National response to HIV/AID in Georgia:

Increasing prevalence and weaknesses in national response

Performance Audit Report

State Audit Office of Georgia

Cc

Executive Summary

Within the 2008-2011 national response against HIV/AIDS, State Audit Office carried out an audit of government's activities which significantly covered government program on HIV/AIDS and its implementing entities, including centers for Infectious Diseases, Georgian AIDS and Clinical Immunology Research Center's (hereafter HIV/AIDS Center) activities.

Audit Background: Government of Georgia uses different instruments for the fight against diseases to improve the epidemiological situation. Despite the fact, that a long-term national strategy has been developed in accordance with the requirements of the international organizations, HIV/AIDS prevalence statistics is increasing every year. Half of those who were tested positive were diagnosed late – at AIDS stage. HIV/AIDS harms the general public health condition significantly.

Audit purpose: The main objective of the audit is to study the effectiveness and efficiency of government's measures undertaken in response to fighting against HIV/AIDS, to identify challenges of the national response to disease prevalence and to identify opportunities for improvement.

In order to meet audit objectives the following issues were studied: undertaking of sufficient and effective measures to test MARPs; measures for preventive intervention, efficient and economic spending of allocated budget for government program.

Methods: Audit was conducted according to ISSAI standards and is based on studying and assessment of existing legal framework, instruments, activities, documents and processes of entities involved in the national response.

Audit Results:

One of the main steps for combating the disease is to identify and estimate the size of MARPs. The number of people spreading HIV/AIDS is not determined in Georgia so far. Only the estimated quantity of MARP is known and the number of tested cities is limited to few cities. Since 2011, the ministry has significantly changed the structure of the National Response program. As a result of reallocating control functions by the government, the total number of MARPs detected and tested has significantly decreased across the nation. Consequently, the quantity of tested IDUs has been decreased significantly and testing of CSW da MSM has been terminated.

The National response entails different activities carried out by all public, private and civil sectors. However, there is no sufficient coordination and data exchange between them neither during the outreach of MARPs, nor during their testing or the consolidation of test results. The timely outreach and testing of the HIV/AIDS infected person remains to be a significant problem. There is no action plan for the intensive outreach. This problem is caused by the limited finances. However, it is possible to increase the outreach area and undertake intensive measures by allocating the resources more efficiently.

HIV/AIDS center does not have an important component that should exist in every public organization – internal control function. This creates high risks of decreasing revenues and the flow of unrecorded patients.

HIV/AIDS center spends as state budget funds, as well as their own income for the procurement of medical equipment and materials. The basic requirements of the law to rationally spend public funds in procurements are not fulfilled.

The government should ensure implementation of the Monitoring and Evaluation (M&E) system according to the UNAIDS guidelines within the country, better coordination among the entities involved in the National Response program and should prioritize the quantitative research of MARPs.

The Ministry and the NCDC should review the detecting measures of infected persons, components of medical service and find innovative ways for improving their efficiency. The Ministry of Health and NCDC should ensure the undertaking of such measures which will strengthen the institutional capacities of those responsible for detecting and testing the MARPs, which will result in improving searching ways of MARPs. The strategy for increasing the coverage of MARPs and improving the communication should be collaborated.

HIV/AIDS center should ensure setting up all components of internal control, in order to achieve the compliance of the activities with the law, efficient and effective actions and the prevention of wasting the resources.

Introduction

Reason for the Audit:

The current status and prevalence of HIV/AIDS infection in Georgia

The first case of HIV/AIDS in Georgia was registered in 1989. Since then, the prevalence of the disease has sharply risen. According to the data collected from the HIV/AIDS center, number of HIV/AIDS positive population was 3 450 persons by August 31, 2012. Out of these, in 2 259 cases AIDS has developed, leading to death of 757 patients.

The trend of increasing prevalence is significant in the audited period. Statistics shows that the prevalence is increasing and the problem remains relevant. This means that HIV/AIDS infection is gradually spreading throughout the country. According to the world statistics, Georgia still belongs to the number of countries with low HIV/AIDS prevalence, and is one of the leaders in the region (in Post-Soviet countries) with minimum level of infection rate.

Compared to other countries in the region, the rapid prevalence of the epidemic was not observed in Georgia. International experts and Georgian scientists believe that the reason for non-rapid prevalence of the infection is due to first practical and scientific steps that Georgia has taken. International experts and Georgian scientists believe that timely scientific researches against HIV/AIDS in Georgia and the establishment of modern evidence-based scientific organization was the reason for non-rapid prevalence.

HIV/AIDS center is recognized as the best HIV/AIDS treatment center in Eastern Europe. The Center has won International and Georgian National awards.

The Statistics of HIV/AIDS treatment and care can be evaluated positively compared to countries from other regions. For instance, the rate of the treated people among HIV/AIDS infected reaches 84% in Georgia, while in the US the same indicator amounts to 77%.[1]

However, compared to the Eastern European countries, picture in Georgia is different. The table below depicts the prevalence level and dynamics in Georgia and other countries of the region in 2008-2010 Prevalence is calculated using the standard method per 100 thousand persons.

