention for KPs Strategy and plan development Quality monitoring (Near Miss Case Reviews) Integrated SRH-HIV service delivery in Abkhazia, Georgia
Ministry of Education, Culture, Science, Sport and Youth Affairs (MoE)	<ul style="list-style-type: none"> Integration of healthy lifestyle education into formal and non-formal systems, including peer education
National State Medical University	<ul style="list-style-type: none"> Online platform for continuing medical education (training module, accredited e-Learning course on SRH/HV prevention)
Public Defender’s Office (PDO)	<ul style="list-style-type: none"> Monitoring/assessments of human rights and gender issues
National Centre for Disease Control/the Global Fund	<ul style="list-style-type: none"> National HIV Prevention standards and costing tool – guidelines and protocols for MSM, SW and YKPs HIV National Strategic Plan 2019-2022 EMTCT National Action Plan 2017-2018 HIV and AIDS Routine Surveillance Guidelines (voluntary counselling and testing (VCT) guidelines, routine surveillance)
NGO Tanadgoma	<ul style="list-style-type: none"> Capacity building in SRH-HIV for KPs
NGO Harm Reduction Network	<ul style="list-style-type: none"> Capacity building in SRH-HIV for KPs
NGO Georgian Youth Development and Education Association	<ul style="list-style-type: none"> Youth engagement and peer education

3 CASE STUDY FINDINGS

3.1 UNFPA and the strategic response to HIV – Coordination and sustainability in the national context

UNFPA plays a key role in coordinating the UN response to HIV in Georgia. It stepped up to lead and coordinate the UN Joint team response in the absence of UNAIDS in country. UNFPA represents the UN on the CCM, the major platform for coordination of the Georgian HIV response, including its PAAC. Using the platform, the CO has leveraged its relatively limited resources and its reputation as a solid partner to reposition and support for HIV prevention within its broader portfolio of SRHR and gender activities. UNFPA has assisted the national Government to strengthen its capacity for sustaining the HIV response through the elaboration of national strategic documents, including the National HIV Strategic Plan and the Sustainability and Transition Plan. Further, it has invested in the development of e-learning platforms to ensure the sustainable reach and availability of internationally approved standards, guidelines and protocols for generations of providers.

For details of the evidence supporting findings in Section 3.1 see the Evaluation matrix (Annex B): Assumptions 1.1, 1.6, 4.1, 4.2, 4.4, 5.2, 6.1, 6.2, 6.3, and 6.4

3.1.1 UNFPA strategic response, including the repositioning of HIV prevention as a priority

Interviews across the board with Government and non-governmental informants support the notion that UNFPA Georgia has been very strategic with its relatively small pot of resources in supporting critical issues in HIV prevention. It has taken up the mantle of leadership on behalf of the UN to move things forward given the lack of a UNAIDS presence in country. This is also in the context of the Global Fund is planning a transition from its support (to take effect in 2022) and following the withdrawal of USAID funding for a robust portfolio of health and HIV-related activities in 2014.

UNFPA strategic response in Georgia is well-aligned with the post-2015 development agenda and the UNFPA Strategic Plan. Its activities are rooted in the middle-income country context and follow the business plan modalities for advocacy, policy dialogue, knowledge management and brokerage of technical expertise. Given the upward trend in HIV infections among KPs, UNFPA has “stepped up” to leverage small amounts of funding to support HIV prevention within its broader portfolio of SRHR and gender activities through a targeted approach, despite HIV not being its main mandate. Stakeholders interviewed noted that the need for a more balanced approach whereby prevention gets more attention and support, as plans are already in place to support drugs needed for treatment by 2022.

The main implementation strategy has been to work with governmental and non-governmental partners on the elaboration of national strategy documents, standards and protocols and related training materials in anticipation of the Global Fund transition and the shifting burden of implementation to the Government. Highlights of UNFPA strategic input have included, but are not limited to, advocacy and consultant support for the development of the NSP for HIV and AIDS (2016); funding for local consultant support for the development of HIV and AIDS NSP (2019-2022) in 2018; initiation of the development of Standard Operating Procedures (SOP) related to gender-based violence in emergencies; the adoption of UNFPA implementation tools for sex workers (SWIT) and MSM (MSMIT) within national standards for HIV prevention and care for KPs (2017); collaboration with WHO and UNICEF to develop EMTCT guidance aligned with the National Maternal and Newborn Health Strategy 2017-2030 (2017).

UNFPA worked closely with the MoH on aforementioned standards and protocols given the latter's responsibility for health care legislation, public health, human resource development and oversight. However, due to the privatized nature of health care delivery, the MoH has limited scope over the actual delivery of health care services in terms of quality and equity which limits the impact of UNFPA inputs. With this in mind, UNFPA is working with the AIDS Centre, the NCDC and Tbilisi State Medical University to support an e-learning platform for continuing medical education in order to promote a sustainable means for building capacity of and updating providers on reproductive health and rights, HIV and sexually transmitted infections (STI). (For more details refer to Section 3.2).

3.1.2 Coordination platforms

The CCM is the major body of coordination for the national response to HIV and AIDS and TB. It has 28 members representing a range of government and non-governmental actors, and is chaired by the Minister of Health. Interviews with stakeholders indicated that the future of the CCM is in question given that the Global Fund is phasing out in 2025; however, they consider it to be a useful mechanism that should be maintained following the transition. There is also a Prevention Task Force, a project-based prevention network and coordination activity created in 2013 by USAID when it was active in Georgia and prior to the establishment of the CCM. It is no longer funded, however, it retains value as a coordination mechanism and a forum for exchange and technical input and advice among its members. It does not duplicate the CCM, and meets when there is a need to discuss strategic issues, to elect CCM members from the NGO/CSO constituency or when there is a crisis. In 2014, the UN Joint Team on HIV and AIDS in Georgia was revitalized with UNFPA assuming the role of Chair (UNAIDS left in 2013.) Since then, UNFPA has been representing the UN at the CCM; it is also on the Policy Advocacy Advisory Council. The other agencies that are active on the UN Joint Team appreciate how UNFPA represents the UN and serves as a conduit for input and information in both directions. UNFPA has been unanimously described by its UN and its national counterparts as a very effective and supportive partner.

3.1.3 Support to strengthen national HIV response

The 2019-2022 NSP is the fifth HIV and AIDS plan in Georgia; the first one was developed in 2003. The Government has acknowledged HIV and AIDS as a priority and mainstreamed HIV and AIDS prevention and control interventions into several state programmes, with the main goal being the early detection of new cases to reduce the spread of HIV and AIDS and provide access to treatment for HIV-positive individuals. As noted in Section 2.1.3, Georgia has reached "high performance levels" in achieving the second and third UNAIDS 90-90-90 targets as a result of its "treat for all" policy established in 2015. However, it is behind in the first 90 target as only 48 per cent of individuals knew their HIV status in 2017. UNFPA advocacy and technical assistance is seen by government stakeholders as critical and strategic. This is exemplified by the comment of a government official who confirmed the strategic importance of attention to prevention and we know "what to do" but need assistance in "how" to do it.

3.1.3.1 Allocation of resources toward sustainable national investment

In anticipation of the withdrawal of Global Fund resources, the Government developed a transition plan in 2016 to support sustainability of AIDS- and TB-related activities by the State. Georgia was among the first few countries in the EECA region to develop such a plan. The plan is seen as feasible by stakeholders given that the Global Fund supports 25 per cent of the HIV response with the remaining funding by the State. Its main objectives are to create a conducive legal environment to ensure smooth implementation of HIV and TB national response; achieve greater engagement of CSOs through public funding; and enhance structural, institutional and human resource capacity to implement and manage quality HIV and AIDS and TB interventions at scale.

The Global Fund is planning to change its funding scheme to a performance-based model; however, stakeholders spoke of major challenges related to the need to design the mechanism and build the capacity of providers and NGOs to report on performance-based results. In particular, stakeholders from NGOs were concerned about this shift as well as the withdrawal of Global Fund resources for HIV-related activities. Many NGOs are fully dependant on the Global Fund. Reimbursement will be based on indicators for new and continuing clients; however, validation will be a huge issue given the use of a unique code identifier to preserve the confidentiality of clients. Technical assistance to the government in health care financing is required, although this would not be sought from UNFPA.

UNFPA supported key strategic exercises to prepare for the upcoming transition from Global Fund to state funding. It supported consultants to assist in the development of the NSP and the Georgia Transition Plan. UNFPA also conducted advocacy through the CCM Policy and Advocacy Advisory Council to prioritize strengthened HIV prevention among KP and contributed to the development of national comprehensive HIV prevention packages and standards, including costing for sex workers (SWs), MSM and YKPs.

Another key aspect of UNFPA contribution to sustainability was to support e-learning platforms for continuing education and capacity development of providers to offer quality, stigma-free services. The Transition Plan acknowledges “moderate risk” in terms of sustainability of human resources for quality HIV and AIDS service delivery. Training activities tend to be supported by external sources for the last decade and there is no institutionalized formal education system. This is exacerbated by the dominance of privately-managed clinics and the lack of a quality assurance mechanism. UNFPA efforts to establish an e-learning platform to serve as a means for continuing education and accreditation is one strategy to mitigate this risk. Its focus on quality of care and reducing stigma and discrimination by providers of KPs also supports sustainability of demand for and access to testing and preventive services by these groups.

3.1.3.2 Knowledge management in the national and regional context

UNFPA Georgia has strong links to the Eastern Europe and Central Asia UNFPA regional office (EECARO) which uses a team approach in its management of COs within the region. This team approach is described by UNFPA regional staff as “horizontal” whereby country colleagues are assigned lead roles in certain technical areas. For example, the HIV programme advisor in Georgia serves as the point person for collaboration with WHO on such activities as guideline development. This regional division of labor has the function of helping to manage the regional workload, while also giving CO staff incentives to work on HIV activities in face of minimal and decreasing resources. It also ensures that country perspectives are represented in regional work and as an effective conduit for sharing and disseminating knowledge and lessons learned within the region. This firm link to EECARO facilitates a strong connection by UNFPA Georgia to regional networks working on HIV-related activities. Staff from COs are sometimes selected to attend regional conferences on behalf of the RO. For example, UNFPA Georgia participated on behalf of the EECARO in a 2016 strategic planning meeting of the Eurasian Network of Women with AIDS (EWNA), a strategic partner of UNFPA EECARO. EWNA is a network of women leaders whose mission is to improve the quality of life of women living with HIV and women affected by HIV in EECA; it was created to ensure that women’s leadership is at the centre of the HIV response in EECA region.

Another regional connection is to the Eurasian Coalition on Male Health (ECOM), a regional member-based NGO located in Estonia. ECOM is focused on evidence-based and human rights-oriented health services, including HIV prevention and treatment for all gay, bisexual and other MSM and all trans people. UNFPA Georgia represents EECARO on the Regional Advisory Group on Strategic Information (RAGSI) for the ECOM Global Fund grant and participated in an assessment of HIV in MSM and trans people in Georgia as well as other countries in the region, including Armenia, Belarus, Kyrgyzstan and

Macedonia. The purpose of the assessment was to further understanding of the epidemic context, vulnerability and exposure to risk and options to alleviate the HIV burden and its impacts among different populations.

UNFPA Georgia at times supports the generation of evidence for policy and advocacy purposes. Evidence generation is an important aspect of UNFPA Georgia country programme theory of change as it relates to the development of policies, standards and guidelines; advocacy for increased access to services by youth and other vulnerable populations; and knowledge management on increased quality and coverage of cervical cancer screening programme. Examples include support for a set of SRHR- and SDG-related indicators to be included in the MICS-6 questionnaire. UNICEF is supporting the overall survey while UNFPA is supporting the development and analysis of data related to family planning. Other evidence generation comprise: an eight-country study of focus group discussions with YKPs which included Georgia; collaboration with Tanadgoma on a qualitative study of truck drivers and sex workers along the “silk road”; the development of a National Cervical Cancer Screening Registry software for incorporation into the broader National Cancer Registry; and a qualitative study conducted with NCDC of early marriage in collaboration with Promundo, a global NGO that promotes gender equality and prevents violence by engagement men and boys in partnership with women and girls.

3.2 Integrating HIV/SRHR/SGBV: the central strategy

UNFPA has adopted service integration as a deliberate strategy to address HIV prevention given its overall mandate in SRHR. This is clearly demonstrated via CO efforts to elaborate standard packages for *HIV Prevention and Service Standards for Key Populations*, based on the UNFPA implementation tools for MSM, SWs and YKPs. This has been an effective strategy to leverage its limited resources to address national priorities and needs related to HIV prevention. However, there are potential missed opportunities for strengthening SRHR-HIV linkages as there was little evidence noted for bi-directional integration in other selected areas such as cervical cancer screening, family planning counselling and service delivery (within the Maternal Neonatal Strategy), VCT and routine maternal health surveillance activities. To strengthen capacity for delivery of quality of integrated SRHR-HIV services, UNFPA supported the development of an e-learning platform based on the aforementioned standard packages for HIV prevention. This helps to mitigate the lack of a systematized process for continuing medical education in the absence of an ongoing supervision and performance management system. UNFPA also supports integrated SRH service delivery in the context of humanitarian services in the breakaway region of Abkhazia, Georgia. e-learning platforms also help to mitigate challenges faced by providers due to travel restrictions and lack of access to information and updates while under Russian oversight.

For details of the evidence supporting findings in Section 3.2, see the Evaluation matrix (Annex B): Assumptions 1.1, 1.2, 1.3, 1.4, 1.5 1.7, 2.5 and 3.3

3.2.1 Models and approaches developed or adapted for quality-focused, client-centred services

The main interventions employed by UNFPA Georgia focus on supporting policy frameworks (guidelines, standards, protocols, strategies and action plans) for ensuring access to integrated reproductive health services, including maternal care, cervical cancer screening and HIV prevention; and addressing unmet need for family planning through advocacy and technical support. There is no overall SRHR strategy in Georgia; rather reproductive health is covered under the Government Maternal and Newborn Health (MNH) strategy. Given the overall shortage of human and financial resources, integration is an opportunistic strategy pursued by UNFPA Georgia to address broader SRHR within the context of its HIV, youth and maternal health activities.

There are a few key technical areas where service integration takes centre stage, such as through the elaboration of standard packages for *HIV Prevention and Service Standards for Key Populations* (based on MSMIT, SWIT, EMTCT and in supporting the effective response of health care providers to sexual and gender based violence, including in emergencies. Efforts to support youth to address HIV and SRHR needs are covered in Section 3.3.2 and 3.3.3. However, in several other service delivery models promoted by UNFPA, in particular, those related to maternal health and family planning, the focus on linkages and integration is either implicit or absent. The lack of a national strategy to prioritize integration exacerbates the potential for missed opportunities to address SRHR more broadly in Georgia.

Standards Packages for the HIV Prevention

UNFPA Georgia has effectively used the collaborative tools developed by UNFPA and others in 2015 as an organizing framework for its advocacy with the government and the eventual development of standard packages (guidelines, protocols and cost calculations) to guide service delivery for KPs. The integrated tools encompass a range of services, including addressing SGBV, condom and lubricant programming, and HIV and SRHR clinical and support services. In 2016, UNFPA supported the elaboration of national standards for SWs and MSM with the wide participation of stakeholders from community organizations, NGOs and state programme providers. In 2017, UNFPA rolled-out the MSMIT and SWIT tools at a Civil Society Forum, and presented the comprehensive prevention package for KPs, including national guidelines and protocols for clinical practice and state standards for the management of clinical cases. According to NGO stakeholders, the MSMIT tool has resulted in a lot of interest from communities and many have asked for training.

Maternal and Newborn Health (MNH) Strategy (including family planning) Strengthening MCH is one of the priorities of the Georgia health care system for 2014-2020 and it is a major focus of the work of UNFPA Georgia in support of UNFPA Strategic Plan Strategic Outcome 1, Output 1. At the request of the MoH, UNFPA provided technical assistance in the development of the MNH strategy for the period 2017- 2030 in 2016 and supported a high-level advocacy meeting in 2017 to present it and a three-year costed action plan to stakeholders.

The aim of the MNH strategy is to provide guidance for the improvement of maternal and newborn health, as well as for related fields of family planning and adolescent SRHR in Georgia. Within the strategy, the main focus of integration is to ensure family planning is provided within the primary health care (PHC) system, with a focus on postpartum and post-abortion family planning within ANC and postnatal care counselling. However, there is only minor mention of integration with HIV and AIDS services in the section on family planning, when it is noted that family planning reduces the incidence of STIs including HIV and AIDS infection. Likewise, within the MNH section on SRH of young people, the strategy mentions that SRH of young people has been a neglected issue and research on STI/HIV prevention is limited, while calling for introduction of school-based healthy lifestyles education. Stakeholder interviews suggested that what originally started as a SRHR strategy was eventually called a MNH strategy to avoid resistance from conservative groups.

UNFPA Georgia has supported efforts to strengthen family planning through the development and dissemination of policy briefs that advocate for strengthening family planning policies and services as a means for reducing the incidence of abortions and to forecast the cost of contraceptives. These briefs, produced in 2017, address some of the challenges related to family planning access. These include an over-reliance on abortion as a method of fertility regulation with limited access to post-abortion contraceptive counselling; the dominant role of obstetrics and gynaecology (OB/GYN) specialists in providing services, with limited availability at PHC levels; and the lack of public funding for contraceptives. UNFPA also supported in 2016 the revision and adaptation of WHO medical eligibility criteria (MEC) for contraceptive use (MEC, 5th edition).

Regarding procurement, UNFPA and USAID discontinued support for contraceptive supplies in 2015 and contraceptives are not included on the essential drugs list. The public sector procurement of SRHR commodities covers vaccines, ARVs and TB medicines. Contraceptives are only available through private pharmacies with prescription, except for emergency contraceptive pills, at relatively high prices and therefore, unaffordable especially for young people. According to stakeholder interviews, lack of public funding is less an issue of money than of political will.

As part of its MNH portfolio, UNFPA supported a pilot of the *Beyond the Numbers*¹²(BtN), a WHO methodology for reviewing maternal deaths and complications, initially in four and then extended to nine selected private maternities in Tbilisi and Kutaisi. The pilot involved conducting “near miss case reviews” (NMCRs) to understand the underlying causes of severe maternal complications, to identify recommendations and to implement actions to improve quality of care. A review in 2018 indicated that very good results have been achieved in nearly all hospitals, with seven out of nine meeting minimum requirements for the quality of NMCR practice. Improvements were seen in internal organization, case identification and selection for review, respect for ground rules, and reference to national guidelines/protocols and local standards.

UNFPA also supported implementation of the Perinatal Care Regionalization project, a MoH initiative that assessed adherence to standards of care in 21 perinatal care facilities in Tbilisi and another 11 in Kvemo Kartli in 2016 and 2017. This led to the development with UNFPA support of the ANC Regionalization Model which categorizes ANC into three levels of care and outlines detailed standards and requirements for each level for infrastructure, services, equipment, supplies and assessment. This model is seen as relevant for reorganizing and staging other health services in Georgia and eventually, the development of integrated care networks. It has been submitted to the MoH for formal approval, expected in late 2019.

Eliminating Mother to Child Transmission (EMTCT)

EMTCT has been prioritized by the MoH; the NSP calls for the elimination of HIV and syphilis transmission from mother to child by 2020. MoH created a national EMTCT Board in 2017 to lead the elimination process. UNFPA supported NCDRC representatives to participate in the WHO Regional Consultation of HIV and Congenital Syphilis in 2015 in the WHO European Region and, in 2017, joined the WHO initiative and partnered with UNICEF to provide technical assistance to the NCDRC to strengthen EMTCT. Technical assistance included the development of a national EMTCT self-assessment indicators with passport and data sources based on the WHO self-assessment tool; support for an EMTCT National Plan for 2018-2019; and a monitoring and evaluation tool, based on targets and objectives of the EMTCT National Plan. There has been no case of vertical transmission for three years.

Cervical cancer screening

Cervical cancer is the second most common cause of cancer death in EECA; every year there are 38,000 new cases and 18,000 deaths in the region, with rates that are up to 10 times higher than in Western Europe.¹³ It is a preventable disease that is curable if detected and treated early; women living with HIV are more likely to become infected with the HPV virus that causes cervical cancer and are four to five times more likely to develop invasive cervical cancer. UNFPA Georgia has supported cervical cancer screening efforts through a variety of interventions, including screening pilots conducted in four clinics in Tbilisi and Gurjaani District (Kekheti Region) in 2016 aimed at improving coverage which is low (9 per cent in rural and 15 per cent in urban). The pilot included training for 85 OB/GYN and family doctors on screening SOPs and Pap Test techniques; the installation of screening

¹² WHO, 2004. *Beyond the Numbers: reviewing maternal deaths and complications to make pregnancy safer.*

¹³ UNFPA EECA Region, accessed from: <https://eeca.unfpa.org/en/tags/cervical-cancer?page=1> accessed July, 2019.

registration software; dissemination of messages regarding the benefits of screening via clinic flyers, billboards, TV talk shows; and on-site supervision and training for family physicians.

In addition to the pilot, UNFPA Georgia supported the development of the National Cervical Cancer Screening Registry software and its incorporation into the broader National Cancer Registry. This effort was undertaken in cooperation with the MoH, NCDC National Screening Centre and local experts to prepare for rollout of the registry through the development of a users' manual and the conduct of a training of trainers workshop (ToT) for NCDC personnel in registry procedures, data definitions and their analysis and interpretation.

Sexual and gender-based violence

One of the areas in the UNFPA Georgia 2016-2020 programme theory of change is to conduct advocacy for the integration of the Minimum Initial Service Package (MISP) for reproductive health and GBV services in crisis situations. The MISP is a series of actions that respond to reproductive health needs of populations in early phases of a refugee situation and addresses maternal health, HIV prevention, contraceptive service delivery, and prevents and manages consequences of sexual violence. In partnership with UNICEF in 2017, UNFPA conducted a technical workshop to integrate GBV interventions into preparedness and humanitarian actions for stakeholders from Government, NGO and UN agencies. This also ensured that MISP is included in the UN Inter-Agency Contingency Plan and the Action Plan (SRHR, GBV, general practice and emergency obstetric care). Further, in 2018 UNFPA initiated the development of SOPs related to gender-based violence in emergencies and protocols on the Clinical Management of Rape. These are under consideration for integration into the national legal and policy framework.

HIV and AIDS Routine Surveillance Guidelines for Voluntary Counselling and Testing (VCT)

In collaboration with WHO, NCDC and the AIDS Centre, UNFPA supported the update of VCT guidelines for routine surveillance to support the capacity to detect new HIV cases, report and conduct routine surveillance at the country level in accordance with new consolidated guidelines developed by WHO and UNFPA on HIV testing services and on HIV self-testing and partner notification. UNFPA supported this effort through the provision of technical assistance for HIV surveillance in KPs, pregnant women and blood donors; HIV surveillance in general population within stand-alone or integrated HIV/Hepatitis C and TB screening; routine epi-surveillance with VCT and without VCT; and data flow, confidentiality and security measures, including electronic data management and security. Per interviews with government stakeholders, UNFPA technical assistance was appreciated as was their quick support of the collaborative process to update these guidelines. However, this effort is vertical in nature and presents a missed opportunity for addressing SRHR-HIV linkages.

3.2.2 Capacity building for integrated services

Quality of care is hampered in Georgia by insufficient undergraduate medical education and an inefficient system for CME. This is exacerbated by the effects of privatization whereby 97 per cent of providers operate independent from government ownership, governance and management. Private ownership results in low incentives for doctors to attend CME courses. Facility management does not pay for these courses, and doctors are unwilling to pay out-of-pocket. Other capacity issues that affect primary health care and SRHR-HIV services include the aging of the OB/GYN cadre at PHC level, lack of interest among younger doctors in this and other PHC-related medical specialties; and the absence of a system for supportive supervision and on-the-job training or feedback. The country also lacks a cadre of nursing professionals; private clinics train their own nurses. There is no state certification programme in nursing and a problem with the quality of nursing education.

With no other way to assure providers are up-to-date, UNFPA Georgia partnered with Tbilisi State Medical University (TSMU) to develop a post graduate platform for online training in contraception

and ANC and provide technical assistance in the training content and personalized tests. The university runs and maintains the platform. The online training is free-of-charge and supports “grassroots level capacity building” for providers from rural underserved areas, including the conflict region of Abkhazia where there are no other options for clinical updates. In cooperation with the NCDC and the National AIDS Centre, UNFPA worked with TMSU to support the development of the online training module for service providers, *HIV Prevention and SRH Service Standards for Key Population*, based on the standards packages discussed in Section 3.2.1. NCDC also worked with UNFPA to create a course with TSMU on SRHR, HIV and STIs. UNFPA coordinated the reproductive health technical content of the course, including questionnaires, and literature references. The course is geared towards public health specialists, OB/GYN, general practitioners, nurses and social workers. It is divided into two parts, a comprehensive section for OB/GYN and doctors, which includes supervision, surveillance and epidemiology and a general knowledge module which is easier and intended for other cadres. In addition to theory, there are practical case studies with quizzes, including counselling in case management to support new skills.

OB/GYN and family practice residents will be required in pre-service to take the course which will help to educate the new generation. The course is free-of-charge and physicians can become accredited using the online course in two months as a substitute for taking the intermediate contraception and ANC exams. This has proven to be an incentive for taking the online course, as all facilities have the requirement to have accredited doctors in order for them to get certified (Clinics are certified, rather than doctors.) The online platform has the benefit of enabling the MoH to analyse who has participated in the areas which need further work (based on test scores). Regarding coverage so far, of the estimated 600 OB/GYN specialists Georgia, 130 have been through training in the first two months of the online platform’s operation. UNFPA supported the mainstreaming of Portfolio, an innovative assessment tool to measure students’ academic achievements and professional development within the OB/GYN speciality as a means to improve the quality of OB/GYN professional development and to ensure that SRHR is part of the portfolio. In an interview with a government official, it was noted that the MoH is committed to implementing the course and that UNFPA advocacy has been useful on the topic of CME and making this course mandatory for physicians. The MoH is also keen to continue this stream of work with UNFPA and to implement undergraduate medical training with protocols and guidelines.

UNFPA has also supported capacity building of NGOs, mainly with respect to HIV prevention for KPs. This will be discussed in detail in Section 3.3.2.

3.2.3 Progress made towards integration of HIV within SRHR services and/or SRHR services within HIV

Because of the aforementioned limitations of the case study and the focus of work at the service delivery level, we cannot offer findings related to actual progress towards bi-directional integration as it is experienced by clients. However, based on group discussions with outreach workers and service providers from two main NGO partners, there is evidence that the training is helping to change provider attitudes in support of integrated SRHR-HIV services. In particular, newer, less experienced providers indicated that training using the tools based on standard packages for HIV prevention was very helpful and practical for its strong content on counselling, and advice on how to explain to and inform clients about the importance of testing as well as how to refer. One social worker who focuses on sex workers noted that the tools (SWIT) and training were helpful to get situated with respect to RH issues and to have a broader perspective that goes beyond HIV.

“Even when working on a specific issue, it is helpful to start with a broader perspective (SRH) as it is easier as an entry point. Start broad, then get specific; also depends on who you are talking to. For example, start with family planning, then move to risk re HIV and take it from there. Even when a client comes in for HIV counselling, they are interested in family planning.”

UNFPA implementing partner, Tanadgoma, conducts a survey every two years of beneficiaries (in its four clinics and in outreach services) to determine needs and how they are being met. The main finding from these surveys is the desire by clients to receive all services (condoms, STI/HIV diagnosis and psychosocial support) at one site rather than piecemeal through referral, suggesting that there is a way to go to achieve true integration of services in a system with parallel structures. Focus group surveys also consistently indicate that confidentiality issues are critical to access.

UNFPA Georgia does not have the resources to undertake behaviour change and communication (BCC) interventions nor is BCC a programming mode supported by the UNFPA business model for middle income countries under the current strategy. Given the many socio-cultural barriers that affect access to HIV prevention, the lack of an overall demand strategy is seen as a missing piece in the HIV response. UNDP is currently supporting a team of BCC experts and one is dedicated to addressing risky behaviors. NCDC is interested in partnering to conduct an assessment which could lead to a strategy and resource mobilisation. Such a project is seen as having potential to become a joint activity of the entire UN Joint Team on HIV and AIDS with financial contributions from other agencies as well. The CO is tracking this development to determine how best to leverage its efforts to address demand-side barriers, especially related to improving the enabling environment for access to prevention by youth.

3.2.4 Access to SRHR-HIV services in Abkhazia, Georgia

As a middle income country under the current UNFPA Strategic Plan and accompanying business model, direct service delivery is not an approved intervention mode, except in the case of humanitarian situations. In the breakaway region of Abkhazia, Georgia the health system is under Russian management and there is limited access to services and the services that do exist are of poor quality. Travel is restricted and medical professionals cannot access training and other capacity building efforts offered by the Georgian MoH.

In 2016, UNFPA led the SRHR component for an EU-supported UN Joint Programme aimed at improving access to quality healthcare services in Abkhazia, Georgia. A series of capacity building workshops were conducted to facilitate the newly adopted family planning protocols and train a core group of 23 SRHR professionals from all regions in Abkhazia, Georgia. UNFPA supported reproductive health commodities, STI tests and medical equipment for distribution to 10 regional health centres. These centres served over 2,300 clients. UNFPA support to the region continued in 2017 with support for the reproductive health centre in Sukhumi and 10 targeted PHC facilities, mainly women's consultations. Activities supported included cervical cancer screening, provision of basic reproductive health commodities, family planning counselling and pregnancy testing, support of CHANNEL training and software, SRHR related training for 60 RH specialists and nurses and establishment of four family planning "cabinets" in Gali, Gudata Gagra and Sukhumi. This support continued in 2018 to the Sukhumi Reproductive Health Centre, the four cabinets and via mobile teams. This was accomplished through a strategic partnership with Union Tanadgoma (UT). Over 9,800 women were supported in 2017 and 36,000 in 2018.

3.3 Efforts to meet the needs of marginalized people and promote rights

UNFPA contributed to ensuring that the National HIV Strategy was aligned with practical recommendations within the national comprehensive HIV prevention packages of standards and related tools, and included the mainstreaming of gender equality and human rights principles within proposed actions carried out for KPs. UNFPA has also contributed to capacity development of NGO partners to meet the needs of KPs, through its adaptation and use of the UNFPA implementation tools (MSMIT, SWIT and YKP). Despite slow progress in the education sector owing to many changes in the MoES over the past few years, UNFPA has nevertheless successfully advocated with the MoES to enhance formal and non-formal education through the integration of SRHR and healthy lifestyle principles within the educational system and process. This advocacy led to an memorandum of Understanding (MoU) between UNFPA and the MoES which resulted in the development of a joint UN programme (in partnership with UNDP and UN Women) to promote gender equality and rights, including support for education. UNFPA also supported informal sexuality education through the implementation of a peer education campaign by youth-led NGOs to educate young people in an age-appropriate manner on issues related to SRHR, HIV prevention, gender equality and SGBV. However, resource constraints and resistance from parents and community members have limited the reach of these activities.

For details of the evidence supporting findings in Section 3.3, see the Evaluation matrix (Annex B): Assumptions 2.1, 2.2, 2.3, 2.5, 3.1, 3.2, 3.3 and 3.4

3.3.1 Policy and advocacy to promote an enabling environment for gender equality and rights

The activities of UNFPA Georgia are focused on disadvantaged and vulnerable groups, and during the period under review the CO has conducted advocacy to promote supportive policies and strategies to meet the needs of KPs, youth, and women and girls. Policy and advocacy efforts in support of a positive enabling environment focus on three technical areas: HIV prevention for KPs (MSM, SW and YKPs); youth policy; and gender equality and rights. UNFPA advocacy efforts are well aligned with the issues identified through stakeholder interviews (see box below), particularly for work related to HIV and AIDS prevention, comprehensive sexuality and life skills education, maternal health, contraception, marginalized and disadvantaged groups and violence against women.

Box 1: SRHR in Georgia – Gaps and Challenges

- **Access to contraceptive information and services:** Policies exist, but lack details on how to address challenges, such as low public awareness, lack of integration of family planning into PHC, no essential medicines list for contraceptives, inconsistent practice regarding the use of prescriptions for emergency contraception (EC), and lack of comprehensive youth-friendly services (YFS).
- **Access to safe abortion:** Although legal, government concerns regarding the high rates of abortion have led to mandatory 5-day waiting period and consent requirements that undermine women's self-determination. Other barriers include unregulated practice of conscientious objection by providers, with lack of referral as a result; requirements for court confirmation on grounds of rape (past 12 weeks); discriminatory restrictions imposed by some clinics for certain groups of women (adolescents, women with STIs, SWs).
- **Maternal health:** Georgia has one of the highest rates of maternal mortality in the region due to low quality ANC and perinatal care, a weak transportation system, weak monitoring, lack of trained professionals at maternity houses especially in rural regions.
- **Prevention and treatment of HIV and AIDS:** HIV law adopted in 2009 improved overall legal environment for the national response and set the stage for the NSP. However, major barriers to testing and treatment still exist due to strict drug laws, ID requirements to show an ID to be tested and stigma and discrimination for KPs (MSM and SWs).

- **Life skills education/CSE:** There is no comprehensive and compulsory programme of age-appropriate life skills/sexuality education in Georgia. Existing courses focus on biological aspects of reproduction and do not address critical issues, i.e., harmful gender stereotyping and SGBV. Inadequate counselling services, limited or inexistent life skills/sexuality education in and beyond schools, and little or no (or misleading) information. Also there are a lack of comprehensive teacher training on subject matter, lack of teaching methodologies and materials, both for students and teachers; and no mechanism to make such training mandatory.
- **Violence against women:** Despite recently adopted legislation, violence against women is widespread in Georgia, with some cases registered under the rubric of “family conflict” resulting in under-reporting of cases. Criminal prosecution of rape happens only if physical injuries are noted. There is no civil law remedy for sexual harassment. Patriarchal attitudes are deeply entrenched, so even with increased awareness, crimes are less likely to be reported and investigated. Other issues include fear of retaliation and stigmatization, lack of trust in law enforcement agencies and lack of effective protection mechanisms for victims.
- **Marginalized and disadvantaged groups:** Persons belonging to vulnerable groups are exposed to discrimination due to inadequate laws or fault practices, both in and outside of health care settings. Stigma and criminalization leads to poor treatment in health facilities and pushes persons in marginalized groups to avoid care.

Advocacy for key populations

As discussed in Section 3.1.1, UNFPA provided technical assistance to NCDC in the development of the National 2019-2022 HIV NSP with a view towards ensuring the plan reflected the needs of KPs, including YKPs and transgender people. It also proposed the inclusion of practical recommendations that aligned with the UNFPA programme tools, MSMIT, SWIT, Implementing Comprehensive HIV and STI Programmes with Transgender Persons (TRANSMIT) and YKP and the national comprehensive HIV prevention packages of standards. The NSP also committed to mainstreaming gender equality and human rights principles within actions carried out for KPs. UNFPA efforts towards these results was supported through the development of a brief based on qualitative research conducted with Tadangoma to explore issues related to integration, social inclusion, access to and availability of SRHR-HIV services, stigma and discrimination and violence by YKPs, including MSM, SWs, PWIDs and former detainees.

Youth policy

According to interviews with stakeholders from government agencies, UNFPA played a crucial role in the development of the national youth policy. Georgia was the first country in the EECA region to develop a youth policy. The policy is for the whole of government and not just the MoES. It addresses youth participation, education, health and special needs and protections. An action plan was also developed to make youth a priority and give it greater political weight than before. Prior to this policy, youth activities were managed mainly by NGOs but, given resource constraints, did not achieve results at scale. Now different agencies will be engaged through the action plan process. A revised action plan is being worked on and the structure will provide direction and budget for 200 activities spanning 14 ministries and 15 state entities. In addition, the Prime Minister has become more engaged and is working closely with the Parliamentary Committee on Youth to monitor and oversee the policy and action plan.

This high-level interest in youth is a relatively new development. Prior to 2016, the youth plan was reviewed annually by a Coordination Council led by the MoES (with UNICEF and UNFPA) and a parliamentary committee that reviewed progress and challenges with the plan. However, since then reviews were postponed due to structural changes at the Ministry. There is concern that a diffused effort across all ministries may be difficult to manage and maintain focus; however, stakeholders are pleased that youth is now getting attention at high levels within the political system.

UNFPA is the leading UN agency coordinating the youth development agenda alongside UNDP, UNICEF, International Labour Organization and the UN Industrial Development Organization (UNIDO); and provides technical assistance to the Parliamentary Committee in a range of areas. These include technical assistance to fulfil the needs of the youth agenda's reform, assess the implementation status of the 2014-2019 youth policy Action Plan, elaborate recommendations on coordination mechanisms and the Youth Dialogue Platform, support renewed Youth Policy Concept development (2020-2030), and to elaborate its monitoring framework (Youth Index).

Gender equality and human rights

UNFPA is participating in a major effort, the UN Joint Programme for Gender Equality, supported by the Swedish Government and in partnership with UN Women and UNDP (Section 3.3.3). UNFPA supported an assessment by the PDO in 2017 to evaluate the current status, gaps and challenges within and beyond the health sector on human rights issues related to SRHR and well-being, with special connection to marginalized groups, legal and policy frameworks, budgeting and financing, delivery and accessibility of health services, and the provision of remedies and redress. This was the first assessment of its kind in Georgia. Its findings inform advocacy for addressing gender and rights within the context of SRHR programming.

3.3.2 Programming to address key populations at service and community levels

UNFPA assistance has been focused on strengthening the quality of SRHR and HIV preventive interventions for KPs through the introduction of the SWIT and MSMIT tools. In 2016, UNFPA supported the translation of MSMIT and SWIT for use in programmes through working group meetings with 30 individuals representing national partners, community organizations, KPs and service providers. A participatory approach was used in the translation to sensitize providers and build capacity of community-led organizations. In 2017, UNFPA supported training for 40 service providers from the cities with the highest prevalence rates as a first step towards the elaboration of the in-line training module developed in 2018 in partnership with NCDC, AIDS Centre and TSMU.

UNFPA also supported two capacity development workshops in 2017 for representatives from community organizations to introduce MSMIT in Tbilisi. Participants were sensitized on Pre-Exposure Prophylactic (PrEP), MSMIT and the *Health, Rights and Well-being Practical Tool for HIV and SRH Programming for YKPs*. Regarding the latter tool, UNFPA EECARO supported its development through advocacy meetings and national level workshops in 2017 to openly discuss challenges and opportunities faced by governments and civil society for addressing the needs of this particularly vulnerable population. UNFPA Georgia then supported the NCDC in the development and preparation of the tool for use at the country level via six workshops for 82 participants from harm reduction organizations, community organizations and activists from HIV positive individuals, and youth NGO representatives. An informant offered the opinion that another tool geared towards YKPs was needed because activities need to be oriented to their needs and issues. It has been used to attract young people to events; once attended, participants can access a platform for communication and knowledge transfer. NCDC has a new project to support testing centres that offer VCT and SRHR to YKPs in university settings. Although not yet collaborating with UNFPA on this project, the NCDC intends to translate the tools to use in their efforts with YKPs.

Group discussions with providers and social workers NGO partners, Tanadgoma and Harm Reduction Network, reflected the value that they place on these tools and the capacity-building efforts supported by UNFPA Georgia. The rollout of the MSMIT tool has sparked interest from communities and many have asked for training once they learned about its existence. NGO staff felt that the tools support their capacity to communicate about HIV prevention and how to motivate action among the KPs themselves. Training in and use of the tool has helped with "everyday experiences," such as

planning activities, how to react to KPs, how to involve and engage participants using methodologies, tactics and approaches provided in the training.

UNFPA Georgia has also provided support to the NGOs to build their capacity to address the needs of KPs. For example, UNFPA worked with the Harm Reduction Network to develop a new strategy to attract sexual partners of drug users, to address the possibility of heterosexual transmission. Sex partners of drug users may also use drugs, but often do not identify themselves as drug users due to self-stigma. This is especially true for women who experience more stigma than men as drug users due to their different life obligations and makes them less likely to seek and receive care. More work needs to be done to address YKP coverage as service sites do not do assessment and targeted prevention for non-injecting drug users. Young people who use non-injecting drugs, such as stimulants, cocaine, etc. are also likely to engage in risky behaviour, but given current service guidelines are not identified. The Harm Reduction Network faces many barriers, including frequent turnover of trained staff and the need for an ongoing capacity development pipeline. Burn-out was mentioned as an issue by staff from NGO Tanadgoma and Harm Reduction Network given large caseloads, and negative attacks, including violence from hostile religious or traditional organizations and individuals. For example, while social media can be used to support effective messaging and communication with YKPs (e.g., in closed Facebook groups), it can also be a source of organized hostility against events or other activities from opponents.

In addition to support at the national level, UNFPA Georgia supports community-led organizations at the regional level in implementation of a Global Fund grant on the right to health for MSM and transgender people with implementation partner, ECOM. This grant covers five countries, including Georgia. The CO represents EECARO on the RAGSI for this project. In 2018, the following documents were developed and endorsed: a) *Guidelines for Collection of Strategic Information on HIV among Gay Men and Other MSM and Trans People in the EECA Region* developed and approved during RAGSI meeting in Minsk (2018); and b) *Protocols for conducting a Legal Environment Assessment for HIV Services for Gay Men, other MSM and Trans Populations in EECA* developed and approved by RAGSI. In addition, in 2018 the assessment of existing strategic information on HIV in MSM and trans people in Armenia, Belarus, Georgia, Kyrgyzstan and Macedonia was updated, and assessments were conducted.

3.3.3 Programming to support adolescent SRHR education and engagement of youth

While there is new optimism that the Georgia youth policy will be accorded a high level of authority, the Government does not yet have a separate youth-oriented SRHR programme. Further, there are no services that address the specific needs of young people who are most vulnerable and at-risk of HIV infection in Georgia. A human rights assessment by the PDO found that teachers are not comfortable about discussing SRHR issues. There are stereotypes that parents and schools are against NGOs. There is a need to find entry points to address sexuality education. Forced marriage is criminalized but not prosecuted. The PDO is monitoring the number of childbirths and trying to get information out that early marriage is illegal. Even when that is understood, the number of engagements increases, and girls still drop out of school. There is a need for more awareness raising to get information about rights to ethnic minority regions and to provide the information locally in Azeri or Armenian language as early marriage is more prevalent in Azeri and Armenian populations. The upcoming findings of the MICS on early marriage will be important evidence to advocate for regulatory reform about schooling.

During the period under evaluation, evidence from stakeholder interviews indicated that UNFPA successfully advocated with the MoES to enhance formal and non-formal education through the integration of SRHR and healthy lifestyle principles within the educational system and process, and strengthen the school health system. The Government committed to specific measures to integrate

SRHR in the curricula for all educational levels as per the Convention on the Elimination of All Forms of Discrimination Against Women fourth and fifth periodic reports in 2014. As a result, UNFPA Georgia provided strategic support to the MoES to attend a conference on best practices in sexuality education in Europe which led to the a MoU as a first step in the development of a larger initiative. Through this MoU, UNFPA committed to providing technical assistance to MoEs through an implementing partner, NGO Tanadgoma, to enhance formal, non-formal and vocational education systems through the integration of healthy lifestyle and gender equality principles and enhance the subject standards for biology and civic education. The healthy lifestyle curriculum was developed in collaboration with Tanadgoma with German Development agency funds.

The MoU between UNFPA and the MoES was the groundwork for the UN Joint Programme on Gender Equality supported by the Swedish government and implemented by UNFPA, UNDP and UN Women. Under this programme, UNFPA has responsibility for the institutional component, including working with MoES with activities related to the revision of school subject standards, supporting teacher capacity development through a “new schools” pilot, and to advocate for the re-establishment of the school doctor system which was disbanded in 2003. Sexuality education in Georgia is fraught politically. The term sexuality education is very delicate; instead the terms “reproductive health” and “healthy behaviour” are used and more acceptable for content related to sexual health. Further, there have been many changes in the MoES – four over the past few years – which has been disruptive in terms of priority setting. The last minister’s priority was parental education, while the current minister is focused on reforms and a new school model to make education more interactive.

In 2017, UNFPA supported the design of 12 lesson plans and piloted the biology standard for basic education level in three public schools (two in Tbilisi and one in Sagarejo). Lesson themes included puberty, SRHR, HIV and AIDS, STIs, physical activity, healthy nutrition and addiction. UNFPA also supported the development of a teacher training module which included practical tips, and interactive learning methods. Information brochures in support of parent education programme run by MoES were reprinted. The new schools pilot is planned for implementation in 50 schools; however, only 25 schools will be involved in the effort and UNFPA can only support half of these due to resource constraints. In 2018, assistance was provided to review subject standards for biology and civic education for basic and secondary education levels, aligned with WHO Standards on Sexuality Education in Europe and UNESCO standards. The revised standards include age-appropriate information on SRHR and HIV and AIDS, healthy lifestyle, contraceptives, addiction and gender equality. Primary and Basic education level standards were approved in early 2018; secondary education level standards were revised and will be approved in 2019. UNFPA also provided technical assistance in the development of the textbooks and reference materials. In 2018, a new topic on society was added to the curriculum. However, concepts related to gender, tolerance and identity were not approved for inclusion in the course and were removed from the curriculum. There is no accreditation process for teachers trained in healthy lifestyle education. Two groups offer possible bodies for accreditation, the Quality Control Centre and the Teacher’s House; however, neither has been explicitly engaged in this task.

In addition to standards, UNFPA partners with NCDC and MoES to strengthen the school health system to address challenges related to availability and access to YFS. In 2016, UNFPA supported the MoES initiative to re-establish the school health system and signed a tripartite agreement with NCDC and EuTeach, the goal of which is to integrate SRHR for youth within the school health system. A training module on adolescent sexual reproductive health (ASRH), communications skills, healthy life style, mental health and first aid was developed; it is the first-ever module developed in Georgia and is based on European framework for quality standards in school health services and competencies for school health professionals. The training module was accredited by the CME system at TSMU. In

2017, training was conducted for 80 school health professionals from the Samegrelo and Kakheti regions based on the accredited training module.

UNFPA has also supported informal sexuality education through the implementation of a peer education campaign to educate young people in an age-appropriate manner on issues related to SRHR, HIV prevention, gender equality and SGBV and to provide them with skills to support informed decision-making regarding their SRHR. UNFPA supported the Georgian Youth Development and Education Association (GYDEA) to conduct peer education ToTs and cascade trainings in Kakheti and Samegrelo regions for young people age 15-25. Peer education is conducted in MoES-sponsored extracurricular youth camps focused on civic education, with this effort focused on the embedding SRHR within these activities. In 2016, over 2,500 young people were reached through this effort. UNFPA provided technical assistance in 2017 to further tailor specific modules for 14-16 and 16-19-year age groups and supported ToT and cascade trainings to reach nearly 3,200 young people in the capital and the two aforementioned regions. The number of individuals reached increased to 4,905 in 2018, including 3,700 students and 1,205 university students. Stakeholders interviewed spoke of recent problems stemming from parental complaints to MoES about content related to gender stereotyping and lesbian, gay, bisexual and transgender (LGBT). Although camps are ongoing, content has been revised.

Peer-to-peer communication by GYDEA and other youth organizations is through social media and closed Facebook groups. Personally written 'questions and answers' are helpful for disseminating accurate and confidential information on where to get HIV tested or access contraceptives; however, those opposed to sexuality education can operate groups as well. Girls from ethnic minorities are less likely to have access to phones and, thus, are cut off from receiving information. It is much more difficult to communicate with youth from Azeri and Armenian communities.

3.3.4 Gender equality and women's empowerment

Gender equality and women's empowerment is one of the three major areas of focus for the UNFPA Georgia third country programme (CP) (2016-2020). The third CP includes (Outcome 3, Output 1) support for *"strengthened capacity of public and civil society organizations and national human rights institutions to advance gender equality and reproductive rights, including prevention of gender-based violence and harmful practices."* A flagship activity to advance this output is the aforementioned Joint Programme on Gender Equality supported by SIDA and implemented in partnership with UN Women and UNDP. The project supports policy, institutional and grass roots level interventions to promote gender equality. Within the Joint Programme, the agency roles include UNFPA on SRHR, UNDP on policy and law development and UN Woman on violence; however, all agencies work together across these issues at policy, institutional and grassroots level. UNFPA works at institutional level with the MoES (discussed in Section 3.3.3), the MoH and the PDO.

UNFPA is collaborating with the MoH on an institutional response to violence against women whereby physicians will have to monitor, document and provide services to victims of sexual violence. The MICS and other official statistics show that there is very high incidence of violence, i.e., there were 7,000 restrictive orders in 2018. An input/output form was piloted in Gurjaani and Tbilisi to support the systematic documentation of cases and how they were treated. Services provided to victims include EC, abortion, Pap smears, and HIV tests, all free-of-charge, paid by the State. Activities supported by UNFPA included the development of SOPs on how to complete the input/output forms, along with a pilot conducted to ensure that training and supportive supervision was completed effectively. SOPs were also developed for mandatory notification for cases of major trauma (gun/knife wounds). The forms were digitized by NCDC. Current medical education for physicians does not include counselling skills and there is no pre-service training. Therefore, UNFPA

support for the e-module platform for continuing education is the strategy being employed to support capacity development in SGBV and other issues.

UNFPA is working with the PDO, a national human rights organization within the Human Rights Monitoring Framework. The PDO has 170 staff and 9 regional offices. Its purpose is to oversee the observance of human rights and obligations, advise the Government on human rights issues, and analyse the nation's laws, policies and practices as they relate to international human rights standards. Since 2015, the PDO has participated in the Joint Programme with UNFPA, UNDP and UN Women. PDO first conducted desk research on state policies and practices related to SRHR and sex education for advocacy purposes (findings discussed in Section 3.3.1).

PDO monitors reproductive health and well-being via country assessments to see how well Georgia is keeping international commitments. The country inquiry looks at how people experience the laws. The PDO submits an annual report to Parliament, followed by parliamentary resolutions and PDO follows up actions. PDO has a monitoring team and can study individual cases where rights are abridged, for example they can monitor SRHR in psychiatric institutions. PDO does not have a mandate to go to court and argue cases on behalf of individuals or groups, but it can prepare briefs. The State is active on human rights, but mainly related to domestic violence. However, Parliament developed a Gender Equality Action Plan which includes aspects of HIV. There is a Gender Equality Commission which is responsible for drafting the monitoring and evaluation plans (overseen by the Executive Branch) and a Gender Equality Council responsible for policy and law development overseen by the Legislative Branch. These are entry points for policy and legal work for PDO and the UN Joint Partners.

So far, the main achievement by the PDO has been to establish mechanisms for financial support to monitor human rights. The monitoring methodology is well-established and this has helped to build capacity. UNFPA hired the consultant who helped develop the monitoring guidelines on the issue of human rights in SRH, and financed the monitoring methodology.

According to stakeholder interviews, there are many gender and human rights issues that require attention. One is sex selection which has large variations based on ethnicity (in particular, Armenian). There is a need for more expertise on how to conduct monitoring of this issue. NCDC just finalized a study to work with UNFPA on sex selection. The study was identified as a good example of how UNFPA collaborates on new and emerging topics where the country needs assistance to find ways to solve problems. In terms of needs, there has been good implementation on domestic and gender-based violence, but not yet on SRHR and LGBT rights. There is an awareness that policy work is just “the tip of the iceberg” and focused implementation of policy is what is most required.

3.4 Forging partnerships and supporting networks

UNFPA has demonstrated a strong partnership ethos between the Georgia CO and the EECARO, as a means to leverage action in the face of limited resources. UNFPA is seen as an essential partner who is responsive to national needs and offers experienced, timely and flexible technical assistance to address emerging, and often, sensitive issues. With the support of EECARO, UNFPA Georgia has effectively supported south-to-south exchange as a key strategy for fostering awareness, ownership for, and capacity to take on new technical areas and issues. UNFPA has demonstrated a strong commitment to supporting networks and promoting participation of beneficiaries in the development of policies, strategies and programmes that affect them by including them in regional and national consultations and forums. However, efforts to foster participation tend to be in the

design stage rather than in processes to monitor and hold implementing agencies accountable for meeting commitments.

For details of the evidence supporting findings in Section 3.4, see the Evaluation matrix (Annex B): Assumptions 1.6, 2.4, 3.2, 4.1, 4.2, 4.3, and 4.4

3.4.1 UNFPA efforts to broker national partnerships for policy and program development

UNFPA efforts to coordinate efforts are described fully in Section 3.1. This section will review evidence about UNFPA reputation as a facilitator of partnership. Interviews with governmental and NGO partners paints a picture of an experienced and flexible broker that knows how to navigate sensitive issues and move things forward.

UNFPA follows a logical process for brokering effort around a particular issue, such as HIV-SRHR for KPs (Sections 3.3.1 and 3.3.2): 1) increase awareness of key national stakeholders through regional or south-to-south exchange at conferences, meetings or workshops; 2) support the generation of evidence to support policy and strategy development; 3) support a consultative process with a wide range of stakeholders to participate and generate ownership; 4) provide technical assistance in the development of strategies, guidelines, standards and protocols; 5) develop curricula and reference materials based on the standards and protocols for use in capacity-building; and 6) support capacity-building through collaborations with government and NGO partners.