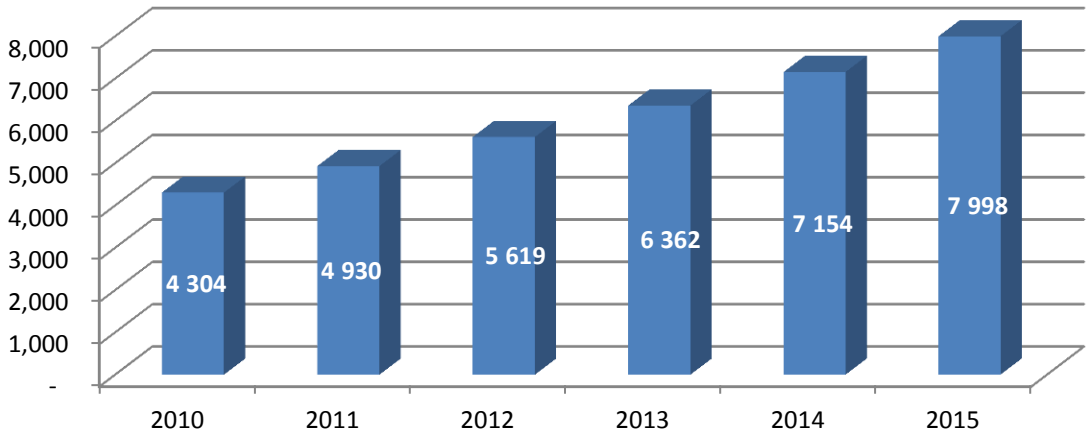
№	Country	Average for 3 years	2008	Increase/ decrease	2009	Increase/ decrease	2010	Infected including 2010
1	Czech Republic	1.5	1.4	7%	1.5	13%	1.7	1 522
2	Hungary	1.5	1.4	0%	1.4	29%	1.8	1 953
3	Serbia	1.8	1.6	13%	1.8	11%	2	2 593
4	Lithuania	4.3	2.8	93%	5.4	-15%	4.6	1 734
5	Azerbaijan	5.1	5	2%	5.1	0%	5.1	2 723
6	Georgia	9.1	8	10%	8.8	19%	10.5	2 691
7	Latvia	13.4	15.8	-23%	12.2	0%	12.2	4 888
8	Moldova	20.5	22.2	-11%	19.7	0%	19.7	6 356
9	Estonia	33	40.6	-24%	30.7	-9%	27.8	7 692
10	Ukraine	35.2	33.9	4%	35.3	3%	36.4	153 108

Source: http://ecdc.europa.eu/en/publications/Publications/111129_SUR_Annual_HIV_Report.pdf

As shown in the table, prevalence is increasing in Georgia. The rate of increase (10% in 2009 and 19% in 2010) is significantly higher than previous year's rates. The forecasting program "Spectrum" approved by UNAID, enables to identify the future

[1]Information Source: Georgian AIDS and Clinical Immunology Research Center

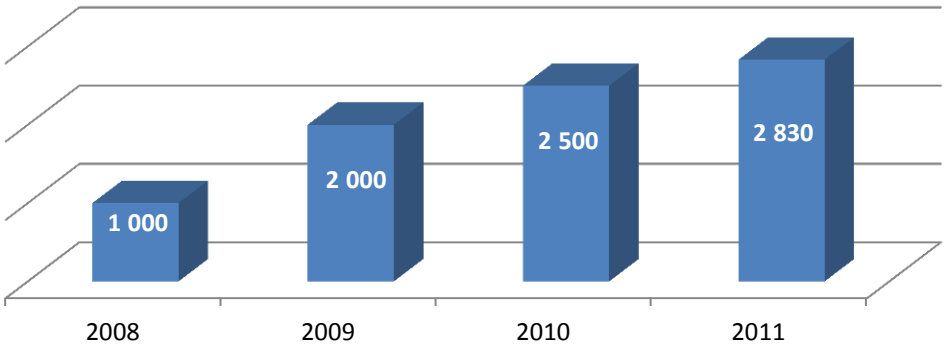
trend of infected people in Georgia and the annual rate dynamics[2]. According to the program forecast, by the 2015 total number of infected people in Georgia will reach 8 000. For the accurate forecasting this program takes into account the resources and intensity of combating HIV/AIDS in the country as well as actual number of people identified and tested with positive results. The chart below presents the results of the forecasting.



Number of people with latent HIV/AIDS infection needs to be taken into account. According to the HIV/AIDS Center experts' estimates and statistical data they amount to 1 500. The rate of timely identification of HIV/AIDS positive people is also very low in Georgia at 47%. In medical facilities the identification of the infected people is possible by observing clinical symptoms which means that the infection is already in the phase of AIDS.

Increase in the number of infected, apart from being significantly harmful to the public health in general, requires more funds from the state and citizens to combat it. For instance, state funding for the relevant programs increases proportionally to the increase of infected people.

[2] Joint United Nations Program on HIV/AIDS



Shortcomings occurring in the national response to the HIV/AIDS cause the developments described above. Accordingly, The State Audit Office examined the underlying reasons for these shortcomings and ways to react on them.

National response to HIV/AIDS in Georgia

National response to HIV/AIDS is a complex system that encompasses regulatory system of disease - legal framework, public, private and civil agencies and relations among them - organizational framework, government action and programs - public services etc.

Legal framework of the national response to the HIV/AIDS is based on the national legislation, namely, "Law of Georgia On public Health," "Laws of Georgia on Protection of Health and About HIV/AIDS". The last one has been passed in 2009 in an updated form that re-defined principles of policy for response to the HIV/AIDS, as well as issues of testing natural persons on HIV/AIDS, treatment of people infected with HIV/AIDS, care for them and issues related to the rights and responsibilities of the infected patients and medical staff.

Organizational framework of the national response to HIV/AIDS defines roles and relationships among Government of Georgia, Coordinating Council, Ministry of Health and other entities.

Government of Georgia within the limits of national response approves specific public health programs and ensures their implementation. Additionally, it creates unified State Coordinating Council for implementation of measures aimed at prevention and control of prevalence of the HIV/AIDS disease and creates a council for coordinating inter-agency activities.

State Coordinating Council within its competence is responsible to:

- Coordinate central, local, social and other organizations for ensuring uncomplicated cooperation of the organizations involved in the prevention and control of the disease;
- Monitor their activities;
- Look for the resources in Georgia with the aim of implementation measures designed to prevent and control the prevalence of HIV/AIDS;
- React promptly on the issues related to HIV/AIDS;
- Participate in preparation of legislation related to the HIV/AIDS, present appropriate recommendations and facilitate international cooperation, ensuring the deliberations of initiatives related to the response measures to HIV/AIDS on the government level, decision-making and implementation.

The Ministry of Labor, Health and Social Affairs (hereafter the Ministry) within the system of national response ensures the preparation of national strategy for prevention and control and organization of its implementation, prepares methodical recommendations for carrying out routine epidemiological surveillance of the HIV/AIDS etc.

National Centre for Disease Control (LEPL under the Ministry) carries out epidemiological surveillance and ensures functioning of medical-statistical system. Within the framework of public health programs for researching the target groups

carries out procurement of test-systems, reagents and other materials and transfers it to the providers of appropriate services.

Medical facilities including public and private hospitals nationwide and the HIV/AIDs Center ensure preventive intervention, awareness, diagnostic, ambulatory and stationary treatments for the HIV/AIDS infected population.

Non-governmental Organizations carry out researches about the prevalence of the disease, preventive intervention simultaneously with the medical facilities; provide test-systems and expensive medicines etc.

Georgia, as a member country of UN, is involved in Fight against HIV/AIDS with the aim of fulfillment of the obligations assumed in line with the global objectives set by the Millennium Challenge. Accordingly, national strategy is prepared with the aim of long-term and structural response to the epidemiological situation, which is based on the UN project (UNAIDS) for fight against HIV/AIDS and World Health organization (WHO) strategies.

The abovementioned international organizations prepared strategy for 2011-2015 to combat HIV/AIDS, which foresees achieving crucial progress for overcoming the disease by 2015. The strategy includes:

1. Achieving breakthrough in the HIV/AIDS prevention;
2. Speeding up of the next phase for disease treatment and aid;
3. In fight against the HIV/AIDS infection preserving human rights and gender equality.

In the prevention part, the global strategy has the following objectives to be achieved:

- Halving the cases of contracting HIV/AIDS by sexual contacts;
- Halving the vertical contraction (from mother to babies);

- Preventing all the new cases in IDUs.

In 2010 the ministry prepared national strategy for 2011-2016 to fight against AIDS, which facilitates achieving the global objectives taking into the consideration the present epidemiological conditions in the country and other circumstances, such as current capacity. National strategy foresees 5 main objectives:

1. Enhance coordination and advocacy efforts of the national response;
2. Improve quality and increase scale of preventive interventions;
3. Maintain universal access to ART and improve treatment outcomes;
4. Assure adequate care and support for PLWH;
5. Strengthening healthcare system capacity for effective response.

Overview of the Public health program – Combating HIV/AIDS

One of the most important instruments of the national response to HIV/AIDS is public health programs that imply funding various measures from the state budget.

Fight against HIV/AIDS is carried out via different public programs including programs directed at HIV/AIDS, program of health of mothers and children, programs of safe blood, tuberculosis, palliative treatment of incurable patients etc.

Out of the public health programs, the only complex one is HIV/AIDS program. Other programs are involved in combating HIV/AIDS as components. For example, testing pregnant women, blood donors etc. Consequently, detailed procedures aimed at achieving audit objectives addressed HIV/AIDS program, and information about other programs has only been processed on the basis of relevant legislation and interviews.

National program of HIV/AIDS, like other programs, during the audited period has been approved by the Minister of Health. Objective of the program is timely identification of new HIV/AIDS cases, preventing its expansion and ensuring

affordability of the treatment for the infected. The beneficiaries of the public program are citizens of Georgia and people serving sentence at the penitentiary.

The program consists of 3 components:

1. Voluntary testing and counseling on HIV/AIDS of persons belonging to the MARPs;
2. Provision of ambulatory service to people infected with HIV/AIDS;
3. Provision of stationary treatment to the infected, including different nosologies.[3]

The program is implemented by various medical facilities that hold license for appropriate medical activities. There have been 21 such facilities in 2008-2001 across the country.

The rates set by the program are determined by the order of the Minister. Tariffs are averaged in 2008-2011. Since 2011, the financing method has changed. The services are reimbursed according to the actual expenses, but not more than determined rate.

The price hike has been initiated on the basis of new price list offered by the center to the ministry, when the center was the only implementing body of the program.

Since 2011, component of counseling and research of HIV/AIDS is conducted by NCDC. By the tender carried out the same year, the component prices have been decreased after July 22.

[3] Donor organizations provide anti-virus medicines for patients on the stage of AIDS

Purpose of the Audit and audit questions

The purpose of the audit is to evaluate to what extent government activities support global and national goals that are set to be achieved by 2015 and whether the activities ensure the coordination between other involved organizations.

In order to achieve the audit purpose, the audit team had to answer the following audit questions:

1. To what extent are the measures taken to detect MARPs sufficient and effective?
2. To what extent are the measures taken to prevent HIV/AIDS sufficient and effective?
3. To what extent are the concepts of economy and efficiency considered when spending the program budget?

1.4 Assessment Criteria

The State Audit Office used several documents and information as assessment criteria:

1. International guidelines and manuals that were used to determine benchmarks and assess HIV/AIDS national response. This includes the guidelines and best

practices on HIV/AIDS, prevention and treatment from WHO (World Health Organization), UNAIDS, Global Fund and other organizations.

2. 2012-2015 Georgian Strategies, as well as strategies of above mentioned international organizations, that present existing challenges and future actions to achieve goals.
3. Legal framework of HIV/AIDS strategy, Georgian Law on HIV/AIDS, Regulatory Act that regulates the HIV/AIDS program, the orders of the Minister and government decrees that determine the system of national response, instruments, role of the participant agencies and authority, as well as rules and regulations of health program.
4. Internal control mechanisms that ensure efficient, reasonable, and legal spending and utilizing of organizational resources and assets.
5. Georgian Law on State Procurement that takes into account the principles of economy for spending state recources and finances.