Interviews with stakeholders noted that UNFPA has been a strong partner, “always ready to support, provide its expertise and collaborate.” Government officials interviewed stated that collaboration is institutional and goes beyond HIV to other areas and capacity building. UNFPA channels both financial resources and technical assistance where government experience is lacking and the CO is quick to respond in evaluating and providing assistance for needs identified. For example, UNFPA supported the development of the NSP by hiring a local consultants to complement the international consultant provided by the Global Fund to ensure that the process was well-balanced and represented national perspectives. UNFPA was quick to support a collaborative process for the development of guidelines that are especially important to address HIV prevention.

3.4.2 Supporting networks of youth, key populations and women to participate in and influence policy dialogue and programming

The CO is committed to supporting networks of “beneficiaries” to influence policy dialogue and programming. For example, in 2016, UNFPA supported a round table and training among professional networks and civil society activists for the rights of women and girls to raise awareness on violence against women who live with HIV and AIDS, use drugs and practice sex work during the *16 days against GBV* campaign in partnership with the Women’s Fund in Georgia, EWNA and other groups in Georgia.

UNFPA partner NGO Tanadgoma undertakes initiatives to ensure meaningful participation of KPs through involvement in design and processes, using processes gleaned from the UNFPA MSMIT, SWIT and YKP tools. In all their projects, they try to include a small initiative that benefits community members. And, every two years they conduct a satisfaction survey of beneficiaries on all premises and via outreach in cities. They are trying out new methods of outreach online.

UNFPA involves young representatives of various groups to support youth participation. The Georgia Youth Development Agency was founded in 2007 with support from UNFPA. It is part of the Y Peer Network which includes 52 national networks focusing on peer education, modules, manuals. Youth festivals were also conducted in cooperation and with the active involvement of the local

governments in Samegrelo and Kakheti regions. In 2018, UNFPA organized a photo project during the festival showcasing the potential of young people and how they can contribute to the development of society if they are empowered to exercise their human rights, have access to quality education, information and services, and have the capacity to participate in decision-making process and influence policies that affect them.

Meaningful participation remains a challenge according to those interviewed. Some stakeholders interviewed suggested that the concept of meaningful participation should be further defined and more attention placed on the accountability side of programming (i.e., whether and how plans were actually implemented) rather than the participation in the drafting of programmes only. Input tends to be on the front end in the design of strategies and action plans indeed, which is necessary but not sufficient and does not fully reflect the meaningful influence of youth, KPs and women on public policies that directly affect them.

3.4.3 South-to-South cooperation promoted by UNFPA

During the period under evaluation, the Georgia CO provided opportunities for south-to-south exchanges. For example, in 2016 the UNFPA EECARO and IPPF European Network convened a Second Regional Consultation on HIV and SRHR among YKPs which was attended by a Georgian delegation that included representatives from the NCDC, the Principal Recipient of the Global Fund grant. UNFPA Georgia also supported colleagues to attend the IV International Workshop for Health future held in Istanbul to share expertise and experiences as speakers and facilitators. Attendance at regional and international conferences build capacity of national leaders and also offers the opportunity for updates, meaningful dialogue and the establishment of direct contacts among medical professional related to issues of interest.

3.5 UNFPA comparative advantage in Georgia

The consensus among its development, governmental and NGO partners is that UNFPA in Georgia plays an important strategic role in SRHR and the HIV response, with the only concern being the future availability of resources to enable UNFPA to continue its work. UNFPA has demonstrated its comparative advantages gleaned from the organization's SRHR mandate, a small cadre of national staff with strong expertise and deep understanding of the Georgian context and its players, and support from a regional office which offers relevant expertise in support of strategic action. In the absence of UNAIDS, UNFPA has taken up the mantle of leadership for the UN Joint Team, with strong appreciation from the other UN agencies for the manner in which it coordinates UBRAF resources and fosters the exchange of information and ideas. UNFPA technical capacities in Georgia are in line with the competencies required for middle income countries (policy and advocacy, coordination and knowledge management) as per the current UNFPA strategy and business model.

For details of the evidence supporting findings in Section 3.5, see the Evaluation matrix (Annex B): Assumptions 5.1 and 5.3.

3.5.1 Role and strategic contribution of UNFPA within UNAIDS Division of Labour

The overall priority areas for UN support in Georgia are advocacy, policy advice and capacity development. Under the Health Focus area this includes SRHR, family planning, MCH, ASRHR, HIV prevention, and response to domestic and gender-based violence as these critical interventions are still not adequately integrated in the PHC. In terms of the division of labor, UNFPA will continue advocating for a HIV prevention with special focus on KP and youth and supporting the strengthening of national systems to deliver integrated SRHR services.

The most recent annual report (2017) for the UN Joint Team illustrates how the different UN agencies work both independently and together in support of outcomes.

- **UNFPA:** Provided strategic input into the transition plan, including cost calculations for HIV prevention services for KPs (MSM and SW YKP); developed standards (guidelines and protocols); supported development of training modules/manuals based on the HIV prevention standards and tools (SWIT, MSMIT, TRANSIT and YKP tool) for KPs; supported capacity development for providers, community organizations, harm reduction service providers and youth and other advocates.
- **WHO/UNFPA/UNICEF:** UNFPA joined WHO in partnership with UNICEF to strengthen EMTCT country efforts and delivery the EMTCT guiding documents aligned with the National Maternal and Newborn Health Strategy 2017-2030.
- **WHO:** WHO mission from headquarters and WHO/European Regional Office facilitated National Spectrum-STI modelling estimation of STI prevalence trends with NCDC/Global Fund and HIV and AIDS Routine Surveillance Guidelines.
- **World Bank:** Finalized an epidemic and allocative efficiency analysis to establish an optimized mix of HIV investments and inform prioritization decision; supported epidemic and response analysis for PWID programmes; and conducted Health Financing System Assessment to facilitate the move away from external financing.
- **UNOPS:** Conducted monitoring activities for implementation of Global Fund HIV grant and related advisory services for the Global Fund. Future directions (as defined in 2015) for UNFPA as chair of the UN Joint Team on HIV and AIDS to address the significant gaps in policies and regulatory mechanisms for quality assurance of health services.
- **UN Women/ UNDP:** collaborate with UNFPA on the SIDA-funded Joint Programme on Gender Equality, under the SRHR and youth development component where HIV issues are integrated as relevant.

Regarding UNFPA role in leading the UN team on HIV, all UN partners interviewed gave UNFPA positive reviews related to its ability to coordinate in an effective, efficient and collegial manner. UNFPA does an excellent job coordinating the UBRAF process; each agency provides information on indicators related to its work and UNFPA enters data and coordinates responses to inquiries in a helpful and timely way. UNFPA is also generous in sharing knowledge and updating the UN partners about discussions and issues emerging from the CCM. A theme emerged through discussions with stakeholders from the UN agencies: Their track record of good collaboration is the result of local, capable staff who have worked together responsibly for decades, coupled with the scarcity of resources which forces them to work and fundraise together.

3.5.2 Technical capacity to carry out assigned tasks

This report has already noted several instances that capture the technical competencies of UNFPA Georgia to support the lines of business associated with a middle income country as per the current UNFPA Strategic Plan and Business Model: policy and advocacy (Section 3.3.1); coordination (3.1.2 and 3.4.1); knowledge management (3.1.3, 3.4.3); and capacity-building (3.2.1 and 3.3.2). Stakeholders interviewed stated that, despite challenges, UNFPA does a good job through its ability to effectively programme and leverage its resources and through its capacity to partner. Though they have a small budget, the funding is very important and is used flexibly to address country needs.

UNFPA is seen as having the strongest technical capacity within the UN family in the area of HIV prevention as evidenced by its effective chairing of the HIV thematic group which coordinates related activities within the UN Joint Team. One official noted that its ministry works comfortably with UNFPA more than any other international organization due to its ability to support policy revisions in a political and sensitive manner and its flexible and strategic support for interventions that can make a difference. The only area of improvement noted in stakeholder interviews was the need for

additional UNFPA resources to fulfil its mandate. UNFPA is anticipated to be the “last agency standing” in the area of SRHR-HIV programming, with past departure of the President’s Emergency Fund for AIDS Relief (PEPFAR) and the impending transition from the Global Fund financing.

4 CONCLUSIONS

The case of UNFPA Georgia in the HIV prevention space demonstrates a high level of value and contribution in face of limited resources. Results have been achieved through strong, collaborative and country-led programming with UNFPA as facilitator and trusted advisor. The CO demonstrates what can be done with limited resources through the leveraging of resources, a collaboration mind-set, with experienced and thoughtful facilitators at the helm. This success should not be taken as a signal that further (and increased) investment is not required to sustain and improve on the gains made thus far in addressing the increased trend in HIV infections.

1. The CO has played a leading role in the repositioning of HIV prevention as a priority health intervention in Georgia. It has contributed in a number of important ways. It has led the revitalization of the UN response to address the need for HIV prevention efforts in light of increased incidence of infection among KPs. The CO has supported key strategic exercises to prepare for the upcoming transition from Global Fund to state funding. It has skilfully advocated and facilitated the development of strategies and policies, and corresponding standards, protocols and curricula to address the needs of most at-risk and KPs.

2. With its strong technical expertise in reproductive health, long-standing presence, and knowledgeable experience working in and with the Georgia healthcare system, and within the UN family, UNFPA Georgia is considered an excellent technical partner by its UN sister agencies and its public and NGO sector implementing partners. There is a strong collaborative ethos within the CO that supports their efforts to leverage a limited budget to achieve results. Their flexibility and willingness to address gaps and take on sensitive issues through evidence-based inquiry has enhanced their role and influence as a trusted advocate in support of SRHR and HIV programmes.

3. Integration is key strategy for UNFPA not just programmatically to strengthen SRHR, SGBV and HIV linkages, but also take advantage of any opportunity to address the needs of vulnerable and marginalized groups. The CO has smartly used its limited UBRAF resources and adapted existing UNFPA tools, MSMIT, SWIT and the YKP package as a platform for country efforts in HIV prevention for these KPs without having to “reinvent the wheel”. As such, the CO contribution to the HIV response seems outsize in comparison to its (quite) small budget through the timely and strategic leveraging of its limited resources. Nevertheless, this work has not yet moved the needle for the establishment of a national strategy and plan in support of integration, and there are many missed opportunities for establishing SRHR-HIV linkages across parallel structures and programmes.

4. Programmatically, insufficient attention has been paid to demand-side issues, given the context of low HIV testing coverage and uptake, resulting in late diagnosis and treatment. Individuals not aware of their status continue to engage in high risk behavior and unknowingly transmit the virus, leading to increased number of infections. The UNFPA business model for middle income countries is also a hindrance which prevents the CO from supporting demand-related interventions. As a result, it is appropriate for UNFPA to consider efforts, consistent with its business model, to address behavior barriers preventing

individuals, especially youth, to utilize freely available HIV testing and to develop respective recommendations for triggering behavior change.

5. The close working relationship between the CO and UNFPA EECARO has benefited both offices. The peer exchange among these UNFPA staff and offices has supported south-to-south exchanges among Georgia implementing partners with other countries and regional networks to support up-to-date and evidence-based advocacy and programming efforts.

6. The CO efforts are well-aligned to the national context of the country that is in the midst of a transition from Global Fund support. UNFPA takes good advantage of opportunities to overcome system challenges such as privatization, verticality, and overall lack of incentives for quality of care. The focus on establishing WHO-aligned policies and standards, and their translation into an e-learning platform for healthcare professionals is a good strategy for building a foundation that can potentially sustain efforts by national partners.

7. The CO embraces and integrates a human rights-based approach in its programming. In particular, it has concrete efforts to address stigma and discrimination, gender equality, access to quality and dignified healthcare, and participation youth and KPs so that they have voice in the policies and programmes meant to serve them. Its work under the Joint Programme for Gender Equality is potentially an important contribution for improving the environment for rights. However, these efforts are nascent and there is a long way to go to ensure the availability and accessibility of quality, rights-based services that can address the specific needs of youth and KPs.

8. Working at the level of policy and advocacy can only go so far if not backed up by interventions to support the gap between policies and implementation. As noted above, working within the construct of the UNFPA business strategy constrains the types of interventions that can be undertaken, and limits holistic and comprehensive programming. In particular, demand efforts are very limited and hamper efforts to support awareness of the benefits of testing and services. Further, the loss of USAID and UNFPA support for condom procurement has resulted in a lack of attention for this important aspect of HIV prevention programming. These are important efforts to sustain the response and will require additional resources, especially given the Global Fund transition. Continued investments are critical for addressing the growing HIV incidence.

ANNEXES

- A. Logical reconstruction of the overall theory of change**
- B. Evaluation matrix**
- C. Key informants interviewed**
- D. Main elements of bibliography**

ANNEX A: LOGICAL RECONSTRUCTION OF THE OVERALL THEORY OF CHANGE

An explicit theory of change describing how UNFPA supports the HIV response is necessary to allow the evaluation to apply contribution analysis to map causality (including the contributions of other actors) and infer the contribution UNFPA interventions have made (or are currently making) to the observed results and outcomes they are trying to influence. It provides evidence about the contribution made and information on whether the UNFPA HIV support is likely to achieve the intended results as well as what lessons can be learned.

The theory of change is also an essential instrument to establish the evaluation matrix (Annex B). The evaluation matrix contains the core elements of the evaluation: what is evaluated (evaluation criteria, evaluation questions and related issues to be examined – “assumptions to be assessed”), as well as the sources of information, indicators and most appropriate and feasible data collection methods for each of the questions identified. The evaluation matrix is a key feature of the structuring phase of the evaluation as it serves as an instrument to organize data collection and analysis.

1. Defining a theory of change

A theory of change is the representation of how a programme or set of activities contribute to desired changes, as well as the causal links and related assumptions that inform it. It demonstrates how and why a desired long-term goal is achieved through a sequence of interrelated results.

The process of developing a theory of change begins with the depiction of the causal links explaining how the activities of the intervention are expected to lead to desired results. The depiction of these causal links – or **pathways** from activities to results - forms the **intervention logic** of the UNFPA support to the HIV response at global, regional and national levels.

A theory of change allows the evaluators to identify the **causal assumptions** behind the links from activities to results – what has to happen for the causal assumptions to be realised. It is, in fact, the combination of a well-constructed intervention logic and the identification of key causal assumptions (clearly spelt out in the evaluation matrix) which characterises a useful theory of change.

2. Evaluative purpose of the theory of change

By visualizing how UNFPA support to the HIV response operates at country, regional and global levels, the development of a theory of change serves the following purposes:

- Identifying causal linkages from UNFPA activities and investments through different results levels to the outcomes and of the *UNFPA Strategic Plan (2018-2021)* – without losing sight of the 2014-2017 Strategic Plan
- Linking UNFPA activities and investments, output level results contributing to the SRAs of the UNAIDS UBRAF 2016-2021
- Making explicit the causal assumptions linking UNFPA support to identifiable results at the output, outcome and goal levels
- Formulating the evaluation questions to be investigated against which findings and conclusions will be reported
- Setting the evaluation design, as depicted in the evaluation matrix, including sources of information and data collection tools, to test the validity of causal assumptions associated with each evaluation question.

3. Nested theories of change

The term “**nested theories of change**” refers to the fact that two distinct types of theory of change can be developed to provide the necessary level of detail for an evaluation (or for programme design). The first type is an **overall theory of change** for UNFPA support to the HIV response (figure 1); it is the foundation for all of the work that follows.

The second theory of change type, **pathways theories of change**, should not be seen in any way as separate from the first. Rather, each pathway illustrates a sub-set of the actions and results documented in the overall theory of change. Pathway theories of change achieve this end by illuminating the causal links connecting different groups and typologies of UNFPA activities and investments to output and outcome level results. An important feature of the role played by UNFPA in the HIV response is the need to tailor the response to the nature of the epidemic and the social and political context in each region and country. As a result, the contribution made by UNFPA in Georgia will differ markedly from the contribution in Indonesia or Namibia. As a matter of fact, UNFPA may support different types of activities, engage with different partners, and focus on different target groups in either country – always within the programming bounds established in the overall theory of change (figure 1).

4. Process for developing the theory of change

The process of developing/reconstructing the theory of change for UNFPA support to the HIV response began with the evaluation team reviewing in detail the ToR and supporting documents. This was followed by an interactive process of consultation and development through the following stages:

1. Individual and group interviews carried out during the evaluation kick-off workshop (first meeting of the evaluation reference group) in December 2018, including presentations by UNFPA headquarters, regional and national staff engaged in support to the HIV response
2. Review of documents
3. Follow-up interviews carried out with UNFPA and UNICEF headquarter staff in January 2019
4. Development of a preliminary overall theory of change by the evaluation team presented at the theory of change workshop
5. A one-day workshop held at UNFPA headquarters on Friday 22 February to review, revise and replace the preliminary theory of change with participation of UNFPA headquarters and regional staff engaged in HIV activities and programming, facilitated by the evaluation team and the Evaluation Office
6. Circulation to the ERG of a note containing draft overall and pathway theories of change
7. Revision of the draft overall theory of change by the evaluation team (figure 1).

The workshop resulted in a re-orientation of the theory of change to better link it explicitly to the *UNFPA Strategic Plan (2018-2021)*, while still identifying how UNFPA support contributes to the SRA of the UNAIDS UBRAF. The workshop also established that prevention of the sexual transmission of HIV as the primary focus and key role of UNFPA in supporting the HIV response. This is achieved through to related and interlinked outcomes:

- Achieving greater linkage between HIV and SRHR policies, systems, communities and integrated services
- The empowerment of adolescents and youth and women to secure their right to information and to services in HIV and SRHR freed from stigma, discrimination, coercion, violence and harmful practices.

While the main focus of UNFPA support is on adolescents and youth (youth and adolescents) and women, UNFPA work in support of the HIV response recognizes as a cross-cutting guiding principle to respond to the needs of populations left behind, the most-at-risk of infection (key populations), and the most vulnerable.

5. How to read the theory of change

The diagram presented in figure 1 depicts the **overall** theory of change for UNFPA support to the HIV response resulting from the consultation process (stages 1 through 6) mentioned above. The structure moves up the chain of effects from UNFPA activities and investments at the bottom of the figure to the overall goal of the UNFPA Strategic Plan on top.

It is important to note that, as a result of the theory of change workshop, **the primary role and function** of UNFPA support to the HIV response was determined to be **the prevention of sexual transmission of HIV** (identified in the second row from the top in figure 1). Similarly, it is worth noting that each of the outputs identified at country level (in the green boxes, in the middle of the figure) are explicitly linked to different UBRAF strategic results areas *by number* (see pink box). While the theory of change is structured around UNFPA strategic outcomes and goal, it retains the necessary link to UBRAF strategic results areas.

Other important features of the theory of change include:

- The overall goal of prevention is achieved through two important strategic outcomes which translate country level outputs into outcomes: **(a) Strengthened linkages between SRHR and HIV** at policy, system, community and service levels along with integrated delivery of HIV and SRHR services; **(b) Adolescents and youth and key populations, including people living with HIV, exercise their rights to access HIV-related information and services** free from coercion, stigma, discrimination, violence and harmful practices.
- However, in order for the activities and investments supported by UNFPA to contribute to the output and outcome level results depicted in the theory of change, the **key critical assumptions**, shaded in blue in figure 1, **will need to be realized**. These assumptions, described in detail for each evaluation area of investigation and related evaluation question (see evaluation matrix in Annex B) are an important focus of the evaluation.

ANNEX B: EVALUATION MATRIX

Area of Investigation One: Extent and scope of UNFPA support to the integration of HIV with other sexual and reproductive health and rights strategies and programmes	
Evaluation Question 1: To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between HIV and SRHR and to integrating HIV and SRHR service delivery?	
Evaluation Criteria	<i>Relevance, Effectiveness, Efficiency</i>
Rationale	Strengthening linkages and bi-directional synergies between HIV and SRHR is an important strategy behind many of UNFPA efforts to support the response to HIV. At the level of service users, an important result of strengthened linkages should be more integrated delivery of HIV and SRHR services as well as integration of HIV and SRHR behaviour change communications efforts.
Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.	
Indicators: <ul style="list-style-type: none"> • National HIV Strategy and SRHR Strategies, Roadmaps and Action Plans incorporate linkages between HIV and SRHR • Health sector strategies and action plans incorporate linkages between HIV and SRHR • National SRHR action plans and programmes, including family planning incorporate links to HIV prevention • Operational guidelines, service protocols and manuals for health services staff incorporate linkages between HIV and SRHR services • Opinions of global and regional stakeholders on UNFPA role in supporting integration (and its overall level of influence) • Extent to which HIV and SRHR strategies and policies address gender equality and HIV-related stigma and discrimination (gender and human rights components) 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • UNFPA Georgia identified a range of strategic interventions to contribute to <i>Strategic Plan Output 1: Increased availability and use of integrated SRH services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.</i> The interventions focus on supporting policy frameworks and institutions for ensuring access to integrated SRH services, including maternal care, cervical cancer screening and HIV prevention; and addressing unmet need for family planning through advocacy and technical support. These include: <ul style="list-style-type: none"> ○ Development of evidence-based policies, guidelines and standards ○ Evidence-based advocacy for increased access by vulnerable populations, including youth, to integrated and rights-based family planning at PHC level ○ Generate evidence and manage knowledge on increased quality and coverage of cervical cancer screening ○ Advocacy for integration of MISP for RH and response to GBV in crisis situations; update state emergency preparedness plans ○ Advocacy for expanding HIV prevention and condom programming with special focus on KPs and youth. ○ Political situation permitting, support improvement of access to SRH services in Abkhazia region. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Country Programme Theory of Change 2016-2020</i>, 2015

<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<ul style="list-style-type: none"> • UNFPA supported the update of HIV and AIDS Routine Surveillance Guidelines (VCT Guidelines Routine Surveillance) in collaboration with NCDC, WHO and AIDS Center. The purpose is to detect new HIV cases, report and conduct routine surveillance at the country level in accordance with new consolidated guidelines (WHO, UNFPA) on HIV testing services and on HIV self-testing and partner notification. UNFPA provided technical assistance in the following areas: <ul style="list-style-type: none"> ○ HIV surveillance in KPs, pregnant women and blood donors ○ HIV surveillance in general population within stand alone or integrated HIV/HCV and TB screening models ○ Routine epi-surveillance with VCT and without VCT ○ Data flow, data confidentiality and security measures, including electronic data management and security • UNFPA in cooperation with the NCDC, National AIDS Center, and Tbilisi State Medical University (TSMU) supported the development of an accredited online training module for service providers, HIV Prevention and SRH Service Standards for Key Population. TSMU is uniquely positioned and led the accreditation process of the online module and its integration in the national CME system. As a result, each service provider working with KPs has access to the course and can obtain certificates. • UNFPA in partnership with Tanadgoma and Harm Reduction Network conducted seven two-day trainings for 123 service providers from 15 organizations that provide HIV prevention services to KPs. The training covered: <ul style="list-style-type: none"> ○ Update on the HIV and SRH legal context and situation ○ Combined SRH/HIV preventive interventions for KPs/YKPs ○ How to implement relevant and effective interventions in the field of SRH, family planning, HIV prevention for KPs/YKPs through provision of updated knowledge and practical skills. • In 2017 UNDP, UNFPA and UN Women jointly supported the development of the National Action Plan on Human Rights, which was adopted in 2018. The plan addressed the development and enforcement of state policy, women’s political empowerment, strengthening of healthcare, fighting against harmful practices, integration of gender equality in the education system and awareness raising through culture and sports. In addition, the National Action Plan on Combating Violence against Women/Domestic Violence has been adopted. This includes measures to be implemented by the healthcare sector to ensure the prevention and elimination of Violence against Women/Domestic Violence cases. (For more information, refer to Evaluation Question 3.) • UNFPA initiated development of SOPs related to gender-based violence in emergencies and elaborated SOPs, 4W Tool for emergencies, and protocols on Clinical Management of Rape. A meeting entitled “Effective response of health care specialists to GBV/gender-based violence in emergencies SOPs” was conducted for key players to explore the integration of these SOPs in the national legal and policy framework. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> • Cervical cancer screening programme (supported since 2015) by UNFPA supported organized cervical cancer screening pilots in Tbilisi and Gurjaani District (Kakheti Region) through: <ul style="list-style-type: none"> ○ Training to 25 OB/GYN screening coordinators by the Irish National Screening Service trainers ○ On the job training for 30 village doctors and 30 nurses in Gurjaani on compliance with SOPs and communication/counselling skills 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017

Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.