Audit Scope and Methodology

The audit procedures were carried out to answer the main audit questions, within the scope of 2008-2011 National Response. Fight against HIV/AIDS consists of several main components:

- Disease prevention;
- Treatment and protection of infected population;
- To reinforce national response opportunities

Based on the shortcomings, audit scope has covered preventative measures of the disease. Audit has also covered several audit procedures to gather audit evidence including:

- Survey questionnaires, structured and unstructured interviews with the officials of appropriate organizations;
- Document and report analysis;
- Gathering qualitative and quantitative evidences;
- HIV/AIDS national statistics; trend analysis and comparison with target rate;
- Analysis of the legislative basis;
- Analysis of control system;
- Policy analysis of testing HIV/AIDS, etc.

Audit team communicated with the Ministry, NCDC, NGOs and other organizations involved in the process.

Audit team has studied the cooperation framework between the public, private and civil sectors. Their objectives and efficiency of information sharing methods have been evaluated.

Audit team studied strategy, testing frequency (how often are the patients that belong to MARPs or are HIV/AIDS negative), policy, international best practices and guidelines, and the database of the persons/population tested on HIV/AIDS in the Center.

Audit team has also studied the structure of the testing as it is considered in the HIV/AIDS program, service capacity and pricing, to evaluate to what extent it is possible to change its structure to maintain compliance with international standards and to present testing process in a more economical and efficient way.

Audit team audited the instruments that were used in the program to ensure MARPs engagement in the program and HIV/AIDS detection between the implementing agencies, before and after the re-allocating the functions.

Consequently, different audit procedures were carried out with above mentioned agencies. In order to answer audit questions, most of the audit procedures

were carried out in the Center, which is a public enterprise and had the leading role in in taking measures over the years as determined in frames of national response.

Taking into account the above mentioned, audit team carried out the audit procedures in the Center. It covered management, internal controls and operating environment, compliance with applicable laws.

Audit Limitation

System of national response to HIV/AIDS does not include the significant component such as the monitoring and evaluation (M&E). According to the subparagraph T of the article 5 of the Georgian Law on HIV/AIDS, the implementation of the above mentioned component is one of the main principles of the government policy in the HIV/AIDS field.

In addition, the monitoring and evaluation system is recognized by guidelines and standards of UNAID. It considers providing data that is necessary to monitor epidemic disease in the country and to improve national fight against the HIV/AIDS. Monitoring and evaluation system is necessary to:

- Plan, coordinate and implement national strategy;
- Evaluate the effectiveness of the programs that fight against HIV/AIDS and detect fields/areas that need improvements[4].

Implementing the 12 measurements and evaluation components of M&E system will result in forming the system in the country, which will enable to detect different trends, to conduct analysis, to plan, implement and evaluate the actions. Above-

[4] Components Monitoring &Evaluation System Assessment, UNAIDS, ttp://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/1_MERG_Assessment_12_Components_ME_System.pdf

mentioned components cover monitoring of organizational structure, human resources, partnership, planning of monitoring and evaluation, communication, etc.

If the M&E is introduced, audit team will study effectiveness of the system that could significantly reduce audit procedures. Since this system does not exist in the country, audit process was considerably limited. Therefore, audit team could not obtain sufficient evidence and data in order to assess the M&E as a whole.

2011-2016 National Strategy foresees the introduction of Monitoring and Evaluation and it is one of the main components of the strategy.

What the SAO Found

1. Size of MARPs

Nowadays many countries are trying to estimate approximate prevalence of HIV/AIDS and MARPs[5]. For instance, it is possible to define what percentage of IDUs are HIV/AIDS positive. In order to plan the national strategy and policy appropriately and utilize existing resources effectively, it is necessary to calculate at least approximate size of the MARPs. Therefore, in the first place, it is important to determine targeted population that is followed by assessing prevalence.

By estimating size of MARPs it is possible to observe to what extent they are involved in the program and determine/estimate amount/size and scope of service provided. On the other hand, the information is important to measure how to improve necessary resources, activities and scope.

As a result of the research conducted by European Center for Disease Prevention and Control, 15 European countries have a national HIV/AIDS Behavioral Surveillance

[5] UNAIDS/WHO Working Group on HIV/AIDS/STI Surveillance: Estimating the Size of Populations at Risk for HIV, 2003, p.2;

system. Information about the system is included in the national strategic or monitoring and evaluation plan[6]. According to the same study, coordination for estimating the size of the MARPs is carried out by the Ministry of Health or in some cases the agency itself participates in the study with other government and non-government organizations[7].

Effective HIV/AIDS prevention and treatment on national level refers to planning so that existing resources are utilized efficiently and effectively. For instance, if the HIV/AIDS prevalence of FSW is twice as much as IDUs, this means that this component is in a need for more resources, more specifically, FSWs need to be more involved and have better access to the program. Planning of any kind of activities without estimating the size of MARPs for HIV/AIDS would not be substantiated[8].

The national HIV/AIDS 2011-2016 strategy was developed based on UNAIDS and WHO 2011-2015 strategy. The goal of the strategy is to achieve decreased indicators:

- To maintain MARPs prevalence up to 5%;
- To reduce late detection from 46% to 25%.

The strategy considers reducing HIV/AIDS prevalence and incidents by defined rate before 2015. For example, to cut in half STI cases, low infection prevalence and incidents, etc.

For the purpose of defining the size of IDUs, with the support of UN Development Fund, in 2009 the study was conducted in 5 Georgian cities by

[6] European Center for Disease Prevention and Control Technical Report: Mapping of HIV/STI Behavioral Surveillance in Europe, 2009,p. 9;

[7] European Center for Disease Prevention and Control Technical Report: Mapping of HIV/STI Behavioral Surveillance in Europe, 2009,p. 9.

[8] UNAIDS/WHO Working Group on HIV/AIDS/STI Surveillance: Estimating the Size of Populations at Risk for HIV, 2003, p. 1, 7;

Implementing Center of South Caucasus anti-drug program and Public Union "Bemon", according to which the size of the IDUs in Georgia reached 40,000.[9]

Based on the study conducted in 2010 by NGO "Support", the size of MSMs varies from 7,900 to 19,900 (the study was carried out only in Tbilisi). [10]

The size estimation of FSWs and other MARPs has not been conducted.

Key players of National Response do not have information on the MARPs detection process which is caused d by various factors.

The above mentioned study seems not to be the priority approach for HIV/AIDS National Response Implementing organizations. The study of risk behavior population is foreseen in the action plan of 2011-2016 Strategy. However, it also states that the mentioned study will be conducted only in the case of enough funding.

The indicators given in the 2011-2016 HIV/AIDS National Strategy will be improperly defined without the estimated the size of the MARPs and will not meet the objectives of determining which part of the MARPs is covered in the program or how to raise awareness on HIV/AIDS infected population in MARPs. Therefore, the conduction of the study should be a significant component of the strategy.

Conclusion

It is impossible to satisfy quantitative indicators, which are given in the strategy, without estimating size of the target groups. The result of the study that estimates the size of the MARPs is necessary to determine appropriate HIV/AIDS National Response. The users of the research are different public agencies, which make decisions about

[9] Estimating the Prevalence of Injection Drug Use in Five Cities of Georgia, BEMONI PUBLIC UNION, 2009, p. 9;

[10] Size Estimation of Men who have Sex with Men in Tbilisi, Georgia, Association TANADGOMA, 2010, p 13-14

HIV/AIDS strategic approach. Mentioned research can influence the decision-making process.

2. Reallocation of Functions in National Response

Several public agencies are engaged in the process of fight against HIV/AIDS. The missions of these organizations are distinct which has a qualitative impact on the efficiency and effectiveness of the implemented activities and therefore on the prevention, as a whole. Hence, the audit team has studied the delegation of duties among public entities and applied instruments for disease prevention.

2.1 . The Structure of Epidemiological Surveillance

According to the directive #217/O issued by the Minister on 23th of July, 2010 several institutions throughout the country are responsible to detect HIV/AIDS cases and carry out reporting within the scope of routine epidemiological surveillance.

The entities that are responsible for the implementation of the program:

1. Institutions - that work on tuberculosis;
2. Medical institutions of penitentiary system;
3. Programs and hospitals that work on drug addiction issues;
4. Blood transfusion centers
5. Medical institutions that work on HIV/AIDS infection diagnostics and treatment;
6. Entities that work on voluntary counseling and tests;
7. Antenatal Clinics;
8. Childbirth Practices.

Potential target group for the HIV/AIDS routine reporting is the following:

1. Patients with Tuberculosis;

2. IDUs;

3. Blood donors;

4. People with HIV/AIDS symptoms;

5. People who are motivated to take tests or/and people who are detected by screening;

6. Pregnant women.

Information about the HIV/AIDS infected persons is sent to the NCDC, where the data is consolidated and the statistical measures on the national level are derived.

2.2 . Delegation of duties

Until 2011, on behalf of the HIV/AIDS public health program, the Center has been offering several services via the public procurements (tests and counseling, dispensary, stationary.) The Center has sub-contractors countrywide. Accordingly, the Center has been taking measures for detecting HIV/AIDS positive persons regardless their belongingness or link to the MARPs. The searches for detecting the HIV/AIDS positives were carried out either by the Center itself or by the sub-contractors. However, the population categories were not differentiated.

In the above mentioned conditions, there was no specific profile within the entities that communicated with the MARPs. They have been acting individually within the scope of their capacities. Specialization included only some categories of the MARPs; For instance, tuberculosis patients in tuberculosis clinics and prisoners in penitentiary medical facilities.

The government of Georgia has reallocated functions among entities since July 2011. The reallocation was determined by the following two criteria: MARPs and the specialization of respective medical facilities. The voluntary counseling and testing component was assigned to NCDC and the stationary and ambulatory treatment component was assigned to the LEPL Social Service Agency. The reallocation of functions was based on 2 criteria: the categories of MARPs and the specialization of the appropriate entities. The reallocation of functions had impact on the management structure of HIV/AIDS National Response. Particularly, a medical facility was acquired with the entitlement to offer medical service for respective MARPs. In conclusion, the services provided to the MARP and service providers were shaped in a following way:

Tests & Counseling	Service Provider
Counseling and Screening for prisoners	Medical Department of Ministry of Corrections and Legal Assistance of Georgia
Counseling and Screening for Tuberculosis-diagnosed patients	JSC National Center for Tuberculosis and Lung Diseases
Counseling and Screening for People having Sexually transmitted diseases	JSC Research Institute of Dermatology and venereal diseases
Counseling and Screening for IDUs	JSC Georgian Research Institute on Addiction
Confirmatory tests for Pregnant women, Tuberculosis-diagnosed patients, prisoners or people in penitentiary institutions, IDUs, people having STD, blood donors, people with risk for	LEPL NCDC
Confirmatory tests for commercial sex workers and homo-bi sexual persons	JSC AIDS Center
Counseling and screening of other MARPs (People having B or C Hepatitis, people with HIV/AIDS symptoms, people being in contact	JSC AIDS Center

To evaluate the impact of reallocation of functions on the disease prevention, audit has studied the statistics of MARPs testing (the number of people tested) and the

test results (number of detected positives). It needs to be taken into consideration that it has been only a year since the reallocation of functions took place.