<ul style="list-style-type: none"> ○ Development of Screening Programme branding book (logo, slogan, design of leaflets and brochures) which was adopted by the City Municipality ○ TV ads and communication campaign in Gurjaani about importance of regular screening ○ Personal dissemination letters from village nurses to 800 eligible women in two pilot villages ○ Blinded external assessment of cervical cytology at Sapienza Unversità di Roma ○ Focus group discussions on knowledge and attitude of women towards prevention and screening ○ Updated SOP approved and endorsed by Tbilisi Municipality and incorporated as part of the service contract ● UNFPA continued the pilot of the BTN approach, a WHO methodology that goes from counting maternal deaths to understanding why these occur and how they can be avoided. UNFPA supported NMCRs in six selected maternities in Tbilisi and Kutaisi; 27 NMCR sessions were organized and five facilities met the minimum requirements for quality of NMCR routine practice. ● UNFPA supported assessment of 33 perinatal care facilities in Tbilisi and Kvemo Kartli as part of the MoLHSA flagship project on Perinatal Care Regionalization. ● In close partnership with MoLHSA, UNFPA convened a high-level advocacy meeting to present the first ever Georgia MNH Strategy, 2017-2030 along with the three-year costed Action plan. The endorsed strategy, developed with UNFPA technical assistance, was formally approved by the cabinet ministers in September 2017 and adopted as one of the sustainable development priorities for the country. The strategy states the Georgia commitment to achieving of ICPD and SDG goals and targets. ● UNFPA supported the MoLHSA to initiate the process to adapt WHO ANC recommendations (released in Nov 2016), in support of new national ANC guidelines. This included the recommendation to increase the number of contacts a pregnant woman has with her health provider from four to eight; it was formally endorsed by the MoLHSA Guidelines Board. UNFPA also supported the development of an online-ANC training course to update service providers with basic principles and practice for ANC, in collaboration with the Tbilisi State Medical University. The web-course IT platform was installed on TSMU server and the faculty has committed to ensuring human resources and IT support to sustain the course. ● UNFPA, in partnership with UNICEF, conducted a technical workshop to integrate GBV interventions into preparedness and humanitarian actions for stakeholders from Government, NGO and UN Agencies. UNFPA led the session on MISP and its implementation process at country level and ensured that the MISP is included in the UN Inter-Agency Contingency Plan and the Action Plan (SRH, GBV, GP, emergency obstetric care). In addition, UNFPA through the SRH working group in partnership with the Department of Emergency Situations, Coordination and Regimen at the MoLHSA, conducted the 2nd MISP preparedness readiness assessment, which will lead to an update of the MISP Emergency Preparedness/Contingency Action Plan. 	
<ul style="list-style-type: none"> ● UNFPA supported the elaboration of the National MNH Strategy and Action Plan for the period 2017-2030 for the MoLHSA (at its request). ● UNFPA Georgia, in a collaboration with EECARO, supported the pilot of BTN methodology approach (WHO BTN), Near Miss Case Reviews, in six selected private maternities in Tbilisi and Kutaisi. Results from 18 NMCR sessions included improvements seen in internal organization/preparation, case identification and selection for review, respect for ground rules, reference to national guidelines/protocols and local standards. 	<ul style="list-style-type: none"> ● UNFPA Georgia, 2016 <i>Annual Report</i>, finalized 13 January 2017

<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<ul style="list-style-type: none"> • UNFPA supported implementation of the Perinatal Care Regionalization project, a MoLSHA initiative, to assess adherence to standards of care in 21 perinatal care facilities in Tbilisi. • UNFPA supported revision and adaptation of WHO guideline, MEC, fifth edition via a review by two local experts (past Presidents from the Georgian OB/GYN Association). Based on the updated MEC guidelines, the Professional Development Council of TSMU accredited the CME programme on family planning. • UNFPA continued support for cervical cancer screening which remained a challenge (9% and 15% coverage in rural and urban settings, respectively) due to access barriers and low public awareness/health seeking behaviour. Screening pilots were conducted in four PHC clinics (in Tbilisi and Gurjaani District in Kakheti Region). Screening coverage increased from 9-27% in Gurjaani, but less so in Tbilisi. Activities included: <ul style="list-style-type: none"> ○ Training for 85 OB/GYNs and family/village doctors on screening SOP and Pap-testing techniques ○ Screening registration software installed ○ Dissemination of messages re cancer screening benefits via clinic flyers, public billboards, TV talk shows. ○ On-site supervision/on-the-job training for family physicians • Refer to Assumptions 2.1 and 2.5 for evidence on UNFPA support for SRH and HIV strategies and interventions for KPs 	
<ul style="list-style-type: none"> • UNFPA Georgia feels responsibility for pursuing issues that no one else is working on. It was through the initiative of the CO to have the JUNTA active in Georgia, given that UNAIDS is not based there (UNAIDS left in 2012.) UNFPA is the member of the PAAC representing the UN HIV and AIDS theme group in this platform and is the member of CCM. • The strategic focus is on KPs and YKPs as part and parcel of the CO youth portfolio and gender. UBRAF funds are used to work on policy and advocacy related to KPs and implementation tools, with the rest of the agenda implemented with core UNFPA and other funding through integration. • The CO has <i>“smartly integrated” SRH-HIV into the Swedish Gender Equality Program and agenda.</i>” • Integration is a strategic issue for the CO, given the scarce resources. <i>“We need to be smart about integration, given our limited human resources and programme staff.”</i> The only way to leverage action and shape the response for impact is through advocacy and collaboration. The resources must be used to enable actions and make investments to bring returns. 	<ul style="list-style-type: none"> • Interviews with UNFPA Georgia
<ul style="list-style-type: none"> • UNFPA provided strategic inputs as the member of PAAC, representing UN at this platform to the Sustainability Transition Plan to support the transition to State funding from external assistance for KPs. UNFPA supported policy dialogue with the PAAC, the Global Fund and NCDC which resulted in the development of the first-ever National Standards Guidelines and Protocols for MSM, SW, YKPs for HIV preventions services for these KPs, including the cost calculation tool. Aligned with this policy, UNFPA also supported a training module for service providers on HIV prevention and SRH service standards for KPs and piloted a three-day training course for 40 service providers from cities with the highest HIV prevalence rates. Training modules/manuals as well as HIV prevention standards and tools are based on SWIT, MSMIT, TRANSIT and YKP tool (including recommendations, approaches, etc.) 	<ul style="list-style-type: none"> • UN JT on HIV and AIDS, <i>Annual Report on Implementation of the Joint Work Plan for 2017</i>, undated, p.2

<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<ul style="list-style-type: none"> • EMTCT has been prioritized by the MoH; it created the national EMTCT Board in 2017 to lead the elimination process. UNFPA was well positioned to participate in this Board, given its support of NCDC representatives to participate in the WHO Regional Consultation on EMTCT of HIV and Congenital Syphilis in 2015. In 2017, UNFPA joined WHO and, in partnership with UNICEF, provided technical assistance to NCDC to strengthen EMTCT through development of self-assessment indicators within the WHO self-assessment tool, the EMTCT National Plan for 2018-2019, and an monitoring and evaluation (M&E) plan to track progress of the national EMTCT plan. 	<ul style="list-style-type: none"> • As above, p.3
<ul style="list-style-type: none"> • The HIV response is delivered through a vertical state programme. The Government is considering exploring potential and feasibility of integrating HIV services into Universal Health coverage and/or private health schemes for the sake of efficiency; however, a plan and mechanism for integration had yet to be developed at the time of the writing of the Georgia Transition Plan in 2016. Per the NSP, there is intended to be a gradual increase in programme coverage in line with the corresponding growth in the capacity of service providers and through the rollout of outreach strategies. Voluntary counselling and testing for risk groups will intensify at drug treatment centres, STI and TB clinics and antenatal care facilities. • Currently, the AIDS Center is working on the guideline for PrEP among MSM population. There is a lack of approved standards for HIV prevention. In 2016, through the financial support from Eurasia Harm Reduction Network, national standards for harm reduction services are being developed. UNFPA provides financial support to elaborate standard packages for comprehensive HIV interventions targeting MSM and SWs as well as prevention standards for the two KAPs in 2016. Based on the OPTIMA study recommendations, while developing HIV prevention standards for MSM population, targeted services for MSM should be also considered. 	<ul style="list-style-type: none"> • Curatio International Foundation, <i>Georgia Transition Plan, 2016</i>, p.33-34
<ul style="list-style-type: none"> • NCDC collaborated with UNFPA to create a line course with Medical University on reproductive health and rights, HIV and STI. This was a good opportunity to educate public health specialists, OB/GYN, nurses, general practitioners, and social workers. UNFPA helped to coordinate the SRH part of the course, including questionnaires, literature references and content. The course is online and free and is accredited by the NCDC and Medical University. This helps to address the biggest challenge, i.e., that there is no professional development or continuing medical education programme. The course is divided into two parts: <ul style="list-style-type: none"> ○ A comprehensive section for OB/GYN and doctors, which includes supervision, surveillance and epidemiology ○ A general knowledge module which is easier and intended to other cadres • The MoLHSA is committed to implementing the course. UNFPA advocacy has been useful on the topic of CME and making this course mandatory for physicians. • Quality of care is an issue in Georgia; there is substandard care and no monitoring of existing guidelines to deal with the 90% of providers in the privatized system. • Other challenges noted: <ul style="list-style-type: none"> ○ Government implements vertical programmes through private sector ○ Weak knowledge of ANC among doctors; they are more focused on curative than preventive care. Also, the focus in MCH tends to be on the health of the child, but not the mother ○ Clients pay out of pocket for their own doctors at hospitals; PHCs are underutilized as it is assumed they provide lower quality of care than hospitals. There is no mechanism to stop referrals to higher level facilities 	<ul style="list-style-type: none"> • Interview with Government official, National Center for Disease Control

<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<ul style="list-style-type: none"> ○ Family planning remains a political issue. The MICS results are “shouting for action” but no one wants to take it on. All types of methods are available, but “not really” because patients cannot afford them. Knowledge and attitudes of doctors are poor; awareness among population is problematic. ● When talking about HIV, one must also address STIs. There is not good data on STI. Need to focus on ST and youth, given problems with low awareness and unhealthy behaviour. There is a need to broaden from HIV to STI. ● For two years, NCDC has been trying to start an app for young mothers to meet their RH needs (pregnancy, family planning, early child development). At present, there is no STI in app, but there is a plan to include it. The app is taking forever to develop given that NCDC must follow the government tender process whereby one must go by the lowest priced vendor, which is not technically sound. 	
<ul style="list-style-type: none"> ● The purpose of the MNH strategy is to provide guidance for the improvement of MNH, as well as for the related fields of family planning and adolescent SRH in Georgia. However, it does not include other related areas such as STI/HIV prevention and control, sexual health promotion in general, men’s SRH, infertility and RTIs and breast cancer. ● Within the MNH strategy section on family planning, it is noted that “efficient family planning reduces the number of unwanted pregnancies and unsafe abortions, prevents pregnancy-induced mortality and morbidity, reduces the incidence of STIs, including HIV and AIDS infection, and protects teenagers’ health....” A priority within this strategy is to fully integrate family planning within PHC system; there is a focus on integration of postpartum and post-abortion family planning with ANC and PNC counselling (no mention of integration with HIV and AIDS services). ● Within the MNH strategy section on SRH of Young People, it is noted that SRH of young people has been a neglected issue and research on young people’s knowledge, attitudes and behaviour regarding sexual relationships, contraception or STI/HIV prevention is very limited. It calls for the introduction of school-based Healthy Lifestyles Education 	<ul style="list-style-type: none"> ● <i>Georgia Maternal & Newborn Health Strategy 2017-2030, Government of Georgia, Ministry of Labour, Health and Social Affairs (MOLHSA), first draft, p 6-7; p 22, 26; p 30-31.</i>
<ul style="list-style-type: none"> ● Strengthening MCH is one of the priorities of the Georgia health-care systems for 2014-2020. UNFPA interventions during the period 2016-2020 (UNFPA Strategic Outcome 1, Output 1) will focus on supporting policy frameworks and health institutions for ensuring equitable access to “high-quality, integrated RH services, including maternal care, cervical cancer screening and HIV prevention; and addressing the unmet need for family planning through advocacy and technical support.” <ul style="list-style-type: none"> ○ Generate evidence on women’s SRH for policy advocacy ○ Support development evidence-based policies, guidelines and standards ○ Evidence based advocacy for increased access of vulnerable populations, including youth to integrated and rights-based family planning services at PHC level ○ Advocacy for discouraging abortion and promotion of modern methods of contraception ○ Generate evidence and managing knowledge on increased quality and coverage of cervical cancer screening ○ Advocating for integration of MISIP for RH and response to GBV in crisis situations ○ Support integration of healthy lifestyles and reproductive health and rights education into formal and informal education systems, including revision of educational materials for teachers, school doctors and students ○ Advocate for evaluating HIV prevention and condom programming, with a focus on KPs and youth, including civil society partners working with these groups 	<ul style="list-style-type: none"> ● UNFPA Georgia, <i>Georgia Country Programme document 2016-2020, p. 4</i>

<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<ul style="list-style-type: none"> ○ If political situation permits, support improving access of conflict affected populations to high quality RH services, including modern methods of contraception (in collaboration with donors and UN organizations). 	
<ul style="list-style-type: none"> ● UNFPA Georgia started working with Ministry for the development of the National MNH Strategy and Action Plan, which is in essence a SRHR strategy without specifically naming it as such to avoid resistance from conservative and religious groups. The strategy includes maternal health, youth RH, contraception, and safe abortion. The HIV/STI issue is noted in the strategy in a couple of places: counsellors refer clients to vertical HIV services, as needed, and VCT is integrated in ANC consultations. Other than transportation costs for referral, services are free. It should be noted that the last case of vertical transmission was three years ago. ● There is sentinel surveillance of women; blood tests for HIV/syphilis are given to all, and women are informed if the results are positive. ● While adolescent SRH is included in the MNH Strategy, it is not operationalized within the related Action Plan because of the confidentiality issue (parental consent) and cost barriers for condoms and contraceptives because these are offered only within the private pharmacies. ● By 2020, the State should offer free contraceptives to targeted beneficiaries and youth (according to the Action Plan). However, the Government needs to allocate funds. The MoH has not yet raised the issue with the Ministry of Finance. 	<ul style="list-style-type: none"> ● Interview with UNFPA Georgia CO
<ul style="list-style-type: none"> ● UNFPA supported the online course as of four years ago. It is a virtual contraceptive course with a platform in Bucharest. Certificates arrive from Romania to the MoH to say that an individual has completed the course. The next step is to collaborate with the British Medical Journal with DoD support to assist Georgia system to get 400 courses translated (for not only HIV, but also infection control and family planning). A challenge is to revise courses when guidelines are updated as this takes time. The courses are used by doctors from Abkhazia and other countries; it is a good thing. ● The online programme is free-of-charge for all facilities in government. All facilities need to be certified/accredited and doctors must have X credits in CME for the facility to get accredited (as opposed to the doctors themselves being accredited). This programme supports the CME process. One of its benefits is that it allows MoH to analyse who has participated and in what areas do they need work (on the basis of test scores). ● Re coverage, of 600 OB/GYNs in the country, 130 have been through training in the first two months of operation. ● Because it is in the cloud, it is easier to add content. Besides theory, there are practical case studies with quizzes, including counselling in case management to support new skills. ● Residents are required in pre-service to take the course. The knowledge of old generation of physicians is out of date and it is difficult for them to change. This effort will help educate the new generation. All family doctors and OB/GYNs can be accredited using the online course in two months as a substitute for the intermediate contraception and ANC exam. This provides an incentive for taking the online course. ● The country has a major shortage of nurses. The Ministry has prepared advocacy/legislation for postgraduate degree in Nursing, as there is no nursing profession. Private clinics train their own nurses; there is no state certification programme in nursing and a problem with the quality of nursing education. This year, the Prime Minister announced that medical education is a priority. Eight nurses attended a ToT in Lyon for RH and cervical cancer screening. There is a need to translate the training programme and add to the 	<ul style="list-style-type: none"> ● Interview with Government official, Ministry of Health

<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<p>platform. The MoH is keen to continue to this stream of work with UNFPA, i.e., to implement undergraduate medical training with protocols and guidelines.</p>	
<p>Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV and SRHR have been implemented.</p>	
<p>Indicators:</p> <ul style="list-style-type: none"> • Regional and national plans for linkage and integration adopted by health authorities • National health authorities confirm adoption of plans/programmes in support of linking and integration • National linkage plans and programmes address three components of Interagency Working Group on SRHR-HIV Linkages (IAWGL) model: <ul style="list-style-type: none"> - Enabling environment - Stronger health systems - More integrated delivery of SRHR and HIV services • Linkage programmes supported by UNFPA at regional national level report on progress (including in integration). 	
<p>Observations</p>	<p>Sources of Evidence</p>
<ul style="list-style-type: none"> • UNFPA supported the training of service providers in 2017 (Tbilisi and Kutaisi) with the objective of strengthening quality SRH, family planning and HIV prevention services for KPs and to capacitate service providers on the National Standards on HIV prevention so that they are able to implement relevant and effective interventions and provide support, consultation, referrals to KPs. Thirty-eight providers were during in two workshops in Tbilisi and Kutaisi implemented by professionals from AIDS Centre and Tanadgoma. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Report on Training on National Standards on HIV prevention for key populations who are providing HIV preventive and SRH services to key populations, 2017</i>
<ul style="list-style-type: none"> • In 2018, UNFPA Georgia supported the provision of basic quality SRH services in the conflicted region of Abkhazia where the local healthcare system is not operating. An estimated 36,000 women accessed quality SRH services free of charge through this effort. Through a strategic partnership with UT, services were provided via the RH Centre in Sukhumi and four pilot PHC facilities in Gali, Gagra, Gudauta and Sukhumi and mobile teams, including: <ul style="list-style-type: none"> ○ Cervical cancer screening (free-of-charge) with reference checks, cytology quality assurance and morphology conducted in Tbilisi ○ Basic RH commodities (modern contraceptives) procured centrally through CSB and shipped and provided to clients with quality family planning counselling and pregnancy testing ○ SRH related trainings for over 30 SRH specialists and nurses ○ Video clip promoting family planning aired over the year on local television. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> • UNFPA supported provision of basic quality SRH services in the breakaway region of Abkhazia, which would otherwise remain uncovered by local healthcare system. Support for the RH Centre in Sukhumi and 10 targeted PHC facilities (mainly women consultations). Overall, 9,844 women were served during 2016-2017. Support included: <ul style="list-style-type: none"> ○ Free-of-charge cervical cancer screening 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV and SRHR have been implemented.	
<ul style="list-style-type: none"> ○ Provision of basic RH commodities (procured through UNFPA PSB), family planning counselling and pregnancy testing ○ Support for CHANNEL training and software ○ SRH-related trainings for over 60 RH specialists and nurses ○ Promotional video clip aired during the year on local television ○ Establishment of and equipment provision for four family planning “cabinets” in Gali, Gudata, Gagra and Sukhumi. 	
<ul style="list-style-type: none"> ● UNFPA led the SRH component in the EU-supported UN Joint Programme aimed at improving access to quality healthcare services for conflict-affected population in Abkhazia. A series of capacity building workshops were conducted to facilitate the newly adopted family planning protocols and train a core group of 23 SRH professionals from all regions of Abkhazia. UNFPA-supported RH commodities, STI tests and medical equipment paid for in 2015 were distributed to 10 regional health centres to serve 2,363 beneficiaries. 	<ul style="list-style-type: none"> ● UNFPA Georgia, 2016 <i>Annual Report</i>, finalized 13 January 2017
<ul style="list-style-type: none"> ● UNFPA supported the rollout and promotion of the Virtual Contraceptive Consultation (ViC) for RH/family planning professionals, aimed at improving provider access, particularly from rural underserved areas, to updated knowledge about modern contraception. Four introductory ViC introductory workshops were conducted and resulted in the registration of 88 SRH professionals on the ViC platform, out of which 46 have successfully passed and obtained a certificate. ● Under a renewed MoH with TSMU, UNFPA supported the mainstreaming of <i>Portfolio</i>, an innovative assessment tool to measure students’ academic achievements and professional development, within the OB/GYM specialization. Two training workshops were conducted for OB/GYN residents and examiners, which allowed the residents to build their course portfolios and for the examiners to track student progress in different areas and skills. This product is intended to improve the quality of OB/GYN professional development and ensure that SRH is part of the portfolio. 	<ul style="list-style-type: none"> ● UNFPA Georgia, 2016 <i>Annual Report</i>, finalized 13 January 2017
<ul style="list-style-type: none"> ● Refer to Assumption 2.5 	
Assumption 1.3: As a result, HIV and SRHR services and interventions have been integrated both in health service delivery settings and in behaviour change and communications efforts, especially in relation to contraceptive services and family planning, including for EMTCT.	
<u>Indicators:</u> <ul style="list-style-type: none"> ● Extent to which operational guidelines, service protocols and manuals that promote delivery of integrated HIV and SRHR services are reportedly used by health services staff ● Reported quality and clarity of operational models for integration ● Programme expenditures on integration ● Evaluation findings on integration initiatives ● Reported experience and views of national health authorities and other implementing partners ● Examples of successful/unsuccessful efforts to link HIV to SRHR services at operational level as confirmed by site visits/discussions with service providers ● Data on aspects of service integration identified in the IAWG indicator list: <ul style="list-style-type: none"> - HIV counselling and testing and family planning integrated - Knowledge of HIV status - Met need for contraception - SW access to services - MSM access to services. 	

Assumption 1.3: As a result, HIV and SRHR services and interventions have been integrated both in health service delivery settings and in behaviour change and communications efforts, especially in relation to contraceptive services and family planning, including for EMTCT.	
Observations	Sources of Evidence
<ul style="list-style-type: none"> Refer to Assumption 1.2 	
<ul style="list-style-type: none"> UNFPA does not have resources to undertake behaviour change activities in a substantive way, although demand-side interventions are required to address many of the socio-cultural barriers that affect access to HIV prevention. UNDP has hired a team of BCC experts and one is dedicated to working on risky behaviours. The consultant is working on a desk review and has started a consultative process. NCDC is looking to partner and engage on an assessment, strategy and UN resource mobilization. This activity could be leveraged to support future demand activities. 	<ul style="list-style-type: none"> Interview with UNFPA Georgia CO
Assumption 1.4: UNFPA has supported effective efforts to strengthen the management of supply chains for male and female condoms and lubricants (including in humanitarian settings).	
Indicators:	
<ul style="list-style-type: none"> Key informant experience and opinion regarding extent to which national capacity in supply chain management for HIV-related SRHR commodities (e.g. male and female condoms and lubricants and STI medications) has been enhanced Reported results on UNFPA support to supply chain management – including volumes of procurement over time Experience and views of supply chain managers at national and district level. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> The NCDC manages the procurement and supply of health products for HIV prevention and treatment. It uses relevant SOPs for forecasting, development of specifications, market search, procurement and distribution that are considered adequate for ensuring continuous supply of these products. ARVs are procured through the Global Fund supported Pooled Procurement Mechanism, giving the Government access to competitive prices. There is a special provision in the State Budget Law of Georgia to enable NCDC to produce through pooled procurement mechanisms without using the common state procurement mechanism. The MoLSHA is considering the possibility of procuring ARV drugs locally through the existing state mechanism. The Transition Plan recommends that this be carefully considered to ensure the high quality of health products going forward. 	<ul style="list-style-type: none"> Curatio International Foundation, <i>Georgia Transition Plan</i>, 2016, p. 37
<ul style="list-style-type: none"> Currently, contraceptives are not supplied through public sector health programmes. UNFPA and USAID discontinued supplies in 2015 and contraceptives are not included in the essential drugs list. Quality of condoms sold in the commercial sector are not controlled and monitored. Contraceptives are available through private pharmacies with prescription, except for emergency contraceptive pills, at relatively high prices and not affordable, especially for young people and families in need, particularly in rural areas. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>Invest in Family Planning: Strengthening family planning policies and services for healthy families in Georgia</i>, Policy Brief, 2017
<ul style="list-style-type: none"> UNFPA conducted a study in 2013 that identified weaknesses in government capacity to provide a supportive environment for effective family planning services, and lack of infrastructure and human resources to provide services. Family planning services are offered mainly through specialized OB/GYNs, with a limited role by primary care. Demand-side problems include low awareness, knowledge and used of contraceptive methods, although this has been slowly improving. Abortion remains an important method of 	<ul style="list-style-type: none"> UNFPA Georgia, <i>Strengthening family planning policies and services – the safe and effective way to reduce</i>

Assumption 1.4: UNFPA has supported effective efforts to strengthen the management of supply chains for male and female condoms and lubricants (including in humanitarian settings).	
fertility regulation. Legislation has been initiated to expand the waiting time for abortion from three to five days, which will increase barriers to these services. Post-abortion contraceptive counselling is not offered (only one-third received contraceptive counselling).	<i>abortions in Georgia, Policy Brief, 2014</i>
<ul style="list-style-type: none"> • UNFPA published a policy brief in 2017 to forecast the cost of providing free contraceptives in Georgia in 2017-2019, but analysed IUDs and oral contraceptives for two target populations, women in vulnerable groups (youth and targeted assistance) and all women of reproductive age (15 to 49 years). Condoms were not included in this analysis. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>The cost of free contraceptives</i>, Policy Brief for the Ministry of Labour, Health and Social Affairs of Georgia, 2017
<ul style="list-style-type: none"> • Public sector procurement of SRH commodities is for vaccines, ARVs and TB meds. All contraceptives are prescription based and available through private sector at a cost. Re procurement, the Global Fund must follow government procurement laws, which call for the lowest price, regardless of quality. Lowest bid must be accepted; quality is not checked as there are not criteria to do so. • UNFPA Georgia also did a policy review and cost-benefit analysis, which resulted in a brief to inform the government and advocate for allocating funds for contraceptive commodities. Lack of public funding for contraceptives is not seen as an issue not of money, but of political will. The Ministry does not have public support to move in this direction; it is six years to the next Presidential election and Parliamentary elections are in 2020. Currently, everything is in “stand-by mode.” 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO
Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.	
<u>Indicators:</u> <ul style="list-style-type: none"> • National HIV and SRHR strategies include reference to Comprehensive Condom Programming and its goals/targets • National programmes and strategies address the enabling political and social environment for demand, access and utilization of male and female condoms • Results reports and evaluation findings on Comprehensive Condom Programmes in case-study countries • Views of national health authorities • Views/experience of non-governmental service providers, including private sector firms • Views of service providers in government health facilities • Experience of selected clients • Trends in condom use • Met need for family planning both in general terms (percentage of women of reproductive age accessing modern methods) and, where available, more specific indicators such as: <ul style="list-style-type: none"> • Percentage of adolescents and youth, especially adolescent girls and young women, reporting the use of a condom during their last intercourse) • Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse • Percentage of SWs reporting the use of a condom with their most recent client • Percentage of men reporting the use of a condom the last time they had anal sex with a male partner. 	