The table below gives the statistics on HIV/AIDS infection testing and the rate of detection is derived:

Medical Standard	2008	2009	2010	2011	2012 (1-9)
Number of Screenings	7 922	13 306	18 550	19 435	12 952
Total number of HIV/AIDS infected	350	385	455	424	393
Detection Rate	4.42%	2.89%	2.45%	2.18%	3.03%

As one can see from the table, the number of tested MARPs has decreased since 2011. According to the results of 2011 19,435 MARPs were tested and in the first 9 months of 2012 – 12,952, which reflects the tendency of 11% annual decrease of tested MARPs. However, the involvement of MARPs is not the only important factor to take into account, but also the screening of the MARPs.

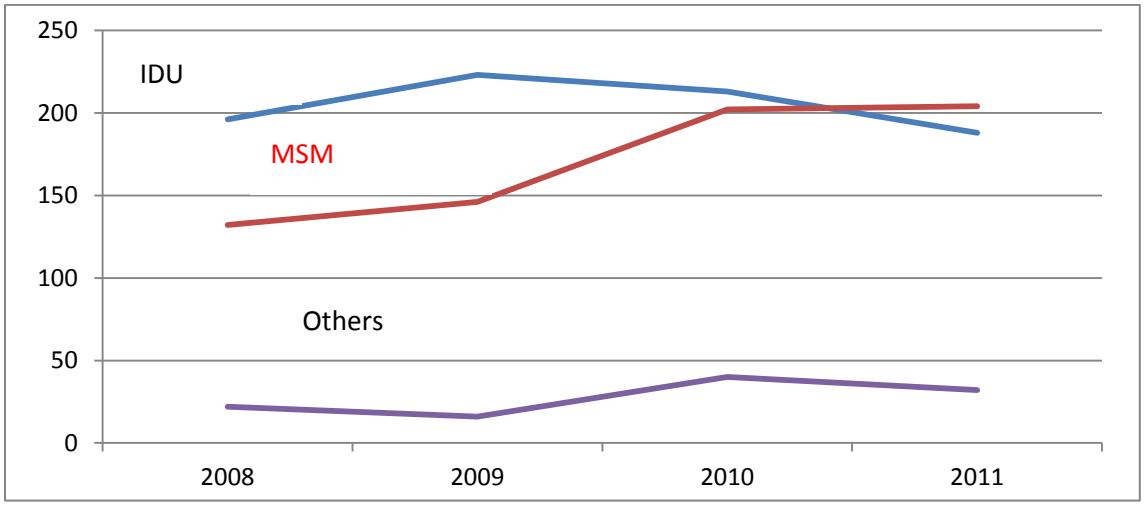
While the overall rate of detection is increasing, the detection rate for specific MARPs has been decreased significantly. For instance, based on tender, in 2011 Georgian Research Institute on Drug Addiction was assigned to screen at least 1000 IDUs. As far as only a small number of IDUs were tested, the detection rate was rather low. Out of 1 036 tested people, only 2 turned out to be HIV/AIDS positive. Since 2012, IDUs have not been tested and due to this fact the detection rate decreases dramatically which raises the risk of faster infection prevalence, while, IDUs has been the main source of the prevalence over several years.

Number of IDUs appeared to be HIV/AIDS positive since 1st of January 2010 until 30th of September 2012 for each year:

Year	Tested IDUs	HIV/AIDS Positive	Rate of Detection
2010	2 336	99	4.24%
2011 (1-6 months)	1 551	46	2.97%
2011 (7-12 months)	1 036	2	0.19%
2012 (1-9 months)	0	16[11]	n/a

After the reallocation of functions the detection rate and the HIV/AIDS positive people among IDUs has significantly decreased.

It is important to compare the prevalence groups in this regard. Recently, the detection rate (the number of newly detected people) shows that heterosexual transmission has become more common than transmission among IDUs. The figure below depicts prevalence rate for each individual MARPs.



The statistics does not necessarily imply that prevalence among IDUs has been reduced. The decreased number of HIV/AIDS positive IDUs might be related to several factors that could have influenced changes in the dominated MARPs. The detection rate

[11] The above mentioned group is not registered as risk group in the National Program

reduction in IDUs might be related to the decreased outreach efforts that were described above.

After the reallocation of functions state program doesn't involve MSM and CSW screening research. Accordingly, the rate of this type of MARPs research has sharply worsened.

In 2011, in frames HIV/AIDS national strategy 85 193 GEL was not utilized on the screening program out of which 58 263 GEL was saved by not procuring the test-system and 26 906 GEL was saved by not testing for the infection. In total, 8 642 persons were not tested by saving this amount of budget.

2.3 Outreach Method for MARPs

There are different approaches for MARPs outreach during the communication process (procedures that are used while communication, what information should be passed on to the MARPs representatives etc.) Community-based outreach strategy is considered in depth in the document of WHO[12]. Additionally, WHO has the manuals for the people who are involved in the outreach process, for instance, manuals for the outreach of IDUs[13] etc.

By the audit it was revealed that the so-called *peer educator* method is only a communication tool that is used for the communication with the MARPs in order to persuade them to take the test. According to this method, a trusted person (by the group member) having the same social status as him/her, persuades the MARPs to take the test.

[12] EVIDENCE FOR ACTION: EFFECTIVENESS OF COMMUNITY-BASED OUTREACH IN PREVENTING HIV/AIDS AMONG INJECTING DRUG USERS, 2004,http://www.who.int/hiv/pub/idu/idu/en/

[13] TRAINING GUIDE FOR HIV PREVENTION OUTREACH TOINJECTING DRUG USERS, 2004, http://www.who.int/hiv/pub/idu/hivpubidu/en/index.html.

This approach is one of the outreach methods for detecting the latent population in the large-scale strategy which is used all over the world and is recognized by the WHO. Peer Educator method is one of the forms of Community-Based Outreach strategy. This strategy is effective to access the part of the society which is hard to reach. It is worth mentioning that this strategy is not limited only by the peer educator method. It includes several components as acting person - neighbor, person with health education, special worker, hierarchal network etc. and the geographical area of the target population (street, district, social institutions).

During the engagement process, several factors have been identified which affect the outreach process negatively and hinder the prevention procedures.

Within the scope of National Response, less emphasis is made on the weaknesses of communication with MARPs, outreach strategy and approach. In order a MARP member to take a test, it is inevitable to reach this person. The contact can occur in many ways one of which is when the patient comes to the medical facility voluntarily or the medical service takes some measures to make the person take the test.

NCDC, the Center and other public agencies do not keep the record whether a person took the test voluntarily or they were outreached or they were found by peer educators. They do not have statistical data. There is no information about outreached and voluntarily tested people. There is no information about the number of people who were outreached and how many were voluntarily tested out of the total number of HIV/AIDS infected people. The Absence of the information proves that the planning in the direction of communication improvement is not a priority and there is no monitoring and evaluation of the processes.

The system does not function sustainably since there is no communication strategy or action plan in order information sharing and transmitting process to be equipped with needed instruments. In addition, information is not well documented.

Above mentioned conditions serve as one of the main causes for the decrease in HIV/AIDS detection rate.

Conclusion

After the government has reallocated the functions between specialized entities for outreach and inclusion of MARPs in the program, searching and screening procedures of IDUs has decreased significantly. Since, 2012 IDUs have not been tested, due to this fact, the detection rate decreases which raises the risk of faster infection prevalence. Moreover, IDUs has been the main source of the prevalence and the biggest MARP.

After the reallocation of functions state program doesn't involve screening research of MSM and Commercial Sex Workers.

This kind of changes can have negative influence on results of response against HIV/AIDS.

The Ministry of health and other agencies involved in national response do not use the relevant communication policies to reach MARPs designed by the international communities that reflect best practices.

After reallocation of functions it is important that all of specialized agencies have relevant technical skills and knowledge. The medical staff should be acquired with the proper professional knowledge, skills and experience in order to achieve the goals. Only in this case can the specialization improve the results.

3. Coordination of Preventing Measures

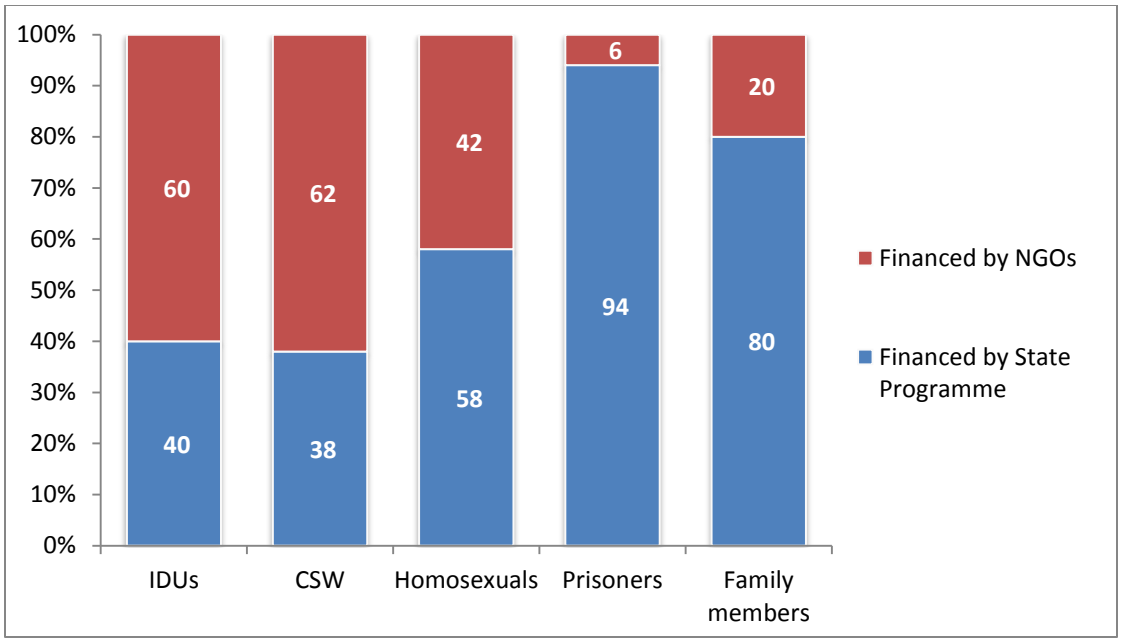
Taking into account its large scales, national response against HIV/AIDS includes not only the public sector but also representatives of other sectors such as civil society, nongovernmental organizations, international partners and donors. These organizations arrange meetings with target groups to raise awareness for the prevention of STDs and other diseases. Additionally, they have self-awareness centers for psychological rehabilitation. They also participate in implementing and developing of the strategic plan and monitoring and evaluation. They work on implementing the epidemiological surveillance system as well.

MARPs outreach, voluntary tests and counseling for HIV/AIDS take place in the frames of public health program by public agencies. Apart from the public health program, HIV/AIDS is detected by other medical facilities and NGOs.

Thus, different sectors are involved in MARPs outreach process: public, private and civil. However, MARPs involvement indicators (i.e. statistics for HIV/AIDS testing) are not satisfactory. Therefore, audit studied the coordination mechanism and forms in national response to HIV/AIDS. Audit assessed whether the information-sharing takes place on a minimum level which would help to improve the MARPs outreach and involvement increase.