<p>Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.</p>	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • There has been no social marketing of condoms or other condom programming for several years. PSI was last in Georgia in 2011/2012 but left when USAID terminated its support. 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO
<ul style="list-style-type: none"> • The national standards for HIV prevention services for KPs are aligned with WHO/UNFPA/UNAIDS/NSWP/WB guidance, “Implementation of comprehensive HIV/STI programmes with MSM (MSMIT), sex workers (SWIT) and the National HIV and AIDS Strategic Plan (NSP for 2016-2018 and fully integrates SRH issues related to condom programming. (Note: this is the only mention of condom programming in the 2016, 2017 and 2018 Annual Reports.) 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2016 Annual Report</i>, finalized 13 January 2017
<p>Assumption 1.6: UNFPA has effectively supported knowledge development and dissemination at global, regional and national level as well as supporting lessons learning and south-south cooperation on strengthening bi-directional linkages between HIV and SRHR and integrating HIV and SRHR services.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Quantity and type of knowledge products at global, regional levels • Quality of global knowledge products • Dissemination activities: volume and frequency; reach • Reported use of global knowledge products at regional/country level • Extent of collaboration with HIV research community. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • UNFPA supported the generation of evidence on women’s reproductive health for policy advocacy, including “spearheading SRH related/SDG localized indicators integration into the MICS-6 questionnaire.” This exercise will generate high quality and internationally comparable indicators and strengthen evidence-based planning and informed decision-making processes. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019, p.3
<ul style="list-style-type: none"> • UNFPA Georgia supported colleagues to attend the IV International Workshop for Health Future conducted in Istanbul to share expertise and experiences as speakers and facilitators. This supported confidence-building through meaningful dialogue and direct contacts among medical professionals related to issues of interest and updates in ANC and SRH. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> • UNFPA Georgia supported the development of the National Cervical Cancer Screening Registry software and its incorporation into the broader National Cancer Registry. The overall aim was to deliver an organized approach to cervical cancer screening and ensure continuity of care using screening variables, data items and key performance indicators aligned with the European Cervical Cancer Association (UNFPA supported) and the International Agency for Research on Cancer (NCDC supported) recommendations and adapted for Georgia. This effort was undertaken in cooperation with national counterparts (MoHLSA, NCDC, National Screening Centre and local experts). The team developed a user manual and conducted a ToT to NCDC personnel on registry protocol and procedure, and data definitions and their interpretation. The system is ready for a national rollout. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> • The government has prioritized the EMTCT and the National EMTCT Board was created by the MoLHSA in 2017 to lead the effort. UNFPA supported NCDC representatives to participate in the WHO Regional Consultation on EMTCT of HIV and Congenital Syphilis in the WHO European Region. UNFPA joined the WHO initiative and in partnership with UNICEF provided technical assistance to NCDC to 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017

Assumption 1.6: UNFPA has effectively supported knowledge development and dissemination at global, regional and national level as well as supporting lessons learning and south-south cooperation on strengthening bi-directional linkages between HIV and SRHR and integrating HIV and SRHR services.	
strengthen EMTCT country efforts and delivery EMTCT guiding documents aligned with the National MNH Strategy. Areas of technical assistance included: <ul style="list-style-type: none"> ○ National EMTCT self-assessment indicators with passports and data sources (based on the WHO self-assessment tool) ○ EMTCT National Plan for 2018-2019 ○ M&E plan based on targets and objectives of EMTCT National Plan. 	
<ul style="list-style-type: none"> • UNFPA supported national implementing partners to attend community level training held in Bishtek on MSMIT, organized by UNFPA, the ECOM, and other civil society partners. • UNFPA Georgia collaborated with EWNA, as the EECARO strategic partner. The Georgia CO Programme Analyst/HIV represented the UNFPA EECARO at the EWNA Strategic Planning meeting in 2016. • In 2016, the Georgian delegation represented by the Global Fund, NCDC, PHYKP and IPPF participated in the UNFPA EECARO and IPPF EN Second Regional Consultation on HIV and SRHR among YKPs. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2016 Annual Report</i>, finalized 13 January 2017
<ul style="list-style-type: none"> • UNFPA Georgia is working with UNICEF on the MICS survey now to analyse the data related to contraception. The last MICS was supported by USAID and UNFPA in 2010. According to preliminary analysis, CPR is at 41%. The 15-19 age cohort has the lowest knowledge and awareness. 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO
Assumption 1.7: Linkage and integration of HIV and SRHR has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably KPs. Including in humanitarian settings.	
<u>Indicators:</u> <ul style="list-style-type: none"> • Observed improvements in client centred services as reported by key informants • Client centred service observed during site visits to service delivery points • Experience/views of organisations representing women, adolescents and youth and KPs • Improvements in access monitored in programme results reports • Increased use of services reported in health information statistics systems (DHIS2) • Client satisfaction survey results such as the UNFPA Supplies annual surveys • Where available, secondary data on aspects of service integration identified in the IAWG indicator list: <ul style="list-style-type: none"> - HIV counselling and testing and family planning integrated - Knowledge of HIV status - Met need for contraception - SW access to services - MSM access to services. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • As part of its commitment to quality assurance, UNFPA supported the MoLHSA to use the NCMR methodology as the quality improvement method to understand the underlying causes of severe maternal complications, to identify recommendations and to implement actions to improve quality of care. In 2018, the NCMR methodology was extended from four existing pilot sites to an additional five maternities. According to a review by international team, the implementation of the NCMR is ongoing and regular sessions are conducted throughout the year. Very good results have been achieved in nearly all the hospitals, with the majority of very 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019

Assumption 1.7: Linkage and integration of HIV and SRHR has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably KPs. Including in humanitarian settings.	
<p>low assessment scores having improved over a two-year period. Seven out of nine facilities met minimum requirements for the quality of NCMR practice. Of note are the following points:</p> <ul style="list-style-type: none"> ○ Women’s views are included in the methodology. ○ Given that maternity hospitals and services are privatized, the MoHLSA has limited authority to control internal management of providers and the implementation of standards. UNFPA will continue to support the strategic priority to improve MNH services and will build upon the successful NMCR experience. <ul style="list-style-type: none"> ● UNFPA also supported the development of the ANC Regionalization Model, which categorizes ANC into three levels of clinical complexity and outlines detailed standards and requirements (infrastructure, services, equipment, supplies and staffing) to ensure risk-appropriate care for pregnant women. This model will underpin a two-year nationwide assessment of all ANC facilities to designate them according to the appropriate level of care. The ANC regionalization model can serve as a model for reorganizing and staging other health services in Georgia and the development of integrated health care networks. 	
<ul style="list-style-type: none"> ● Quality of care is hampered by the lack of obligatory protocols and guidelines that ensure quality of care. There is no accreditation system in country. There is considered to be an integration of pharmaceutical companies and medical service providers, which is unusual in the EECA region and broader European context. 	<ul style="list-style-type: none"> ● UNFPA Georgia, 2018 Annual Report, finalized 31 January 2019
<ul style="list-style-type: none"> ● Quality of care is an important theme for the CO. It is the biggest priority within the healthcare system given the extent of privatization and because the continuing medical education system based on the Soviet model was disbanded due to corruption. There is no other way to assure providers are up-to-date. UNFPA Georgia partnered with TSMU to develop a postgraduate platform for online training in contraception and ANC and provide technical assistance in the training content and personalized tests. The University runs and maintains the platform. The online training is free-of-charge and supports “grassroots level capacity building” for providers. 	<ul style="list-style-type: none"> ● Interview with UNFPA Georgia staff

Area of Investigation Two: Extent UNFPA support to the HIV response corresponds to the needs of most vulnerable and at risk populations	
Evaluation Question 2: To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of at risk, most vulnerable and marginalized people especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities?	
Evaluation Criteria	<i>Relevance, Effectiveness, Efficiency</i>
Rationale	UNFPA has joint leadership under the UNAIDS division of labour for the prevention of HIV infection among adolescents and youth and KPs. In addition, UNFPA Strategic Plan, 2018 - 2021) and the guiding principles for UNFPA action in HIV emphasize the principle of No-One Left Behind, and the requirement to focus on meeting the needs of those at risk of HIV infection and most vulnerable.

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, KPs and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.

Indicators:

- National HIV strategies, action plans and programmes incorporate policies and promote approaches prioritizing needs of adolescents and youth, women and KPs
- Operational guidelines for HIV and SRHR programming include measures specifically targeted to meeting needs of adolescents and youth/women/KPs for HIV prevention
- National strategies and programme documents make specific reference to the evolving nature of the epidemic and its implications for changing needs of adolescents and youth/women/KPs
- Where available, reported changes in national strategies, action plans, programmes and service guidelines to reflect changes in the epidemic.

Observations	Sources of Evidence
<ul style="list-style-type: none"> • The UNFPA Georgia 2nd country programme (2011-2015) focused on three mandated areas: a) SRH, b) gender equality and gender-based violence, and c) development of evidence-based population policies, with youth issues as crosscutting. The third country programme (2016-2020) focuses on three areas: a) SRH, including adolescents and youth, b) gender equality and women’s empowerment, and c) population dynamics. Programming strategies (for middle-income country context) include advocacy, policy dialogue and advice, generating evidence for policy development, knowledge management and brokerage of technical expertise. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Georgia Country Programme document 2016-2020</i>, p 3-4
<ul style="list-style-type: none"> • UNFPA Georgia identified as Output 2 in the Country Programme to <i>strengthen capacity of national institutions and partners to enable inclusion of human rights and SRH needs of adolescents and youth into national policies, plans and programmes</i> as a contribution to UNFPA Strategic Outcome 2: <i>Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and SRH.</i> Strategic interventions include: <ul style="list-style-type: none"> ○ Strengthen monitoring system for the national youth policy action plan ○ Support participatory partnership platforms to advocate for increased investment in marginalized adolescents and youth ○ Support integration of healthy lifestyle and RH and rights education in formal and informal education systems, including the development and revision of education materials for teachers, school doctors and students ○ Generate evidence on causes, consequences and existing practices of early marriage, and develop prevention policies, including for ethnic minorities. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Country Programme Theory of Change 2016-2020</i>, 2015
<ul style="list-style-type: none"> • The Government does not have a separate youth-oriented SRH programme and there are no services that address the specific needs of adolescents and young people who are vulnerable and most at-risk of HIV infection in Georgia. However, the new HIV and AIDS NSP 2019-2022 acknowledges the importance of implementing HIV prevention for YKPs. Recommendations regarding YKPS in the new strategy were based on the UNFPA/IPPD YKP programme tool • There are no prevention programmes in Georgia oriented to transgender persons. However, the NGO sector has begun implementation of a project “Empowering Communities on the Right to Health” to empower underserved groups of trans and HIV-positive trans-persons and support their involvement in advocacy for rights to health. In support of these efforts, UNFPA Georgia 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019

<p>Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, KPs and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.</p>	
supported the translation of the TRANSIT tool (Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions); and assisted in development briefs and presentations for the training module.	
<ul style="list-style-type: none"> Refer to Assumption 1.1 re UNFPA support for national HIV strategies and programmes, which prioritize HIV prevention and needs of KPs, including YKPs. 	
<ul style="list-style-type: none"> Per UNFPA Georgia, there are no major changes in the evolution of the HIV epidemic over the past several years, as HIV prevalence remains low (0.4%). The epidemic is concentrated among MSM, PWIDs and SWs, with sexual transmission as the main route transmission followed by injecting drug use. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> UNFPA assistance has been focused on strengthening the quality of SRH and HIV preventive interventions for KPs. In partnership with NCDC and the Global Fund, UNFPA introduced the SWIT and MSMIT tools and supported training for 40 service providers from the cities with the highest prevalence rates. This was a first step towards the elaboration of an on-line training module in partnership with NCDC and AIDS Centre and its accreditation by TSMU CME system in 2018. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017
<ul style="list-style-type: none"> UNFPA partnered with NCDC and MoES to strengthen the school health system in two additional regions of Georgia in order to address priority challenges related to available and access to youth-friendly health care services (including SRH services), and quality comprehensive education re human rights, health life styles and RH issues. Training was conducted for 80 school health professionals based on the accredited training module on adolescent and youth SRH, communication skills and healthy life styles, mental health and first aid in the Samegrelo and Kakheti regions. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017
<ul style="list-style-type: none"> The development of national comprehensive HIV prevention packages of standards (and cost calculations) for SWs, MSM and YKP is a priority for UNFPA Georgia. UNFPA supported the elaboration of national standards with the wide participation of stakeholders from community organizations, NGOs and state programme providers. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2016 Annual Report</i>, finalized 13 January 2017
<ul style="list-style-type: none"> In a review conducted youth, the following barriers to HIV testing were identified in Georgia (Tbilisi): <ul style="list-style-type: none"> There is limited access to free HIV testing. HIV tests are free of charge at the AIDS prevention and control centre and some service non-profit organizations. Otherwise, the test costs USD 4 Article 6 of the Law of Georgia on HIV and AIDS states that HIV testing of individuals should be anonymous and confidential; however, in reality official identification (e.g., a passport) is required. There is an absence of quality pre- and post-test counselling. 	<ul style="list-style-type: none"> UNAIDS EECA Regional Office and ViiV Healthcare, <i>Barriers to access to HIV Testing for adolescents and youth in three EECA countries: Russia, Ukraine and Georgia</i>, 2017
<ul style="list-style-type: none"> The activities of UNFPA Georgia are clearly focused on disadvantaged and vulnerable groups, among which include young girls and women, IDPs, SWs and MSM. Further, the CO <i>“has paid high attention to mainstreaming women’s and young people’s concerns.”</i> 	<ul style="list-style-type: none"> Gotsadwe, T. <i>Country Programme Review</i>

<p>Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, KPs and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.</p>	
<ul style="list-style-type: none"> UNFPA Georgia was effective in improving access of vulnerable groups to quality health, education and essential social services. 	<p><i>Report for the UNFPA Second Country Programme for Georgia 2011-2015, January 2015, p. xv-xvi</i></p>
<ul style="list-style-type: none"> UNICEF works together with UNFPA on the UN Joint Strategy on Youth, which requires each country to have a coordination group under the JUNTA. UNFPA is seen as doing a good job, and the Ministry is becoming more interested. The Prime Minister's office plans to take on the issue of youth going forward. The National Youth Strategy is not being implemented, as political will has been missing. The policy is good (with topics related to participation, health education, and special needs youth) but has not been a priority for government. Youth as a topic has moved around ministries and is now in the MoES. Recently, the parliamentary committee on youth has become more active and is working closely with the advisor of the Prime Minister who himself is relatively young (age 37). 	<ul style="list-style-type: none"> Interview with UNICEF Georgia CO staff
<ul style="list-style-type: none"> UNFPA worked on evidence generation (with UBRAF funding) to conduct focus group discussions in eight countries with YKPs, including Georgia. In 2015, UNFPA Georgia collaborated with Tanadgoma on a qualitative study of truck drivers and SWs along the Silk Route. Unfortunately, the study results were not followed up as resources were not adequately mobilised. 	<ul style="list-style-type: none"> Interview with UNFPA Georgia CO
<ul style="list-style-type: none"> NCDC conducted a qualitative survey of early marriage with UNFPA and Promundo. The national birth registry since 2016 now catches all cases of pregnancy at the first ANC visit and women are followed to the end of pregnancy. Early childbirth at age 16-17; cut off is at age 18. Fourteen per cent of all marriages are early (under 18) according to MICS. This is tied to education; when a girl drops out cultural norms dictate that she must get married. This is more common among Azeri and Armenian ethnicities. 	<ul style="list-style-type: none"> Interview with Government official, NCDC
<p>Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> Where available, survey results regarding changing knowledge of HIV causes and prevention among adolescents and youth (e.g. percentage of women and men aged 15-24 who correctly identify both ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission) Experience and view of partners implementing interventions targeting adolescents and youth – including ministry of education staff responsible for formal and non-formal education Guidelines and teacher training curricula for comprehensive sexuality education include HIV prevention components Observation of adolescents and youth friendly service outlets for HIV prevention and SRHR Experience and views of adolescents and youth attending service outlets. 	

<p>Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.</p>	
Observations	Sources of Evidence
<ul style="list-style-type: none"> UNFPA Georgia provided technical assistance to MoES to enhance formal and non-formal education through the integration of SRHR and healthy lifestyle principles within the educational system and process. Assistance was provided to review subject standards for biology and civic education for basic and secondary education levels, aligned with WHO Standards on Sexuality Education in Europe and UNESCO standards. The revised standards include age-appropriate information on SRHR and HIV and AIDS, healthy lifestyle, contraceptives, addiction and gender equality. Primary and basic education level standards were approved in early 2018; secondary education level standards were revised and will be approved in 2019. UNFPA also provided technical assistance in the development of the textbooks and reference materials. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> UNFPA supported the design of 12 lesson plans and the piloting of the biology standard for basic education level in three public schools (two in Tbilisi and 1 in Sagarejo) by a group of experts from MoES, National Centre for Teacher Professional Development. Lesson themes included puberty, SRHR, HIV and AIDS, STIs, physical activity, healthy nutrition and addiction. UNFPA also supported the development of a teacher-training module, which included practical tips, interactive teaching/learning methods. Information brochures in support of parent education programme run by MoES were reprinted. (This activity is supported through a tripartite agreement among UNFPA, EuTEACH at the Continuing Education Service of the University of Lausanne, and NCDC.) Under the CEDAW Convention fourth and fifth periodic reports to Georgia (July 2014), the country is to take specific measures to integrate SRHR in the curriculum on all educational levels (recommendation 26.e). UNFPA provided strategic support to MoES as stipulated in a signed MoU to build expertise within the MoES, via facilitating the participation of the Head of the General Education Unit in an international conference in Berlin. This conference was a platform of exchange re latest research results and good practices in the field of sexuality education, including the current state of sexuality education in WHO European Region. The experience at this conference was used to shape the MoU between the MoES and the Joint UN Programme for cooperation through 2020. UNFPA committed to providing technical assistance to MoES to enhance formal, non-formal and vocational education systems in the country through the integration of SRHR, healthy lifestyle and gender equality principles. UNFPA provided technical assistance through an implementing partner, NGO Tanadgoma, to revise and enhance the subject standards for biology and civic education for the basic education level (grades VII-IX). The standards were finalized and agreed by the Ministry; however, approval was postponed to 2018 due to the replacement of the Minister of MoES at the end of the year. UNFPA provided technical assistance to promote the peer education methodology aimed at equipping the young generation with age-appropriate and relevant knowledge and skills to enable them to make informed decisions regarding their reproductive health and rights. Technical assistance was provided to tale specific modules for 14-16 years and 16-19 years old age groups; 3,196 youth in the capital and two regions of the country (Samegrelo, Kakheti) were reached through ToTs and cascade training sessions. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017
<ul style="list-style-type: none"> UNFPA continued efforts to support the MoES initiative to re-establish the school health system by deploying school health professionals in public schools throughout the country. In partnership with NCDC and within the frame of the tripartite agreement among NCDC, UNFPA, and EuTEACH the goal of which is to integrate SRH for Youth within the school health system. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2016 Annual Report</i>, finalized 13 January 2017

<p>Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.</p>	
<ul style="list-style-type: none"> • The training module on ASRH, communications skills, healthy life style, mental health and first aid was developed; it is the first-ever module developed in Georgia and is based on European framework for quality standards in school health services and competencies for school health professionals. The training module was accredited by the CME system at TSMU. • UNFPA continued implementing a peer education campaign to educate young people on issues related to SRH, HIV prevention, gender equality, and GBV in cooperation with GYDEA. Peer education training sessions were organized in Kakheti and Samegrelo regions for young people aged 15-25. Cascade trainings included a series of meetings in Anaklia Youth Camp; overall, 2,524 youth were reached. • UNFPA Georgia provided technical assistance to MoES to elaborate pass through standard on healthy lifestyle education. This document will be used as a reference for subject-specific standards at the basic and secondary education level for the General Education system. As part of the Joint Programme for Gender Equality (UNFPA, UNDP and UN Women), a comprehensive MoU was developed in 2016 to outline collaboration with the MoES starting in 2017. 	
<ul style="list-style-type: none"> • UNFPA Georgia works with young people within the education sector and supports peer education in summer camps. These are clubs established for extracurricular civic education; UNFPA supports the integration of SRH information within these activities. The hope is for the government to integrate peer education into the system. 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO staff
<ul style="list-style-type: none"> • As part of the Joint Programme on Gender Equality supported by the Swedish government (in collaboration with UNDP and UN Women), UNFPA is responsible for the institutional component and works with the MoE on formal education. Activities include: <ul style="list-style-type: none"> ○ Assisting with the revision of school subject standards, revisions for basic level education were completed. There is strong commitment to go all the way up to grade 12 and to integrate content on civic education and biology, including HIV prevention and rights, harmful practices for 8-9th graders ○ Supporting teacher capacity development through the new schools pilot in 50 schools (with UNFPA supporting ½ of the 50 schools to integrate content within new training modules ○ The follow-on to the joint programme plans to advocate for the school doctor system to be re-established in 2021, as this was disbanded in 2003. • A major issue related to youth in grades 9-10 as they can leave school then to get married. This is more common for Armenian and Azeri ethnic groups. Reform is underway to determine how to change regulations re age for youth to drop out. Once they drop out, girls tend to get married. The current percentage of early marriage among girls will be identified in the current MICS whose analysis is underway. • Re informal education, interventions include: <ul style="list-style-type: none"> ○ Support for Gydea in three regions (Tbilisi and East and West Georgia) to conduct peer education, now embedded as an extracurricular activity within schools 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO staff

<p>Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.</p>	
<ul style="list-style-type: none"> ○ Development of a MoU to integrate SRHR modules within peer education on civic education. The term sexuality education is very delicate; instead, the terms “reproductive health” and “healthy behaviour” are used and more acceptable for content related to sexual health. 	
<ul style="list-style-type: none"> ● In the summer, the MoE holds youth camps, which include the provision of information and training on SRH, HIV and family planning. There was a recent problem when a parent complained to MoE about content related to gender stereotyping and LGBT. Camps are still ongoing, and will continue but the content has been revised. 	<ul style="list-style-type: none"> ● Group discussion with NGO partner staff
<ul style="list-style-type: none"> ● Reproductive health education in schools is called “healthy lifestyle education” not comprehensive sexuality education. UNFPA did a good job advocating with MoE. The healthy lifestyle curriculum was developed in collaboration with Tanadgoma with German Development agency funds under the spectre of widespread religious and community opposition. ● MoE introduced school doctors, and this opportunity was used to educate doctors as educators re adolescent RH and help them to address adolescents’ questions. MoE salaries for doctors are not attractive and NCDC advocated for the hiring of nurses. However, there is a shortage of nurses and an oversupply of doctors. 	<ul style="list-style-type: none"> ● Interview with Government official, NCDC
<ul style="list-style-type: none"> ● Sexuality education in Georgia is fraught with political problems. There have been many changes in the Ministry of Education – four over the past few years. This has been disruptive in terms of priority setting; the last minister’s priority was parental education, while the current minister is focused on reforms and a new school model to make education more interactive. ● Standards are in place for elementary (1-6) and primary (7-9) grades for both biology and civic education; currently working on secondary grade (10-12) standards. In 2018, a new topic on society was added to the curriculum. Tanadgoma experts were involved in standards development; standards were not approved by the Ministry of LHS, but the approval process was re-initiated just recently. ● Tanadgoma is working with UNFPA to revise the process in elementary and primary levels. Reform is being implemented in 50 pilot schools across the country; however, in reality, only 25 schools are being included in the pilot due to resource constraints. 	<ul style="list-style-type: none"> ● Interview with NGO partner staff
<ul style="list-style-type: none"> ● Tanadgoma has had a fruitful partnership with UNFPA via a 5-year MOU. The IP (implementing partner) agreement runs from 2016 to 2020. This has included work to support interactive teacher training for the new curriculum for seventh graders on puberty (within the reproductive health module) which focuses on how to talk to students about RH issues, how to use interactive methods and the pilot lesson plan. ● Training for teachers needs an accreditation process. Neither the Quality Control Center nor Teacher’s House knows who is supposed to accredit the courses. ● Concepts related to gender, tolerance and identity were not approved for inclusion in the course and were removed from the curriculum. Family is defined only as mother/father/grandparents/children. ● UNFPA has been an excellent partner. It not only provides financial resources, but also offers recommendations to others re working with/through Tanadgoma. Its role is more important than money. “When UNFPA comes with its mandate, it helps to open doors.” <p>General information on Tanadgoma:</p> <ul style="list-style-type: none"> ● Tanadgoma Centre for Information and Counselling in Reproductive Health was the first to develop a RH counselling centre based on a Medicins Sans Frontier (MSF) model. It was first a project of MSF Greece, founded in 1999. Tanadgoma has been working for 20 years 	<ul style="list-style-type: none"> ● Interview with NGO partner staff

<p>Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.</p>	
<p>in reproductive health and has two main priorities: 1) SRH and work with KPs for HIV/STI and 2) Mental health support for vulnerable groups (prisoners, IDUs, female partners of IDUs)</p> <ul style="list-style-type: none"> • Tanadgoma has implemented 120 projects working with the Global Fund, USAID, UN agencies and all donors in the region. It is also involved in regional initiatives and partners with other networks related to RH, HIV and KPs. • Tanadgoma as 100 staff in Georgia; it is the largest NGO in Georgia. There is a headquarters in Tbilisi with four regional branches to enable Tanadgoma to cover the whole country. They also have a social enterprise building and rehab centre for IDUs. 	
<p>Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV and SRHR services that meet the needs of adolescents and youth, KPs, women – and other at risk and marginalized groups (also applies to evaluation question 3).</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Experience and view of partners implementing interventions targeting adolescents and youth/women/KPs • Guidelines, service protocols and manuals for HIV prevention services integrated into SRHR address needs of adolescents and youth/women/KPs • Level of national government funds allocated to comprehensive sexuality education for adolescents and youth. • Examples of changes in policies and laws to include provisions for quality and human-rights-based HIV and SRHR services that meet the needs of adolescents and youth, KPs and women • Observation of adolescents and youth friendly service outlets for HIV prevention and SRHR • Experience and views of adolescents and youth attending service outlets • Observation of integrated HIV and SRHR services targeted to adolescents and youth/women/KPs. • Experience and views of organisations representing (and led by) adolescents and youth/women/KPs) 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • A lesson learned from the 2nd country programme (2011-2015) was that knowledge management and capacity development maximized results of evidence-based policy dialogue and promoted sense of ownership among partners 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Georgia Country Programme Document 2016-2017</i>, p 3
<ul style="list-style-type: none"> • In 2018, UNFPA continued supporting peer education campaign with the MoES through MoUs with 10 schools in Samegrelo and 4 schools in Kakheti regions to implement peer education training sessions. Four ToTs were held in Kakheti and Samegrelo regions to prepare a new cadre of trainers. The trainees conducted cascade training sessions in their schools on gender equality, SRH and reproductive rights, family planning, contraception, early marriage, gender stereotypes, gender identity and gender roles. A total of 410 students were reached through this effort in 2018 in both regions. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> • UNFPA played a crucial role in youth policy development. The development of the policy itself should be considered an achievement. Georgia was the first of the Soviet/Balkan countries to develop a youth policy. The policy is for the whole of Government and not just the MoES; it addresses youth participation, education, health and special needs and protections. An action plan was also developed to make youth a priority and give it greater political weight than before. Prior to this policy, youth activities were managed mainly by 	<ul style="list-style-type: none"> • Interview with Government officials, Ministry of Education

<p>Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV and SRHR services that meet the needs of adolescents and youth, KPs, women – and other at risk and marginalized groups (also applies to evaluation question 3).</p>	
<p>NGOs but they could not achieve desired results (at scale). Now different agencies will be engaged through the action plan process. A revised action plan is being worked on and the structure will provide direction/activities/budget for 14 Ministries and 15 State entities (n=200 activities).</p> <ul style="list-style-type: none"> Implementation of the plan was reviewed annually until 2016; however, there has been no review since then due to structural changes at the Ministry. Overview of the youth policy will move to the Prime Minister’s Office and a new action plan will be developed to identify new priorities and directions. There is concern that a diffused effort across all Ministries may be difficult to manage and maintain focus; however, the fact that youth is getting attention at high levels within the political system is good especially if the priorities are based on evidence. The Coordination Council will still exist, with the Prime Minister as the chair (The MOE chaired the Council with UNFPA and UNICEF, with a parliamentary committee that reviewed progress and challenges with plans. 	
<p>Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, KPs and women to engage meaningfully and advocate for national policies and programmes, which prioritize, access to effective integrated HIV and SRHR services (also applies to evaluation question 3).</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> Work plans illustrate direct support of networks Narrative reports of network activities illustrate role of UNFPA support Examples of network advocacy for integrated HIV and SRHR services Experience and views of UNFPA staff/network representatives/national authorities. 	
<p>Observations</p> <ul style="list-style-type: none"> UNFPA Georgia supported the GYDEA to integrate peer education within its Youth Camps organized by LEPL Children and Youth National Centre (under the MoES). GYDEA conducted 23 informational sessions reaching 4,725 youth (3,700 students and 1,205 university students). Youth festivals were also conducted in cooperation and with the active involvement of the local governments in Samegrelo and Kakheti regions. During the festival, UNFPA organized a photo project showcasing the potential of young people and how they can contribute to the development of society if they are empowered to exercise their human rights, have access to quality education, information and services, and have power to participate in decision-making process and influence policies that affect them. UNFPA Georgia hosted a workshop in collaboration with Bemoni Public Union, Georgian Harm Reduction Network, and the Centre for Information and Counselling on Reproductive Health – Tanadgoma, to provide information to service provider organizations on the legal context and needs related to HIV risks and SRH and on main principles of programming for young people, especially YKPs. Sixty-two providers representing 15 organizations were trained. The organizations provide services to drug users, SWs and the LGBT community. 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> UNFPA Georgia, <i>2018 Annual Report</i>, finalized 31 January 2019 UNFPA Georgia, <i>Report on Capacity development on implementation of a practical tool for HIV and SRH programmes with young key populations in Eastern Europe and Central Asia: “Health, Rights</i>

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, KPs and women to engage meaningfully and advocate for national policies and programmes, which prioritize, access to effective integrated HIV and SRHR services (also applies to evaluation question 3).

	<p><i>and Well-being, May 2018.</i></p>
<ul style="list-style-type: none"> • UNFPA Georgia wrote a brief to summarize the current situation of HIV prevention strategies and HIV/SRH services for YKPs to support advocacy aimed at increasing and improving the programmatic, policy and funding actions in support of this group. It was based on qualitative research carried out in June 2015 by UNFPA Georgia with NGO partner Tanadgoma. Five focus groups were conducted with 47 YKP representatives (8 SWs, 10 MSM, 9 PWIDs, 9 former detainees and 10 orphanage graduates). FGD topics included integration and social inclusion; access to and availability of SRH/HIV services; and legal context, combating violence, stigma and discrimination. • Key recommendations from the research findings follow: <ul style="list-style-type: none"> ○ Re access/availability of SRH/HIV services: <ul style="list-style-type: none"> ▪ Advocate for human rights-based approach ▪ Sensitize health service providers on different needs ▪ Ensure SRH services are provided to YKP ▪ Ensure that comprehensive, friendly, free-of-charge and gender-sensitive SRH services are provided to YKPs ▪ Strengthen youth-friendly centres ▪ Promote Condom Social Marketing among private sector and contribute to public-private partnership ▪ Integrate youth friendly SRH services into the PHC level, utilize existing infrastructure and services for youth and YKP ○ Re integration and social inclusion: <ul style="list-style-type: none"> ▪ Prioritize community mobilization and empowerment, especially among SWs and MSM ▪ Capacity building and empowerment through community based interventions targeting YKPs ▪ Support involvement of YKP into community work ▪ Strengthen networking and to work with the community ○ Re legal context and combating violence, stigma and discrimination <ul style="list-style-type: none"> ▪ Advocate to improve legislative framework to protect key young population and reduce discrimination practices ▪ Advocate for liberalization of drug legislation. ▪ Advocate for regulating sex work in order to avoid massive harassment of SWs by law enforcement ▪ Educate public servants, law enforcement representatives, police officers, media representatives on rights and SRH issues. ▪ Ensure that YKPs have access to free of charge legal advice and assistance ○ Cross-cutting: <ul style="list-style-type: none"> ▪ Conduct broad mass media campaigns – social ads through TV, radio and internet, printed materials, printed media – in order to raise awareness, influence public opinion and change societal attitudes stigmatizing and discriminating YKPs ▪ Develop and implement the communication strategy and action plan with participation of all stakeholders (YKP, community led NGOs, government representatives) 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Report card: Young key populations on access and service barriers to HIV Services in Georgia, 2015</i>

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, KPs and women to engage meaningfully and advocate for national policies and programmes, which prioritize, access to effective integrated HIV and SRHR services (also applies to evaluation question 3).	
<ul style="list-style-type: none"> ▪ Raise the level of knowledge and awareness of young people on SRH&R issues through formal and informal education ▪ Ensure continuation of HIV prevention programmes, targeting KPs, with specific focus on YKP-tailored approaches ▪ Address the issue of the phasing out of the Global Fund in at least one of the recommendations ▪ Strengthen capacities of CSO and NGOs that provide health services to KPs. 	
<ul style="list-style-type: none"> • Tanadgoma initiatives include meaningful participation of KPs through involvement in design and processes. In all projects, they try to include a small initiative with community members. Every two years, they conduct a satisfaction survey of beneficiaries on all premises and via outreach in cities. They are trying out new methods of outreach online. • UNFPA involves young representatives of various groups to support youth participation. 	<ul style="list-style-type: none"> • Interview with NGO partner staff
Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV and SRHR services for adolescents and youth, KPs and women (<i>also supports evaluation question 3</i>). Further, service providers have the capacity to provide these services.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> • Quantity and content of programming tools • Examples of dissemination/training efforts for health facility staff using the programming tools supported by UNFPA • Evidence that training in linking and integrating HIV into SRHR has been accompanied by measures addressing incentives, equipment, supplies and infrastructure as needed. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • UNFPA EECA led the development of a practical tool for SRHR and HIV programmes for YKPs and conducted advocacy meetings and workshops in 2017 at national level in collaboration with CO to openly discuss challenges and opportunities faced by governments and civil society for addressing the needs of this particularly vulnerable population. UNFPA Georgia supported the NCDC in the development and preparation of the tool for use at the country level via six workshops. In total 82 participants from hard reduction organizations, HIV-positive community organizations and activists, youth NGO representatives. • UNFPA supported two capacity development workshops for representatives from community organizations to introduce the manual on MSMIT in Tbilisi. Community organizations were sensitized on PrEP, MSMIT and the Health, Rights and Well-being Practical Tool for HIV and SRH Programmes for YKPs. 	<ul style="list-style-type: none"> • UNFPA Georgia, 2017 <i>Annual Report</i>, draft 16 October 2017
<ul style="list-style-type: none"> • UNFPA provided technical assistance to NCDC/the Global Fund in the development of the National 2019-2022 HIV NSP. UNFPA provided technical assistance in the following thematic areas: HIV prevention for MSM, SW and prisoners; AIDS Treatment and Care; M&E framework; coordination between the state and the Global Fund and health system strengthening; and transition from donor support to State funding. UNFPA advocacy ensured that the plan reflected the needs of KPs, including YKPs and transgender people for the first time and proposed practical recommendations based on the UNFPA programme tools: SWIT, MSMIT, TRANSMIT and YKP. The plan also acknowledges gender equality and human rights as core values and commits to mainstreaming these principles into actions carried out for KPs. 	<ul style="list-style-type: none"> • UNFPA Georgia, 2018 <i>Annual Report</i>, finalized 31 January 2019
<ul style="list-style-type: none"> • UNFPA supported the translation of MSMIT and SWIT for use in programmes and interventions targeting KPs. In 2016, UNFPA supported three working group meetings with national partners, community organizations, KPs, and SRH providers (n=30) to ensure 	<ul style="list-style-type: none"> • UNFPA Georgia, 2016 <i>Annual Report</i>, finalized 13 January 2017

<p>Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV and SRHR services for adolescents and youth, KPs and women (<i>also supports evaluation question 3</i>). Further, service providers have the capacity to provide these services.</p>	
<p>participatory approach while translating the tools, improve the capacity of community-led organizations, and sensitize providers engaged in the provision of SRH and Harm Reduction services to KPs nationwide.</p>	
<ul style="list-style-type: none"> UNFPA Georgia presented HIV prevention strategies and tools for KPs at the Civil Society Forum in February 2017 in Tbilisi, <i>Implementation of comprehensive HIV/STI programmes with Sex workers (SWIT), and MSMs (MSMIT) – Practical Approaches from Collaborative Interventions</i>. Also presented was the comprehensive HIV Prevention Package for KPs, including national guidelines and protocols for clinical practice, state standards on management of clinical cases. 	<ul style="list-style-type: none"> UNFPA Georgia, PowerPoint Presentation, <i>Strengthening HIV prevention strategies targeted at key populations in Georgia</i>, February 2017
<ul style="list-style-type: none"> UNFPA Georgia worked with Tanadgoma on a survey of 100 truck drivers (major clients of SWs) which included an analysis of truck driver routes. Recommendations of this survey supported the rollout of MSMIT and SWIT. Georgia was the first country in the region to rollout these tools. In 2016-2017, the tools were translated with UNFPA funding and formal training was conducted with service providers, state actors and community groups. Tanadgoma also conducted a survey of YKPs who engage in high-risk behaviour/low condom use. MSM, youth and SWs are KPs in the SRH and HIV work done by Tanadgoma. The rollout of the MSMIT tool has resulted in lots of interest from communities. Many have asked for training. 	<ul style="list-style-type: none"> Interview with NGO partner staff (social workers)
<ul style="list-style-type: none"> UNFPA supports the Harm Reduction Network, a NGO that supports affiliated providers that mainly work with IDUs. The purpose of the programme is to prevent the spread of HIV and AIDS among IDUs and minimizing other harms (overdose, health problems and blood borne disease spread). Integrating SRH into HIV work is a new area for this group. Training was initiated just last year however, reinforcement is needed. Major challenge relates to capacity development as outreach workers are former drug users and not reliable as a continuing workforce because they move (out of the country to Russia or Turkey) to find higher paying jobs or they relapse and do not return. Need to establish a continuous programme given the turnover. Out of 315 staff, 69 have a drug history. Despite low HIV prevalence (0.4%) in the general population, Georgia faces significant risk of an expanding epidemic due to widespread high-risk practices and growing HIV prevalence among groups including PWID. Continued criminalization of drug consumption impedes access by PWID to HIV prevention and care services, which contributes to low levels of testing and late seeking of treatment. Harm Reduction Network expressed concern about the shift to the new financing scheme proposed for harm reduction services as part of the transition from Global Fund to state funding. Money will be provided to service providers based on number of clients seen (unit cost/tested client). UNFPA worked with Harm Reduction Network to develop a new strategy to attract sexual partners of drug users, given possibility of heterosexual transmission. Sex partners of drug users may also use drugs, but do not identify themselves as drug users due to self-stigma. Women experience more stigma than men as drug users due to their different life obligations, making them less likely to seek testing and/or care. 	<ul style="list-style-type: none"> Interview with NGO partner staff

<p>Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV and SRHR services for adolescents and youth, KPs and women (<i>also supports evaluation question 3</i>). Further, service providers have the capacity to provide these services.</p>	
<ul style="list-style-type: none"> • Issues with YKP coverage: service sites do not do assessment and targeted prevention for non-injecting drug users. Young people exhibit riskier behaviour from non-injected drugs such as stimulants, cocaine, etc., such as “camp sex.” 	
<ul style="list-style-type: none"> • Providers who participated in group discussion (n=5) work mainly with IDUs. • UNFPA support has included training for service providers on SRH and rights, HIV prevention and counselling. Providers with long experience found the training helpful as a refresher. Newer, less experienced providers said the course was extremely helpful. The training was found to be practical, with strong content on counselling, including how to explain and inform clients about the importance of testing and how to refer. Some providers noted how much their own attitudes (stigma/discrimination) changed as a result of the training, i.e., people are sick, not criminals. • Providers noted some problems/barriers: <ul style="list-style-type: none"> ○ Cannot assist non-citizens (although, when probed, this wasn’t a large number of people, e.g., 3-4/year) ○ Drug users come in for testing, but do not bring partners for fear of violence if found positive. Have had several trainings on domestic violence, but not for gender-based violence. There are shelters for trafficking and domestic abuse. The GHRN refers when necessary. ○ Drug users are classified as part of the general youth population (and not as IDUs). Some cases need additional tests and are not followed up (ultrasound?). Testing is OK for ages 16-18, but under 16 requires parental consent. • Providers noted that they serve 15-20 clients per day, but could see more with promotion/incentives. 	<ul style="list-style-type: none"> • Group discussion with NGO partner staff (service providers)

Area of Investigation Three: Extent of UNFPA promotion of human rights in the context of HIV	
<p>Evaluation Question 3: <i>To what extent has UNFPA support contributed to engage and empower communities (including but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to HIV and SRHR services?</i></p>	
Evaluation Criteria	<p><i>Relevance, Effectiveness, Efficiency</i></p>
Rationale	<p>As well as access for marginalized people, a key dimension of UNFPA support to the HIV response is its intended focus on empowerment and rights protection, including gender equality.</p>
<p>Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • UNFPA guidelines on human rights-based approaches to HIV and SRHR services – in use at CO level • Extent to which implementing partners are aware and knowledgeable about the content of the Guidelines on human rights-based approaches and HIV and SRHR • HIV and SRHR service guidelines incorporate some or all components of human rights-based approaches 	

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.	
<ul style="list-style-type: none"> Experience and views of service providers and clients. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> The third Country Programme includes (Outcome 3, Output 1) support for “strengthened capacity of public and civil society organizations and national human rights institutions to advance gender equality and reproductive rights, including prevention of gender-based violence and harmful practices.” Activities included: <ul style="list-style-type: none"> Generate evidence on GBV and early marriage, and analysing effects on RH and women’s participation for use in policy/advocacy Advocate monitoring of reproductive rights by strengthening the public defender’s office Strengthen health system response to GBV against women as part of national referral mechanism through improved standards, protocols and education of health professionals Strengthen gender-transformative approaches used by enhancing civil society capacity to engage men and boys Policy dialogue and public advocacy for addressing gender-biased sex selection. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>Country Programme document 2016-2020</i>, p 5 UNFPA Georgia, <i>Country Programme Theory of Change 2016-2020</i>, 2015
<ul style="list-style-type: none"> UNFPA (under the UN Joint Programme for Gender Equality supported by the Swedish Government and along with UN Women and UNDP), supported a desk review to evaluate the current status, gaps and challenges within and beyond the health sector on human rights issues related to SRH and well-being, with special connection to marginalized groups, legal and policy frameworks, budgeting and financing, delivery and accessibility of health services, and the provision of remedies and redress. This was the first assessment of its kind in Georgia. The assessment concluded the following re status, gaps and challenges related to SRHR in Georgia: <ul style="list-style-type: none"> Re access to contraceptive information and services: Policies recognize the need to address challenges but they lack details on how to do this. Other challenges include low public awareness, lack of integration of family planning into PHC, no essential medicines list for contraceptives, inconsistent practice re use of prescriptions for EC, and lack of comprehensive YFS. Re access to safe abortion: Abortion is legal, yet government concerns re high rates of abortion have led to mandatory 5-day waiting period and consent requirements that undermine women’s self-determination. Other barriers include unregulated practice of conscientious objection by providers, with lack of referral as a result; requirements for court confirmation on grounds of rape (past 12 weeks); discriminatory restrictions imposed by some clinics for certain groups of women (adolescents, women with STIs and SWs). Re maternal health: Georgia has one of the highest rates of maternal mortality in the region due to low quality antenatal and perinatal care, a weak transportation system, weak monitoring, lack of trained professionals at maternity houses especially in rural regions. There is a lack of comprehensive data disaggregated by ethnicity, age, etc.; and concerns that the current reimbursement scheme by Government has resulted in over-use of C-sections by providers due to financial incentive. Re prevention and treatment of HIV and AIDS: HIV law adopted in 2009 improved overall legal environment for the national response and set the stage for the NSP. However, major barriers still exist due to the overly broad criminalization of HIV transmission, strict drug laws, requirements to show an ID to be tested in the frames of government funded programmes and stigma and discrimination for KPs (MSM and SWs). It is more commonly accepted to say one has Hep-C rather than HIV. Low testing coverage of people at risk is the core problem. 	<ul style="list-style-type: none"> Public Defender’s Office of Georgia, <i>Human rights in the context of sexual and reproductive health and well-being in Georgia: Country assessment, 2017</i>

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.	
<ul style="list-style-type: none"> ○ Re life skills education/comprehensive sexuality education: There is no comprehensive and compulsory programme of age-appropriate life skills/sexuality education in Georgia. Existing courses focus on biological aspects of reproduction and do not address critical issues, i.e., harmful gender stereotyping and GBV. Inadequate counselling services, limited or inexistent life skills/sexuality education in and beyond schools, and little or no (or misleading) information. Also there are a lack of comprehensive teacher training on subject matter, lack of teaching methodologies and materials, both for students and teachers; and no mechanism to make such training mandatory. ○ Re violence against women: Despite recently adopted legislation on violence against women and gender equality, deficiencies still exist both in law and in practice. Violence against women is widespread in Georgia, with some cases registered under the rubric of “family conflict” resulting in under-reporting of cases. Definitions of rape are not in line with CEDAW requirements and Istanbul Convention. Criminal prosecution of rape happens only if physical injuries are noted. There is no civil law remedy for sexual harassment. Patriarchal attitudes are deeply entrenched, so even with increased awareness, crimes are less likely to be reported and investigated. Other issues include fear of retaliation and stigmatization, lack of trust in law enforcement agencies and lack of effective protection mechanisms for victims. ○ Re marginalized and disadvantaged groups: Persons belonging to vulnerable groups are exposed to discrimination due to inadequate laws or fault practices, both in and outside of health care settings. Stigma and criminalization leads to poor treatment in health facilities and pushes persons in marginalized groups to avoid care. 	
<ul style="list-style-type: none"> ● Under the Soviet Union, health care financing in Georgia was centralized system for universal health coverage (Semashko model), as was the case in all Soviet Republics. Following independence, the Georgian government was unable to maintain this system, and eventually transitioned to a market-based approach and the privatization of public facilities without effective regulatory mechanisms to ensure equity or quality of healthcare. 	<ul style="list-style-type: none"> ● Shengelia, L., et al, “Impact of healthcare reform on universal coverage in Georgia: A systematic Review, <i>Diversity and Equality in Health and Care</i>, 2016, 13(5):349-356
<ul style="list-style-type: none"> ● UNFPA organized the UN Care training (since 2002-2003), which increases awareness about workplace dignity and inclusion for UN staff. It includes topics related to HIV, human rights-based approaches and anti-discrimination. 	<ul style="list-style-type: none"> ● Interview with WHO
Assumption 3.2: Networks representing adolescents and youth, women and KPs have the capacity to meaningfully participate in, influence national dialogue, and prompt changes in national policies and programmes to reduce stigma and discrimination for their members, including people living with HIV. Further, they are able to assert their right to hold service providers accountable.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> ● Examples of changes in national policies, laws, strategies and programmes which explicitly recognize and respond to the needs of adolescents and youth, KPs, and women (for example, anti-discrimination laws protecting people living with HIV in place, decriminalization of HIV transmission, universal access to SRHR and HIV services etc.) ● Experience and views of network staff ● Experience and views of national health authorities ● Experience and views of policy makers in areas effecting stigma and discrimination including criminal justice, education and health among others. 	

<p>Assumption 3.2: Networks representing adolescents and youth, women and KPs have the capacity to meaningfully participate in, influence national dialogue, and prompt changes in national policies and programmes to reduce stigma and discrimination for their members, including people living with HIV. Further, they are able to assert their right to hold service providers accountable.</p>	
Observations	Sources of Evidence
<ul style="list-style-type: none"> UNFPA supported a Round Table and training among professional networks and civil society activists for the rights of women and girls to raise awareness on violence against women who live with HIV and AIDS, use drugs and practice sex work during the 16 days Against GBV Campaign in partnership with EWNA, ACESO and Women’s Fund in Georgia. The Georgia Youth Development Agency was founded in 2007 with support from UNFPA. It is part of the Y Peer Network, which includes 52 national networks focusing on peer education, modules, and manuals. The regional office for the network is in Sofia. It conducts peer education training with others (Kerthet, Sam UAct, Network on SRH and Rights)¹⁴. A major issue and challenge is how to push comprehensive sexuality education as part of formal education. Youth policy adopted in 2014. Ministry of Youth Affairs is the main donor of forums. All NGOs working in the field participate and discuss policy issues. After policy is developed, youth advocates are engaged to work on action plan. However, there is no monitoring and evaluation system to determine how the youth policy is being implemented. UNFPA is work on the youth policy documents and a lot of good advocacy is being done with the MoES, etc. The agency supports formal and non-formal education in SRHR in summer camps. This year, activities related summer camps were cancelled because of parental opposition to content regarding gender and youth sexuality. There are many stereotypes regarding sexuality education. The number of activities in peer education and learning are decreasing because of lack of funding and opposition. Twenty-five young people were trained to go to schools to delivery information and mentor others. Civic education centres (are supposed to) take the work forward from there. A lot of communication is through social media and closed Facebook groups. Personally written “questions and answers” are helpful for disseminating accurate and confidential information on where to get HIV tested or access contraceptives; however, those opposed to sexuality education can operate groups as well. There is a lack of youth-friendly services especially in rural areas. Girls from ethnic minorities are less likely to have access to phones and, thus, are cut off from receiving information. It is much more difficult to communicate with youth from Azeri and Armenian communities. Services for KPs, including YKPs are provided by sub-contractors of the Global Fund; they are not integrated within the PHC system. Therefore for youth are poor with respect to confidentiality, the types of services provided, etc. Re the future, it would be good to strengthen collaboration with UNFPA to continue the peer education sessions in focus (priority) regions and find ways to extend the education training. Also, there is a need to work with teachers on health issues and reduce resistance to the topic of sexuality. 	<ul style="list-style-type: none"> UNFPA Georgia, <i>2016 Annual Report</i>, finalized 13 January 2017 Interview with Youth NGO representatives
<p>Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), KPs, women and those with disabilities.</p>	
<p><u>Indicators:</u></p>	

¹⁴ The only information available regarding this groups is on Facebook (closed groups), mainly in Georgian language, therefore, the names and other aspects of these networks cannot be accessed.

<p>Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), KPs, women and those with disabilities.</p>	
<ul style="list-style-type: none"> • Evidence that training in linking and integrating HIV into SRHR has been accompanied by measures addressing incentives, equipment, supplies and infrastructure as needed • Extent to which training for health staff integrates avoidance of stigma and discrimination, gender sensitivity, attitudes towards KPs, YFS delivery, and SRHR and choices • Experience and views of national health authorities • Experience and views of health workers • Experience and views of adolescents and youth, KPs and women on HIV and SRHR services • Where survey data reports it, percentage of PLHIV who report experiences of HIV-related discrimination in health care settings • Views of staff of organisations and networks representing HIV and SRHR needs of adolescents and youth, KPs and women. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • Per the third Country Programme document, “service provision will be supported only in conflict-affected regions, including within the framework of the United Nations Joint Programme.” 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>Georgia Country Programme document 2016-2020</i>, p. 4
<ul style="list-style-type: none"> • See evidence re capacity building efforts in Assumptions 1.1 and 1.2. 	
<ul style="list-style-type: none"> • Implementing NGO partner, Tanadgoma, conducts a survey every two years of beneficiaries (in its four clinics and in outreach services) to determine needs and how they are being met. The main issue that has emerged from these surveys is the desire to receive all services (condoms, STI/HIV diagnosis, psychosocial support) at one site rather than piecemeal through referral. Focus group surveys consistently indicate that confidentiality issues are critical to access. 	<ul style="list-style-type: none"> • Interview with NGO partner staff
<ul style="list-style-type: none"> • Re training in MSMIT tool, it supports the capacity to communicate re HIV prevention and supports capacity development of community organizations as it emphasizes community development and strengthening and how to motivate action among MSM. • Re YKP tool: Why is another tool needed? The YKP tool is oriented to the needs and issues of YKP and it has been used to attract young people to events (in nightclubs, with Global Fund funding) to provide messages. After training, a platform was created to focus on communication, education, training and to transfer knowledge. • The tool has helped to deal with everyday experiences, i.e., planning activities, how to react to KPs, how to motivate, how to involve participants using methodologies, tactics, approaches provided in the training. There is very practical advice given in the tools, especially about the benefits of engagement. • These tools and the training from UNFPA are considered very important by the trainees. UNFPA is also working to change formal education system in order to reach larger numbers of groups beyond what an NGO can do. • One social worker who focuses on SWs noted that she was a newcomer to the RH field, unlike many of the others participating in the group discussion. She stated that the tools/training was extremely helpful to get situated with respect to RH issues. The tools help to work with a broader perspective, not just HIV. <i>“Even when working on a specific issue, it is helpful to start with a broader perspective (SRH) as it is easier as an entry point. Start broad, then get specific; also depends on who you are talking to. For example, start with</i> 	<ul style="list-style-type: none"> • Group discussion with NGO social workers

<p>Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), KPs, women and those with disabilities.</p>	
<p><i>family planning, then move to risk re HIV and take it from there. Even when a client comes in for HIV counselling, they are interested in family planning.”</i></p> <ul style="list-style-type: none"> • Many barriers are faced in doing this work with KPs: <ul style="list-style-type: none"> ○ Working with youth is difficult due to their lack of knowledge about issues related to gender identity, parental involvement, homophobic attitudes, etc. Easier to work in universities ○ Try to work with state social workers, but some are open while others are not. More work needs to be done to sensitize them. This could be an area for future work of UNFPA ○ Georgia is quite a conservative, patriarchal society, with many barriers from religious and traditional organizations and individuals. Social media is used to generate resistance effectively ○ Burnout is a big issue. It is hard to remain motivated when under attack. Shocked by the level of hostility to work with KPs. Recently social media was used to promote an attack at an event; police sided with neighbours. Need more done to combat stigma and discrimination, such as a big countrywide campaign. ○ Social workers are also overloaded (100 cases per social worker). Not enough time to attend trainings. 	
<ul style="list-style-type: none"> • UNFPA is doing very important work in peer education with MoE and with continuing education. They supported a TV anchor to provide info on HIV prevention in summer camps. 	<ul style="list-style-type: none"> • Interview with Government official, MoH
<p>Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Percentage of women aged 15-49 years who experience physical or sexual violence from a male intimate partner (12 months) • Reported trends (where available) in early marriage (as context) • Where survey data reports it (as in recent DHS), proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives • National strategies and programmes developed and implemented with goal of preventing/reducing GBV – with specific reference to preventing HIV • National HIV strategies/roadmaps/ work plans incorporate efforts to protect women and girls from GBV and from coercion with its impact on HIV • Presence of laws, policies and regulations that protect adolescents and youth, KPs, women and PLIHV against GBV • Staff of facilities report that post-GBV clinical care integrates HIV and SRHR • Views of national health and HIV authorities • Views and experience of networks and organisations engaged in protecting women and girls from GBV, including in relation to HIV prevention. 	
<p>Observations</p> <ul style="list-style-type: none"> • In support of UNFPA SP Outcome 3 (Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized) UNFPA Georgia has identified CPD Output no 3, strengthened capacity of public and civil society organizations, and national human rights institutions to advance gender equality, including prevention of gender-based 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> • UNFPA Georgia, Country Programme Theory of Change 2016-2020, 2015

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.

violence and harmful practices. The following are strategic interventions to be carried out according to the 2016-2020 theory of change:

- Generate evidence for use in policy/advocacy on GBV and analyse its effects on RH, well-being and socio-economic participation of women/girls
- Advance monitoring of reproductive rights through the strengthening of the PDO
- Strengthen the health system response to GBV against women, as part of national referral mechanism and through improved standards/protocols and education of health professionals
- Strengthen gender-transformative approaches by enhancing civil society capacity to engage men and boys in addressing violence against women and girls and harmful practices
- Policy dialogue and public advocacy for addressing gender-biased sex selection

- In support of UNFPA SP Outcome 4 (Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, SRH and RR, HIV and gender equality), UNFPA Georgia has identified CPD Output no 4, **strengthening body of evidence for formulation of rights-based policies through cutting edge analysis on population dynamics and its inter-linkages with sustainable development.**

- UNFPA is collaborating with UNDP and UN Women on a SIDA funded project to support policy, institutional and grass roots level interventions to promote gender equality. Within the Joint Programme, the agency roles include UNFPA on RH/Rights, UNDP on policy and law development and UN Woman on violence; however, all agencies work together across these issues.

- Policy level: Work with Executive Branch on strategies, laws and briefs
- Institutional level: Work with MoE, MoH and PDO
- Grassroots level: Work with media and promote youth participation

- UNFPA is collaborating with the MoLHSA on an **institutional response to violence against women whereby physicians will have to monitor, document and provide services to victims of sexual violence.** An input/output form was piloted in Gauhati and Tbilisi. Services include EC, abortion, Pap smears, and HIV tests, free-of-charge, paid by the State. Activities include:

- Development of SOPs on how to complete the input/output forms, along with a pilot conducted to ensure that training and supportive supervision was completed effectively. There was a huge resistance to filling out these forms among the trainees.
- SOPs include mandatory notification for major trauma (gun/knife wounds)
- NCDC digitized the forms. Providers had a difficult time filling out all the fields; requested training
- Medical education for physicians does not include counselling skills and there is no pre-service training. Therefore, the e-module platform for continuing education is the strategy being employed to support capacity development in this and other issues.

- UNFPA is working with the **PDO**, a national human rights organization within the Human Rights Monitoring Framework. PDO **monitors RH well-being** via country assessments to see how well Georgia is keeping international commitments. The country inquiry looks at how people experience the laws. The PDO submits an annual report to Parliament, followed by parliamentary resolutions and PDO follows up actions.

- Interview with UNFPA Georgia CO

<p>Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.</p>	
<ul style="list-style-type: none"> • The Parliament developed a Gender Equality Action Plan, which includes aspects of HIV. The Executive Branch oversees the Gender Equality Commission, which is responsible for drafting the monitoring, and evaluation plans while the Legislative Branch oversees the gender equality council, which is responsible for policy and law development • Work on awareness and attitudes is being undertaken by PDO and Tanadgoma • UNFPA is anticipating a second round of funding; a first draft is currently under review by SIDA. 	
<ul style="list-style-type: none"> • NCDC just finalized a study to work with UNFPA on sex selection, which has large variations based on ethnicity. This is a good example of how UNFPA collaborates on “new” topics where the country needs assistance to find ways to solve problems. 	<ul style="list-style-type: none"> • Interview with Government official, NCDC
<ul style="list-style-type: none"> • PDO is a national human rights institution with 170 staff and 9 regional offices. Its purpose is to oversee the observance of human rights and obligations, advise the Government on human rights issues, and analyse the nation’s laws, policies and practices as they relate to international human rights standards. • The PDO works with the UN on gender equality. Since 2015, it has participated in the Joint Programme with UNFPA, UNDP and UN Women. PDO first conducted desk research on state policies and practices related to SRHR and sex education. The State is active on human rights, but mainly related to domestic violence. However, under the project, the PDO works with social workers and vulnerable groups. KPs tend to have more awareness, but less access to services. Mostly, PDO is working with the the general population; the project is working with schools on the lack of information on SRH, contraception, transmission of STI/HIV. • There is no comprehensive information in schools; teachers are not ready and SRHR topics are not discussed. There are stereotypes that parents and schools are against NGOs. There is a need to find entry points to address sexuality education. Research on education has shown that teachers are uncomfortable talking about sexuality issues. Legal marriage is at age 18. Forced marriage is criminalized but not prosecuted. There are lots of stereotypes about ethnic minorities and norms regarding facilities. PDO is monitoring the number of childbirths and trying to get information out that early marriage is illegal. Even when that is understood, the number of engagements increases, and with this, girls drop out of school. There is a need for more awareness raising to get information about rights to ethnic minority regions and to provide the information locally in Azeri or Armenian language. • PDO has a monitoring team and can study individual cases where rights are abridged, for example, they can monitor SRHR in psychiatric institutions. • PDO does not have a mandate to go to court and argue cases on behalf of individuals or groups, but it can prepare briefs. • Regarding abortion, doctors are judgmental as there is socio-cultural stigma against abortion, yet they are incentivised by the fees-for-service. Contraception is expensive, especially for young people. Young girls and women lack the purse strings. Confidentiality is also a big issue. • There is a need to work with men on support for contraception and against domestic violence. PDO is monitoring and studying domestic abuse cases. The MICS and other official statistics show that there is very high incidence of violence, i.e., there were 7,000 restrictive orders in 2018. PDO works with men and boys on seminars and activities including campaigns related to stereotypes, gender roles, etc. 	<ul style="list-style-type: none"> • Interview with Public Defender’s Office

<p>Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.</p>	
<ul style="list-style-type: none"> • Main achievement so far has been to establish mechanisms for financial support to monitor human rights. The monitoring methodology is well established and this has helped to build capacity. UNFPA has been a strong partner, always ready to support, provide its expertise and collaborate. UNFPA hired the consultant who heled to develop the monitoring guidelines on the issue of human rights in SRH, and financed the monitoring methodology. • UN Women convinced PDO to work on gender. It was not a strong part of the PDO portfolio. From this work, PDO is proud of its reputation and the trust it has developed among the population and State agencies (although the latter are not always happy). In terms of needs, there has been good implementation on domestic and gender-based violence, but not yet on SRHR and LGBT rights. There are CSOs that work on LGBT. Policy work is just the tip of the iceberg. There are many ideas that need future attention and research, HIV prevention, transgender rights. We need and want expertise to conduct monitoring of sex selection (worse in Armenia). 	

<p>Area of Investigation Four: Extent of UNFPA efforts as a broker to facilitate the participation of a broad spectrum of actors and contribute to forging partnerships</p>	
<p>Evaluation Question 4: To what extent has UNFPA been effective at global, regional and country level in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including participation in programme design, planning and implementation?</p>	
<p>Evaluation Criteria</p>	<p><i>Effectiveness, sustainability, coordination</i></p>
<p>Rationale</p>	<p>In order for those at risk and vulnerable, notably adolescents and youth and KPs to have access to effective integrated HIV and SRHR services and to secure their rights to information and services free from stigma, discrimination and violence, it is important they participate meaningfully in regional, national and local dialogues and influence decision making on HIV prevention. Networks, coalitions and partnerships are effective mechanisms for engaging these groups in critically important debates on HIV policies and services.</p>
<p>Assumption 4.1: UNFPA has effectively supported platforms for south-south cooperation and joint lessons learning on strengthening bi-directional linkages and integrating HIV and SRHR (also applies to assumption 1.6).</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Type and number of platforms and mechanisms for south-south consultation and cooperation supported by UNFPA • Frequency of south-south meetings/workshops/interactions on linkages/integration • Reported utility of south-south cooperative efforts on linkages/ integration supported by UNFPA. 	

Assumption 4.1: UNFPA has effectively supported platforms for south-south cooperation and joint lessons learning on strengthening bi-directional linkages and integrating HIV and SRHR (also applies to assumption 1.6).	
Observations	Sources of Evidence
<ul style="list-style-type: none"> UNFPA Georgia is represented on the RAGSI for the ECOM Global Fund grant on behalf of UNFPA EECARO. An assessment was conducted of existing strategic information on HIV in MSM and trans-people in Armenia, Belarus, Georgia, Kyrgyzstan and Macedonia for an understanding of the epidemic context, vulnerability and exposure to risk among different populations and options to alleviate the burden of HIV and its impacts. UNFPA Georgia also represented UNFPA EECARO, while working on development of UN Common Position Paper on Ending Tuberculosis, HIV and Viral Hepatitis Through Intersectoral Collaboration. This position paper was developed within the framework of the United Nations SDGs Issue-based Coalition on Health and Well-being for All at All Ages in Europe and Central Asia. The paper was endorsed at the Regional UN System Meeting for Europe and Central Asia, in Geneva 9 May 2018 and officially launched at the UN General Assembly in New York, through a dedicated side event co-organized by the Slovak Republic, WHO and IOM regional offices 27 September 2018. The process was left by the WHO Regional Office. 	<ul style="list-style-type: none"> UNFPA Georgia, 2017 <i>Annual Report</i>, draft 16 October 2017
<ul style="list-style-type: none"> UNFPA Georgia has strong links with regional HIV networks. There is a strong team at EECARO that leads the process. 	<ul style="list-style-type: none"> Interview with UNFPA Georgia
<ul style="list-style-type: none"> UNFPA is well connected to regional networks like ECOM (on men’s engagement), a regional advisor group collecting information on young MSM. UNFPA works on supporting partners with capacity-building/training, information sharing, introducing new tools and guidelines from WHO and others, training with service providers. UNFPA shares resources and updates all organizations working in the field (10-12 different organizations). 	<ul style="list-style-type: none"> Interview with NGO partner staff
<ul style="list-style-type: none"> ECOM is a regional network of NGOs in EECA. Its vision as noted on its website is described below: <ul style="list-style-type: none"> <i>“MSM and trans* people have access to timely treatment and support options on sexual, reproductive and mental health where they can openly disclose treatment-relevant information on their sexual behaviour and gender identity.</i> <i>The level of stigma towards gay and other MSM and trans* people has been reduced, primarily among health care providers. HIV-service organizations serving MSM and trans* people acknowledge the value of human rights in HIV prevention; while LGBT organizations include sexual and reproductive health care into their agenda.</i> <i>State, non-governmental, international organizations and businesses have partnered up in creating health care services for MSM and trans* people. Representatives of HIV-service organizations, dealing with MSM and trans* people, as well as LGBT organizations are members of coordination and operational structures at international, national and local levels.</i> <i>Legislative framework and policy environment as a minimum have no barriers to effective operation of MSM/trans*-service and LGBT organizations:</i> <i>MSM and trans* people are defined as a separate target group under national HIV prevention programmes;</i> <i>Scope of services for MSM and trans* people is adopted through regulation and implemented in the majority of countries in EECA region;</i> 	<ul style="list-style-type: none"> ECOM website, accessed on 7/16/19 at: https://ecom.ngo/en/about-ecom/

<p>Assumption 4.1: UNFPA has effectively supported platforms for south-south cooperation and joint lessons learning on strengthening bi-directional linkages and integrating HIV and SRHR (also applies to assumption 1.6).</p>	
<ul style="list-style-type: none"> ○ HIV-related programmes and services for MSM and trans* people are well-funded including through state and local budgets; ○ Legislative barriers for official registration of community organizations are removed. ○ A comprehensive system has been put in place for monitoring and evaluation of HIV epidemic among MSM and trans* people, including quality assessment involving communities. ○ Anti-discrimination legislation has been adopted the countries of the EECA region, prohibiting sexual orientation and gender identity discrimination.” 	
<ul style="list-style-type: none"> ● UNFPA organized a study tour to Scotland, supported the development of a webpage to ensure that all studies are available online and updated all monitoring and indicators re adolescent birth. The web portal is mainstreamed with the action plan. UNFPA used a small amount of money to leverage something useful. 	<ul style="list-style-type: none"> ● Interview with Government officials, MoES
<p>Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> ● Inter-governmental statements of policies and strategies for HIV and SRHR reflect need for integration and protection of rights of adolescents and youth/women/ KPs ● HIV prevention re-positioned as high priority in global and regional intergovernmental HIV strategies and policies ● Views of national health authorities and national HIV commissions ● Views of members of global, national HIV prevention coalitions. 	
<p>Observations</p> <ul style="list-style-type: none"> ● The collaboration between UNICEF and UNFPA is very good. They have good experience in MCH. Collaboration started with the 2010 Plan, which the government approved but did not carry out, for political reasons. When government acceptance finally came, UNICEF no longer had the resources to support it. Government then invited in other stakeholders and UNFPA joined. Each organization was assigned regional areas to work in and the effort was well coordinated by Government (2015-2016) using the same implementing partners. During this time, UNFPA was tasked to support the RH strategy, which grew into the MCH strategy. UNFPA invited UNICEF to participate in this effort. The implementation plan for the MCH strategy is more of a wish list, due to limitation of resources in both agencies. ● In July, WHO will evaluate status of the plan of action. Promising signs exist that health is becoming more important to the Government, then perhaps for donors (EU). Currently EU is not financing health; health is packaged with its support for public administration. ● Deputy Ministry for PHC is writing the Health Sector Development Strategy now. This will inform donor strategies for overall development. ● Other examples of good collaboration between UNICEF and UNFPA included the conduct of the EMTCT assessment, report and indicators and the collaboration on the MICS (with UNFPA taking the lead for the RH module and analysis). 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> ● Interview with UNICEF CO staff

<p>Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.</p>	
<ul style="list-style-type: none"> • Reason for good collaboration: local, capable staff working together for decades, with both responsibility and authority coupled with scarcity of resources, which forces partners to work and fundraise together. • UNFPA does an excellent job coordinating the UBRAF process; UNICEF provides information on indicators related to its work and UNFPA enters data and coordinates responses to inquiries in a helpful and timely way. • There has been lots of joint work in the past on youth and adolescence, e.g.: <ul style="list-style-type: none"> ○ Support for youth camps where UNFPA supported HIV awareness and UNICEF supported drug abuse awareness. ○ Worked together on UN Joint Strategy on youth; UNFPA doing a good job on youth advocacy. Minister is becoming more interested and Prime Minister’s office will take the lead on this issue. 	
<ul style="list-style-type: none"> • The Prevention Task Force was a project-based coordination activity funded by USAID. It assembled all stakeholders for coordination (prior to CCM being established). The Prevention Task Force (PTF) elects members to the CCM on a rotational basis. PTF has value as a coordinating mechanism although there is no longer financial support. It is still functioning; two NGOs form the secretariat. It serves as a forum for exchange and technical input/advice. It is very active in December when members are working on funding proposals. • CCM is the major body of coordination for the HIV response and has 28 members representing government and non-government actors; the Minister of Health chairs. The Global Fund more likely, will phase out in 2025 and it is not clear what will happen to CCM then. 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO
<p>Assumption 4.3: The development of policies and programmes for HIV prevention is characterized by the participation of diverse actors as advocated by UNFPA—especially organisations representing and led by adolescents and youth, KPs and women. This may include private sector participation in a total market approach to distribution of condoms for HIV prevention.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Extent and frequency of national consultations on HIV prevention policy • Extent and frequency of participation by organisations representing and led by adolescents and youth, women and KPs in national forums and platforms for HIV prevention • Reported involvement of private sector actors in consultations on national HIV prevention strategies and programmes • Experience and views of national health authorities • Experience and views of staff of organisations representing adolescents and youth/women/KPs • Experience and views of organisations representing social marketing agencies and private sector firms engaged in distribution and sale of family planning products including condoms and lubricants. 	
<p>Observations</p> <ul style="list-style-type: none"> • Only one group, Women in Reality, is working on SRHR issues in women with disabilities. The 2016-2018 action plan has not been implemented. Their attendance at meetings (see below) has opened up a new world. 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> • Interview with Youth NGO representatives

<p>Assumption 4.3: The development of policies and programmes for HIV prevention is characterized by the participation of diverse actors as advocated by UNFPA—especially organisations representing and led by adolescents and youth, KPs and women. This may include private sector participation in a total market approach to distribution of condoms for HIV prevention.</p>	
<ul style="list-style-type: none"> • YKP collaboration has focused on invitations to events in SRHR. For example, such a meeting included the UNFPA and IPPF EECA Regional Consultation on HIV and SRHR among YKPs during the 31 Oct-3 Nov 2018 UNFPA EECA team meeting and consultation in Kiev, Ukraine. This focused on how to use the YKP platform of many organizations working with KPs. Many youth organizations do not have a focus on KPs. • There is a need to examine terminology regarding what is meant by “meaningful participation.” Youth need to participate in actual activities, not just in meetings as “tokens.” Questions need to be asked regarding how activities or attitudes have changed as a result of youth input. Face-to-face interactions with young people directly will help to raise opportunities for young people that are systemic and sustainable. (Note: this point was made generally regarding youth participation, and not directed at UNFPA. UNFPA is regarded as being very focused on ensuring that youth voices are heard). 	
<p>Assumption 4.4: National governments have been responsive to UNFPA advocacy for and support of meaningful participation of non-governmental actors in dialogue on HIV prevention policies and programmes including in programme development, implementation and accountability.</p>	
<p><u>Indicators:</u> As per assumption 4.3</p>	
<p>Observations</p> <ul style="list-style-type: none"> • HIV has been the responsibility of the NCDC since its establishment in 1996. In 2014, it began coordinating the Global Fund grants. NCDC has been involved in all developments as the State Department of Surveillance for HIV, TB and STIs. • Collaboration with UNFPA is institutional and goes beyond HIV. UNFPA channels financial resources and technical assistance where NCDC is lacking in experience. They are quick and responsive in evaluating and providing assistances for needs identified. • UNFPA supported the development of the National HIV Strategy by hiring local consultants to complement the international consultant provided by the Global Fund to ensure that the process was well balanced. They are currently working on surveillance guidance. The current guideline was developed in 2009 and is outdated. UNFPA was quick to support a collaborative process for the guidelines development; WHO will support the translation and review process. • Re UNFPA collaboration on SRH, the Global Fund supported a technical review panel to support recommended changes to improve implementing partner capacity in SRH. UNFPA has ready-to-use tools to support capacity building for the Harm Reduction Network and Tanadgoma. The National AIDS Centre offers treatment, which provide social and psychological support. UNFPA used to supply condoms, but no longer. • NCDC has a new project to support testing centres that offer VCT and SRH to YKPs in university settings. Although not yet collaborating with UNFPA on this project, the YKP tools will be translated to use in it. • UNFPA does a good job despite challenges. Though they have a small budget, it is very well leveraged. The funding is very important and flexibility is key. UNFPA is able to address country needs. UNFPA has the strongest technical capacity within UN family. It chairs the HIV thematic group, which coordinates within the UN family. All UN agencies have very small budgets, but use them effectively. For example, the development of EMTCT assessment and plan with UNICEF. Unfortunately, it is not being implemented as the Deputy 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> • Interview with government official, NCDC

Assumption 4.4: National governments have been responsive to UNFPA advocacy for and support of meaningful participation of non-governmental actors in dialogue on HIV prevention policies and programmes including in programme development, implementation and accountability.	
Minister left. However, the new Minister is interested. Now we are training OB/GYNs and will work on implementing updated guidelines.	
<ul style="list-style-type: none"> UNFPA collaboration has been healthy and solid. The MoES works comfortably with UNFPA, more than any other international organization. The only area to improve would be to have more funding to fulfil its mandate. They cannot tackle the situation if they have no money to work on youth direction. UNFPA agreed to support politic revision and this is greatly appreciated. The staff are all very capable and collaborative. 	<ul style="list-style-type: none"> Interview with Government officials, MoES

Area of Investigation Five: Extent UNFPA has optimized its comparative advantage within the UNAIDS division of labour and has contributed to the collective strength of the cosponsors	
Evaluation Question 5: To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS division of labour?	
Evaluation Criteria	<i>Coordination, Efficiency, Effectiveness</i>
Rationale	It is essential that UNFPA is able to accept and carry out functions at global, regional and national level which reflect its comparative advantages among the UNAIDS cosponsors
Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the JUNTA organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.	
Indicators:	
<ul style="list-style-type: none"> Variation in roles taken on by UNFPA (under the UNAIDS cosponsor division of labour at country level) matched with changes in context of the epidemic and UNFPA technical capacity and mandate Experience and views of UNFPA CO staff Experience and views of national health and HIV authorities Experience and views of members of the JUNTA at country level Experience and views of implementing partners. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> UNFPA Georgia was found to provide high added value based on comparative advantages related to its long-standing in-country presence, close contact and cooperation with various stakeholders and its in-depth knowledge of the political and cultural context and its people at national and local levels. The CO is also skilled in facilitating and supporting processes of political and inter-institutional dialogue, has strong convening power and is guardian of institutional memory in a continuously changing context. <i>“The added value of UNFPA as a development partner is high particularly where UNFPA has acted as a facilitator and its ability and commitment to place sensitive themes on the national agenda, such as the reduction of maternal mortality, gender equality, youth</i> 	<ul style="list-style-type: none"> Gotsadze, Tamar, <i>The United Nations Population Fund Second Country Programme for Georgia 2011-2015, Country Programme</i>

<p>Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the JUNTA organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.</p>	
<p><i>health and rights.” Moreover, the CO has demonstrated that it can make significant changes in strategy and practice, albeit slowly, has become an authority on Reproductive Health and population development, has growing competence in youth health and HIV and AIDS, and is an increasingly powerful advocate in these areas. In each of its three focus areas, UNFPA has made good use of its comparative strengths, thus bringing added value to the global external aid received by the country.”</i></p>	<p>Review Report, January 2015, p 83-84</p>
<ul style="list-style-type: none"> • Priority areas for UN support are advocacy, policy advice and capacity development. Under the Health Focus area, this includes SRH, FP, MCH, ASRH, HIV prevention, response to domestic and GBV as these critical interventions are still not adequately integrated in the PHC. In terms of the division of labour, UNFPA will continue advocating for a HIV prevention with special focus on KPs and youth; will support strengthening national systems to deliver integrated SRH services. WHO will continue to provide policy advice and technical assistance in development and implementation of HIV strategies and action plans with focus on KPs. • Future directions (as defined in 2015) for UNFPA as chair of the JUNTA to address the significant gaps in policies and regulatory mechanisms for quality assurance of health services include: <ul style="list-style-type: none"> ○ Continue to support to the NCDC and Public Health as the Principal Recipient of the Global Fund and CCM to work on priority needs for transition period ○ Establish a policy and advocacy advisory council, develop effective mechanisms (standards of service) for transitioning of HIV prevention activities to the state funding, develop operational policies, regulations and guidelines to address issues affecting access to HIV services. The policy and advocacy plan for sustainable HIV response will focus on development and promotion of specific mechanisms for increased involvement of PLWH and KAPs, as well as civil society organizations and networks in the development and delivery of essential HIV services including community-based outreach. 	<ul style="list-style-type: none"> • UN Joint Team on HIV and AIDS, Georgia, <i>UN Joint Programme Monitoring and Reporting, Country Report for Georgia</i>, 2015, p. 3
<ul style="list-style-type: none"> • As the Global Fund is transitioning its support in Georgia, UNFPA is well-positioned as a major partner of NCDC and the Global Fund regarding policy development on HIV prevention for KPs including YKPs, regulations and guidelines to address issues affecting access to HIV services, and ensuring that the programme tools (MSMIT, SWIT and IDUIT) are mainstreamed within transition and sustainability plans. 	<ul style="list-style-type: none"> • UNFPA Georgia, <i>2017 Annual Report</i>, draft 16 October 2017
<ul style="list-style-type: none"> • UNAIDS left Georgia in 2012. The local PTF was created in 2003 with support from USAID; however, USAID left in 2014 and there are no vestiges of PEPFAR. WHO provides technical assistance. UNFPA is leading the JUNTA, and is leveraging its work through advocacy and collaboration. 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO staff
<ul style="list-style-type: none"> • UNFPA convenes the thematic group on HIV and AIDS, which includes UN agencies, and the World Bank. UNFPA leads the development of joint action plans, reviews progress, shares information on new developments, brings info from UN perspective into the CCM and prepares reports on behalf of the JUNTA. 	<ul style="list-style-type: none"> • Interview with UNICEF CO staff
<ul style="list-style-type: none"> • UNFPA is very active on the UN Country team and partners well with Government. Activities are driven by the UNDAF for sustainable development (2016-2020). Joint work started with MAPS (Mainstreaming, Acceleration Priority Strengthening). There are five technical directions/sectional groups. WHO leads the health group with active participation from UNICEF and UNFPA. UNDP leads on process re who is doing what and communicates with Government. Focal points in health identify new issues and gaps. 	<ul style="list-style-type: none"> • Interview with WHO staff

<p>Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the JUNTA organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.</p>	
<ul style="list-style-type: none"> • UNFPA leads the UN team on HIV. WHO participates as a member with focal points. The UN team develops a joint work plan and shares technical information. UNFPA also participate in PAAC under the CCM (WHO is also a member). Other joint activities include working together on the surveillance document with the AIDS Centre and NCDC (WHO will translate and conduct technical review) and the EMTCT initiative to develop national strategy and indicators. During the last two years, a joint work plan was developed to produce joint outputs and deliverables and conduct joint fundraising. The key objective under the UNDAF is to improve access to quality services by vulnerable populations. Within that outcome, UNFPA and WHO had separate and joint outputs. UNFPA compiles the indicators for UNAIDS/UBRAF; WHO provides technical inputs for reports, etc. • Collaboration is determined by a document signed by 14 UN agencies at regional level with the main idea to work on the social determinants of health. • WHO has a road map to scale up the HIV response; it is intended to address gaps over two years, e.g., in testing. In July, a ministerial meeting was held in Amsterdam to discuss how to approach KPs. The country needs to do much more to address the first 90 goal. It has improved from 48-67%. More involvement of civil society and greater community involvement is needed. Also, criminalization must be addressed. There is a National Strategic Plan and budget for HIV; however, the Government has not approved the budget. It is under negotiation between the Global Fund and Government. • The partnership between UNFPA and other UN agencies is fruitful, serious and professional. UNFPA is flexible, for example, works with MoE on standards of RH, linked to HIV prevention for student populations. • As part of the effort within the UN Disaster Management Group to develop emergency plans (for earthquake and flooding), UNFPA introduced the MISP. 	
<p>Assumption 5.2: UNFPA supported activities and investments are strategically important to the HIV response, at global, regional and national level.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • National HIV strategies/roadmaps/action/plans/ programmes reflect advocacy and policy engagement by UNFPA (and cosponsors) • UNFPA supported activities concentrated in functional areas designated as high priority in national HIV strategies and programmes • UNFPA supported activities in HIV prevention and rights protection positioned to influence national policies and programmes going forward • Experience and views of national health and HIV authorities • Experience and views of members of the JUNTA at country level and bilateral agencies supporting the HIV response. 	
<p>Observations</p> <ul style="list-style-type: none"> • UBRAF funding is considered a “bridge” for UNFPA activities, i.e., while HIV is not the major mandate for UNFPA, however, UNAIDS does not have a presence in the region except in Ukraine. Given that there is an upward trend in HIV infections, there is still a window to stop it from becoming a generalized epidemic. For a “tiny amount of money” for HIV, UNFPA is doing a good job with very little through a targeted approach. STI issues are ignored in this region; could be an important part of UNFPA niche. • UNFPA Georgia works to leverage its small amount of resources by working with others. For example, under the gender portfolio, UNFPA CO works with UNDP and UNICEF in a silo-free manner. The work in this project is to strengthen SVC response to address 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> • Interview with UNFPA Georgia CO staff

Assumption 5.2: UNFPA supported activities and investments are strategically important to the HIV response, at global, regional and national level.	
violence; UNFPA has worked to include HIV and SRH linkages as part of the strategy. Unfortunately, there are no indicators for leverage to showcase how resources are being invested in order to make strategic returns.	
<ul style="list-style-type: none"> There is a need to have a balance between advocacy and capacity building. Advocacy will not solve all problems without concerted effort to follow-up with capacity to address the issues. UNFPA is in a position, when working with Government, to use the more principled approach to push change. 	<ul style="list-style-type: none"> Interview with Youth NGO representatives
Assumption 5.3: UNFPA maintains the technical capacity required to carry out effectively the tasks assigned to it at global, regional and national levels as part of the UNAIDS consortium.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> See Assumption 5.1 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> Per 3rd Country Programme document, “in line with the new business model, UNFPA CO will consist of a non-resident UNFPA country director, an assistance representative, two national programme analysts and several support staff. Given the new focus on upstream engagement, the CO will adjust the profile of its staff to be able to advance the UNFPA agenda through partnerships, negotiation, communications and other skills associated with advocacy and policy advice.” 	<ul style="list-style-type: none"> UNFPA Georgia, <i>Georgia Country Programme document 2016-2020</i>, p. 5
<ul style="list-style-type: none"> The second country programme review in 2015 indicated that UNFPA made good use of its human and financial resources to implement the country programme. It managed to mobilize more resources from the government and other donors than planned, demonstrated a high financial programme implementation rate, and built national ownership through planned execution through its partnerships with governmental and non-governmental partners. Stability of core staffing contributed to strong implementation of programme activities in Georgia. 	<ul style="list-style-type: none"> Gotsadze, Tamar, <i>The United Nations Population Fund Second Country Programme for Georgia 2011-2015, Country Programme Review Report</i>, January 2015, p 39-44

Area of Investigation Six: Extent of UNFPA efforts to support the coordination of actions and resources to strengthen national leadership in the HIV response	
Evaluation Question 6: To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV?	
Evaluation Criteria	<i>Coordination, Sustainability</i>
Rationale	UNFPA and its partners are engaged in a common effort to encourage national leadership to increase sustainable national investments in HIV prevention over time. This requires concerted and coordinated efforts advocacy and associated financial and technical support along with responsive national authorities capable of making and realizing associated commitments.

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> See assumption 5.1 above 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> Terms of reference for the JUNTA in Georgia reference the role of UNFPA as chair, as designated by the Resident Coordinator through a collegial process among UN Country team members. The JUNTA was “revitalized” in April 2014 with UNFPA as chair; since August 1, 2014 UNFPA became a member of the Country Coordinating Mechanism, representing the UN in the main platform for dialogue and participatory decision-making on HIV-related issues. Although the role is rotational, UNFPA has held the chairmanship since 2014. The role of the Chairperson/Chair Agency is to ensure that an annual work plan for the JUNTA is established, implemented and monitored. 	<ul style="list-style-type: none"> UN JT on HIV and AIDS, Georgia, <i>Terms of Reference</i>, undated
<ul style="list-style-type: none"> The 2016 JUNTA Report on Implementation was prepared by UNFPA and outlines the main activities in support of two key outcomes: <ul style="list-style-type: none"> Coordinated UN support to strengthen HIV prevention with particular focus on KAPs, including YKP. Outcome indicator: <ul style="list-style-type: none"> Recommendations of service standards for KPs elaborated for integration of quality service standards UN Joint Advocacy and Policy Dialogue to strengthen national response to HIV and AIDS. Outcome indicators: <ul style="list-style-type: none"> UNPSD 2016-2020 integrates HIV and AIDS Quarterly meetings of the JUNTA conducted Advocate for strengthened HIV prevention among KAP through CCM Policy and Advocacy Advisory Council. (UNFPA Programme Analyst/HIV as the representative of JUNTA Chair Agency to represent the UN in Policy and Advocacy Advisory Council). 	<ul style="list-style-type: none"> UN JT on HIV and AIDS, Georgia, <i>Annual Report on Implementation of the Joint Work Plan for 2016</i>, undated
<ul style="list-style-type: none"> The 2017 JUNTA Annual Report on Implementation was prepared by UNFPA and outlines the main activities in support of two main outcomes: <ul style="list-style-type: none"> Outcome 1: Coordinated UN support to strengthening HIV prevention with a particular focus on KPs Outcome indicator: <ul style="list-style-type: none"> Advocacy and technical assistance provided for implementation of National Standards on HIV prevention for KPs Outcome 2: UN Joint advocacy and policy dialogue to strengthen national response to HIV and AIDS, with particular focus on HIV prevention. Outcome indicators: <ul style="list-style-type: none"> UNPSD 2016-2020 integrates HIV and AIDS Quarterly meetings of the JUNTA conducted Advocate for strengthened HIV prevention among KPs through CCM and PAAC. 	<ul style="list-style-type: none"> UN JT on HIV and AIDS, Georgia, <i>Annual Report on Implementation of the Joint Work Plan for 2017</i>, undated
<ul style="list-style-type: none"> The 2016 JUNTA Annual Report notes how different agencies work either independently or together in support of the outcomes, e.g., <ul style="list-style-type: none"> UNFPA: Advocacy through CCM and PAAC, support for National Sustainability and Transition Planning, advocacy to prioritize development of national comprehensive HIV prevention packages/standards (including costing) for SWs, MSM, and YKPs; elaboration of relevant national standards through process engaging wide number of participants and aligning with international standards; supported translation of MSMIT and SWIT tools for adoption and institutionalization into PHC and community; participation in UNFPA EECAO and IPPF EN 2nd regional consultation on HIV and SRHR (Kiev, 2016); and support for World AIDS Day 	<ul style="list-style-type: none"> UN JT on HIV and AIDS, Georgia, <i>Annual Report on Implementation of the Joint Work Plan for 2016</i>, undated

<p>Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.</p>	
<ul style="list-style-type: none"> ○ UNHCR: Produced information brochure on State Universal Healthcare Programme in Georgia for refugees, asylum seekers and humanitarian status holders detailing protection concerns, such as management of TB or HIV infection and AIDS; integration of HIV into broader UNHCR projects such as SGBV project and mobile visits in rural areas in Gali, Ochamchira and Tkvarcheli districts in Abkhazia region. ○ WHO: Supported strengthened human resource capacity through participation of national specialists in WHO-organized regional trainings/workshops and technical consultations ○ IOM: Launched a two-year regional project, Enhancing Mechanisms for Prevention, Detection and Treatment of HIV and AIDS and Tuberculosis among Migrant and Mobile Populations in South Caucasus Countries to be implemented in close coordination with IOM Missions in Armenia and Azerbaijan. IOM will work with governmental institutions in charge of HIV and AIDS and TB surveillance to ensure capacity building of relevant national authorities and facilitate progress of cross-border referral mechanisms. ○ UNOPS: Conducted monitoring activities of the Global Fund grant and advisory services for the Global Fund. 	
<ul style="list-style-type: none"> • The 2017 UN JT Annual Report notes how different agencies work either independently or together in support of the outcomes, e.g., <ul style="list-style-type: none"> ○ UNFPA: provided strategic input directly to the development of the HIV prevention standards, which were included in the National Sustainability and Transition Plan, while serving as member of the PAAC (representing UN on behalf of HIV JT). This included cost calculations for HIV prevention services for KPs (MSM and SW KP). In addition, UNFPA embedded SWIT and MSMIT tools within standards for HIV prevention for KPs; developed first ever training module on HIV prevention and SRH service standards for KPs and supported pilot training for service providers (n=40); advocated (NCDC and the Global Fund) for HIV prevention services; supported community organizations in implementation of the Global Fund grant on rights to health for MSM, transgender people, including participation in RAGSI for the ECOM Global Fund grant on behalf of EECARO and strategic data collection; conducted two capacity development workshops for five community organizations to introduce the MSMIT; collaborated with EWNA and supported the development of the Strategic Plan and Action Plan to address needs of women living with HIV, including SWs, and GBV work with SWAN member organization; generated evidence from focus group discussions among YKPs on access and barriers to HIV/SRHR services; conducted six workshops on how to delivery HIV and SRHR programmes for YKPs for 82 participants from harm reduction service organizations, SRHR service provider organizations, LGBT community organizations, HIV-positive community organizations and activists, SW community organizations and activities, and youth NGO representatives. ○ WHO/UNFPA/UNICEF: UNFPA joined WHO in partnership with UNICEF to strengthen EMTCT country efforts and delivery the EMTCT guiding documents aligned with the National MNH Strategy 2017-2030. ○ WHO: supported WHO mission from headquarters and WHO/Euro to facilitate National Spectrum-STI modelling estimation of STI prevalence trends with NCDC/the Global Fund. ○ World Bank: finalized an epidemic and allocative efficiency analysis to establish an optimized mix of HIV investments and inform prioritization decision; supported epidemic and response analysis for PWID and IST as separate programmes; conducted Health Financing System Assessment, Transition protocol for HIV and AIDS and TB to facilitate the move away from external financing. 	<ul style="list-style-type: none"> • UN JT on HIV and AIDS, Georgia, <i>Annual Report on Implementation of the Joint Work Plan for 2017</i>, undated

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.	
<ul style="list-style-type: none"> ○ UNOPS: Conducted monitoring activities for implementation of the Global Fund HIV grant and related advisory services for the Global Fund. 	
Assumption 6.2: Platforms and structures for coordinating support to the HIV response do not duplicate the work of other structures for coordinating action in HIV and SRHR.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> • Frequency of meetings of platforms for coordinating the HIV response and related platforms for coordination of other SRHR interventions (including mother and child health and family planning) • Overlapping mandates (or not) of HIV and SRHR related coordinating platforms • Cross-membership in platforms for coordinating action in HIV and in SRHR • Reported overlap or duplication of effort among coordinating platforms as reported by participants. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • The CCM is the major body of coordination for the national response for HIV and AIDS (and TB). However, one of the weaknesses is that the CCM is not “well placed” within the government hierarchy and lacks legal power to assure effective coordination across different sectors. Plans are underway to improve CCM coordination (based on a 2016 EHG mission) and includes the development and approval of a costed HIV and AIDS National Strategy and Action Plan for 2019-2023 and recommendations for optimal positioning of CCM within the governmental hierarchy. 	<ul style="list-style-type: none"> • Curatio International Foundation, <i>Georgia Transition Plan</i>, 2016, p. 30-31
Assumption 6.3: External partners, including UNFPA, have worked in concert to promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> • Agreed strategies and approaches among UNAIDS cosponsors and multilateral and bilateral partners regarding promotion of national investment in HIV response • Trends over time in national investment in the HIV response both in absolute terms and in relation to external support • Changes in national budget procedures and criteria which institutionalize investments in HIV: i.e. commencing a specific, regular budget line for HIV budgets at national, regional, district level • Integration of HIV budgeting and resource allocation into efforts to put national health systems on a sustainable footing including development of national health insurance schemes/programmes • Efforts to encourage private insurers and/or private, for profit, firms to invest in national and local HIV response. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • The Global Fund has supported HIV and TB programmes in Georgia since 2004/2005. The Global Fund plans to phase out external funding for HIV and AIDS by 2022. A transition plan was developed to address two main objectives: <ul style="list-style-type: none"> ○ Create a conducive legal environment to ensure smooth implementation of HIV and TB national response and achieve greater engagement of civil society organizations through public funding ○ Enhance structural, institutional and HR capacity of the country to implement and manage HIV and AIDS and TB interventions without interruption or compromising the scale, scope and quality of national HIV and TB national responses. 	<ul style="list-style-type: none"> • Curatio International Foundation, <i>Georgia Transition Plan</i>, 2016, p. 4, 10, 15-16, 17 23 and 39.

<p>Assumption 6.3: External partners, including UNFPA, have worked in concert to promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country.</p>	
<ul style="list-style-type: none"> • The Government health budget has increased more than 2.5 times in the years 2012-2016. Introduction to universal health care in Georgia is proof of political commitment to health by the Government. By adopting the National Strategic Plans for TB and HIV and AIDS, the Government has also given these issues priority. The plan is considered contingent on political stability, which is a concern given the existence of two “breakaway” (Russian-occupied) regions, Abkhazia and South Ossetia. • Government ability to finance the full range of activities related to its commitment to population health and wellbeing might be undermined by slow economic growth over the last five years. With the introduction of the Universal Health Coverage programme, the state budget allocations have increased and the share of health spending in the general government budget has reached 8.8% in 2016. This is considered relatively low compared with other countries in the European region, given the high level of expenditures from private sources. • Over a three-year period, the share of public funding for HIV increased from 33% in 2013 (USD 4.9 million) to 55% in 2015 (USD 8.7 million). There is a dedicated line in the MTEF (Medium Term Expenditure Framework) that is aligned with the National HIV and AIDS Strategic Plans and the Government issued resolution #326 on July 11, 2016, legally endorsing the NSP for HIV and AIDS and confirming its commitment for sustainable funding for HIV control. • There is moderate risk in terms of sustainability of human resources for quality HIV and AIDS service delivery as there is no policy for production/training of non-medical staff or CSO personnel. Training activities have been fully covered by external sources for the last decade and not yet institutionalized within a formal education system. During the transition period, a comprehensive policy/plan for capacity building will be developed, and will define professional competencies, qualification frameworks for various specialists and accreditation/certification procedures. • The organizational capacity of the NCDC, the organization responsible for managing the HIV national response, is considered adequate for programme management, service delivery, M&E, procurement and supply management. 	
<ul style="list-style-type: none"> • Georgia was among the first few countries in EECA region to develop a Transition and Sustainability Plan in 2016, in order to ensure a smooth transition from The Global Fund towards fully national funding of HIV and TB by 2022. 	<p>Government of Georgia, <i>Georgia HIV and AIDS National Strategic Plan 2019-2022</i>, undated, p. 4</p>
<ul style="list-style-type: none"> • Seventy-five per cent of the AIDS response is State-funded, with 25% funded by the Global Fund (and small amounts from other donors). • In 2020, the government will start investing in harm reduction in drug users; by 2021, it will cover work with SWs and MSM. Funding will be changed to a performance-based model. The big challenge will be the mechanism designed and the capacity to report on performance-based results. The Government is looking for technical assistance in health care financing (but not from UNFPA). Right now, there is no mechanism in place. However, it will start on July 1st and has potential to disrupt and affect NGOs. Eventually they could benefit, but the state needs to sign the mechanisms, establish reimbursement contracts, provide advance payments, etc. Providers will get 70% up front for the budget presented and will report once/month. Reimbursement will be based on indicators for new and continuing clients. Validating the indicators will be a huge issue given the use of a “unique code identifier” to preserve confidentiality. 	<ul style="list-style-type: none"> • Interview with Government official, NCDC

Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.	
Indicators:	
<ul style="list-style-type: none"> • As in 6.3 plus: • Views of national budget authorities • Views of Staff of UNAIDS cosponsors • Views of UN CO staff • Views of bilateral agencies supporting HIV prevention. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • The government of Georgia has declared health a priority in 2013 with the announcement of the Universal Health Programme and approved in 2014 the State Concept of Health Care System of Georgia for Universal Health Care and Quality Control for the Protection of Patient’s Rights 2014-2022. HIV and AIDS is acknowledged as one of the priority communicable diseases along with Hepatitis C, Tuberculosis, and other vaccine-preventable diseases. • The 2019-2022 NSP is the fifth HIV and AIDS plan; the first one was developed in 2003. Main directions are aligned with the UNAIDS 90-90-90 Strategy, the UN Sustainable Development Goals and the WHO Europe Health Sector Action Plan for HIV and AIDS. • The Government is a signatory to many human rights instruments, including the CEDAW. The 2014 Association Agreement between Georgia and the EU also requires Georgia to bring national legislation into conformance with international standards. 	<ul style="list-style-type: none"> • Government of Georgia, <i>Georgia HIV and AIDS National Strategic Plan 2019-2022</i>, undated, p.4-6
<ul style="list-style-type: none"> • Georgia has reached “high performance levels” in achieving the second and the third UNAIDs 90s targets, as compared to other countries of the region. Georgia implemented “treat all” policy in 2015, and since then all HIV positive persons have been offered antiretroviral therapy (ART) regardless of immune status or disease stage (funded by the State and the Global Fund). The country is approaching fast-track targets for ART and viral suppression. Among diagnosed persons, ART coverage increased from 62% in 2015 to 81% in 2017; viral suppression rates among those on treatment increased from 84% in 2015 to 89% in 2017. • The Government has mainstreamed HIV and AIDS prevention and control interventions into several state programmes: the HIV and AIDS Prevention and Treatment Programme; the Safe Blood Programme and the PMTCT Programme. The main purpose of the State Programme on HIV and AIDS prevention is early detection of new HIV and AIDS cases to reduce the spread of HIV and AIDS and provide access to treatment for HIV and AIDS-positive patients. 	<ul style="list-style-type: none"> • UNFPA, <i>ICPD+25 Georgia Country Report</i>, 2018, p. 30
<ul style="list-style-type: none"> • The main implementation strategy for the Georgia CO is to work on the elaboration of strategy documents, working jointly with partners. The strategy documents have included standards, protocols and implementation tools. The Government has adopted and approved these standards. • This strategy is implemented given that the burden of implementation is shifting from the Global Fund to the Government • New partnership framework with government aims to nationalize the SDGs. Georgia was the first country in the region to develop such a framework. • The Transition Plan is integrated into the NSP for HIV and AIDS. This is based on the transition preparedness assessment supported by the Global Fund and undertaken by Curatio International Foundation, a Georgian NGO. • UNFPA Georgia provided 5 local consultants to support the development of the NSP, providing input on sections related to HIV prevention for MSM, prisoners, AIDS treatment, M&E, coordination between State and the Global Fund, and the Global Fund health system strengthening and transition issues. 	<ul style="list-style-type: none"> • Interview with UNFPA Georgia CO

Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.	
<ul style="list-style-type: none"> • Tanadgoma has a diverse portfolio, as most NGOs are largely dependent on the Global Fund. Tanadgoma’s major donor is the Global Fund (55% of its funding). Tanadgoma has also received funding from SIDA (received through RFSU) for five years, focused on SRHR. Two big projects with the EU just ended, one focused on former prisoners and probationers (including IDU’s) psycho-social rehabilitation and integration, the other GBV and discrimination among drug users and FSWs. Other projects include one funded by the French for HIV prevention strategies with MSM community and another TB project with NCDC (funded by the Global Fund) to raise awareness across the country. • It is widely recognized that donor funding is diminishing and there are many concerns regarding the lack of opportunities for programme support. Social contracting has possibilities for sustainability; however, as of present there is no social contracting in health (although there is social sector). This is a big issue for the Global Fund transition. 	<ul style="list-style-type: none"> • Interview with NGO partner staff
<ul style="list-style-type: none"> • Regarding the transition from Global Fund to State funding, the treatment programme is not a problem for the government. Plans are in place to support the drugs needed by 2022. However, advocacy is still required regarding the most important (read “strategic”) things to do in the area of prevention. Technical assistance in the “how” is more important than” the what” in prevention. There is a need for a more balanced approach, whereby prevention gets more attention and support. A successful example was the Hepatitis C problem related to poor infection control. The Ministry decreed regulations to put in place after a period of regulation and poor quality standards, which helped to solve the problem. • The UN is important – it stays behind when others leave. Advocacy is not only important, but technical assistance is critical, e.g., ANC guidelines. Most important is to change Georgian mentality. Education must be maintained. It is good to have the ANC and family planning courses, but other content needs to be added. 	<ul style="list-style-type: none"> • Interview with Government official, MoH
<ul style="list-style-type: none"> • Two-thirds of National Health Account funds are spent on curative services at hospital level. (Refer to WHO 2015 Health Use and Expenditure Survey and Client Satisfaction Survey (online). There is a good Hepatitis C elimination programme, which uses an integrated approach for HIV and TB. An integrated screening pilot was started at PHC level, which trained MDs. This was a good effort and produced less stigma for Hepatitis C. 	<ul style="list-style-type: none"> • Interview with WHO country staff

ANNEX C: KEY INFORMANTS INTERVIEWED

Name	Organization	Position
Badridze, Nia	National AIDS Centre	Physician-epidemiology, Epidemiological Division
Bakradze, Lela	UNFPA Georgia	Head of Country Office (AR)
Bandzeladze, Mariam	UNFPA Georgia	UNFPA Component Manager, UN Joint Programme, Enhancing Gender Equality in Georgia
Beradze, Bela	Ministry of Education, Culture, Science, Sport and Youth Affairs	Division of Youth Issues Research and Analysis
Bokhua, Zaza	Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs	First Deputy Minister of Health
Chikhladze, Sergi	NGO Tanadgoma	Programme Manager
Chitishvili, Nino	Georgian Youth Development and Education Association	Youth advocate
Gogia, Maka	Georgia Harm Reduction Network	Programme Director
Khajomia, Khatuna	NGO Tanadgoma	Project Coordinator
Mamulashvili, Nino	WHO Office in Georgia	
Mataradze, Gegi	UNFPA Georgia	Programme Analyst
Mosiashvili, Anuki	Georgian Youth Development and Education Association	Youth advocate
Pruidze, Nana	UNICEF Georgia	Health Education Officer
Shengelia, Lela	National Centre for Disease Control and Public Health of Georgia	Director, Division of Maternal and Child Health
Shengelia, Mamuka	Ministry of Education, Culture, Science, Sport and Youth Affairs	
Skhiladze, Ekaterine	Office of the Public Defender	Deputy Public Defender
Stvilia, Ketevan	National Centre for Disease Control and Public Health of Georgia	HIV Programme manager, TGF implementation unit
Ugulava, Tamar	UNICEF Georgia	Health Specialist
Zakareishvili, Natalia	UNFPA Georgia	Programme Analyst
Sabedashvili, Tamar	UN Women	Programme Specialist
Kozharov-Tsuleiskiri, Rati	NGO Tanadgoma	Outreach/social workers for MSM and SWs
Gabadadze, Beka		
Khvedelidze, Revaz		
Tevdorashvili, Tamar		
Patsatsia, Iryna	Georgia Harm Reduction Network	Service providers

Name	Organization	Position
Laskhki, Gela		
Kirvalidze, Tamar		
Djavakhishvili, Tsiuri		
Kokhroidze, Tsiala		

ANNEX D: MAIN ELEMENTS OF BIBLIOGRAPHY

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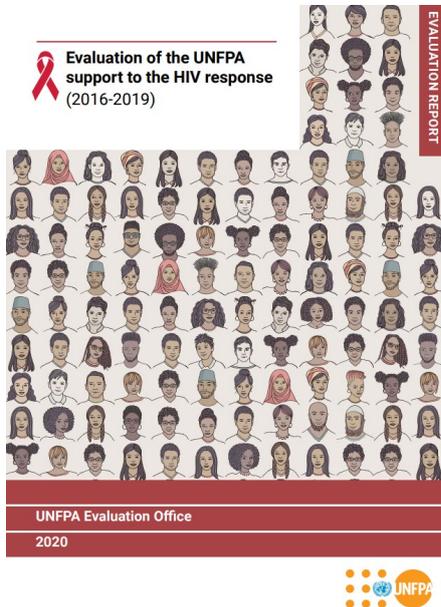
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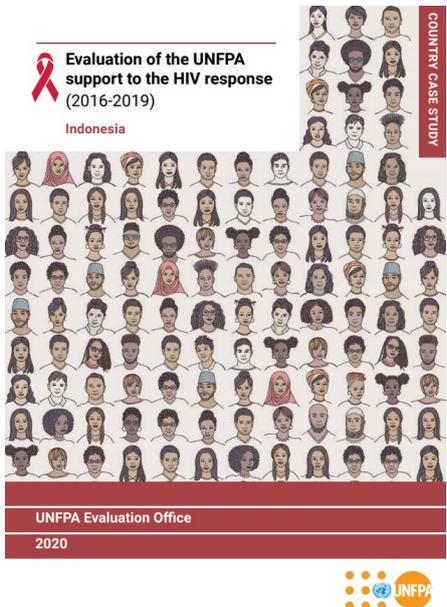
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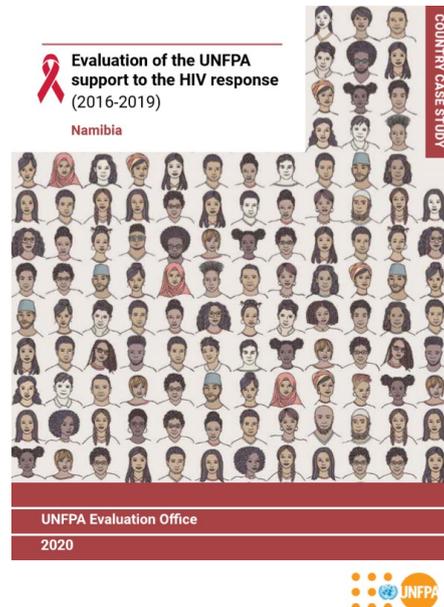
Evaluation report of the UNFPA support to the HIV response (2016-2019)



Evaluation brief of the UNFPA support to the HIV response (2016-2019)



Indonesia case study



Namibia case study



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