3.1 Civil Sector

Non-governmental organizations with the financial support of international donors test various MARPs and mainly IDUs on HIV/AIDS, homosexuals and commercial sex workers. According to the 3 NGOs statistics, in 2008-2011 amount of tested on HIV/AIDS exceeds the amount of tests conducted within the public health program in a number of MARPs. The table below depicts the volume of funds received from NGOs and government for testing MARPs.



Data on those who were tested on HIV/AIDS for the first time by NGOs and medical facilities was unified countrywide with the unique identification codes in the NCDC epidemiological database. There is a special questionnaire, which is filled out while counseling people about HIV/AIDS. During the counseling, the specialist questions a MARP about the previous HIV/AIDS testing cases and the results.

After conducting the survey among NGOs and program implementing medical facilities, it was revealed that these organizations do not use the obtained statistical information to manage national database. In particular, MARPs get tested in any case, not taking into account the fact that some of them might already have been tested as being HIV/AIDS negative.

In order to optimize existing resources these organizations do not process the information on already tested people. The information is not used by other facilities.

They do not share the information. The main reason is the patient confidentiality as defined in the legislation.[14]

A countrywide system that will promote information-sharing does not exist, which according to the legislation will support data-sharing between those organizations that test people on HIV/AIDS.

Based on the orders #176/O and #177/O July 23[15], 2008 of the Minister, there are 15 digits unique codes approved, according to which the HIV/AIDS tested people can be identified. Currently, individual ID numbers are used to identify people tested on HIV/AIDS (only if the person is treated within the public health program) and Epidemic-Surveillance 15 digit code that is used by NGOs.

A unique identifier that distinguishes individuals enables to protect patient anonymity and confidentiality. In order to process data it is reasonable to assign unique code to all patients, despite the fact they are involved in the health program or not. After assigning a unique code, it will be possible to share information between the medical facilities and NGOs that test on HIV/AIDS so the appropriate organization can plan to reach estimated number of MARPs.

By sharing information on tested individuals, facilities will be able to outreach and detect those MARPs that have never been tested on HIV/AIDS. For instance, according to the research, there are 40,000 IDUs in the country. In 2008-2011 the number of the IDUs tested on HIV/AIDS reached only 18,194[16], which is a 45% of the estimated target population[17]. Thus, 55% of the population is still not tested. Within the public health program only 7,339 IDUs were tested. By identifying already tested individuals

[14] The Law on HIV/AIDS infection, Article 6, paragraph 1
[15] "Treatment and Care for HIV/AIDS infected persons", "Management of HIV/AIDS and Tuberculosis co-infection", guidelines for clinical practices and national standards for managing clinical condition
[16] The total number of tested people by the three NGOs, HIV/AIDS Center and NCDC
[17] The coefficient of the people who were double-tested has to be taken into account and it is not subtracted from the number 7 339

resources will be saved in terms of avoiding parallel/dual testing and it will enable more new MARPs to be covered by the response.

3.2 Private Sector

According to the HIV/AIDS National Response there is only voluntary counseling and testing available[18] to outreach the infected population that is known as a *Client Based Testing*. Besides, WHO, UNAIDS and international best practice uses other methods like provider initiated testing, when private facilities, when necessary, test individuals on HIV/AIDS. These are the cases when specific medical services include testing on HIV/AIDS or when patient's symptoms indicate about the infection[19]. The reason for this approach being effective is that patient that visits any medical facility tests on HIV/AIDS; therefore the detection rate will be higher.

The analogous testing method in Georgia is limited and concerns only those several categories of individuals that are foreseen by the public health program. For example, the proactive approach is only practiced on pregnant women and blood donors. Consequently, the testing is conducted on all pregnant women and blood donors.

In any other cases, detection of the infection depends on whether the symptoms of the patient suspects the possible infection and they are recommended to test on HIV/AIDS. This testing process is a free choice of an individual and is not financed by the government.

Based on the data of detected MARPs, average 47% of the detected individuals are on the stage of AIDS, which means that within the national response their detection

[18] Client-initiated testing.
[19] Provider-initiated testing.

and diagnosis process is much delayed. The detection of individuals of these categories takes place after more than 12 months period of time from being infected.

Audit team revealed that the existing coordination between private, civil and government sectors is not sufficient within the national response program. Epidemic Surveillance information reporting system in the NCDC does not anticipate research on recent/last medical evidence of detected infected individuals (Despite the timeliness of the detection) and their visits in medical facilities.

Additionally, there is no information whether private clinics have recommended citizens to be tested in appropriate facilities and whether those people have directed to such facilities.

Private treatment facilities that consist of the huge part of the health sector and are primary facilities can play an important role in the improvement process of national response. Yet not detected MARPs, as ordinary citizens, use medical services in these facilities. In the terms of adequate attention to suspect the individuals in the infection and recommend them to test, according to the international guidelines and norms, will improve the engagement of people in the public health program and increase the detection rate.

Conclusion

Coordination between the agencies of national response is not sufficient enough to timely detect and prevent further prevalence of HIV/AIDS. The coordination and communication needs to be improved. This can be done by defining of the coordination areas and set up mechanisms which refer to timely identification of the infected individuals.

4. Testing and Counseling Measures - Economy and Efficiency

4.1. Double Testing of MARPs

One of the main components of the national response to HIV/AIDS is to detect, test and treat MARPs. The goal of 2012-2015 WHO and also of the National Strategy is to reach 90% engagement of those infected in the public health program. Frequency of HIV/AIDS testing depends on the behavior of the MARP individuals. According to the guidelines of WHO and UNAIDS, if a patient has risk behavior, it is recommended to test them again in the 6-12 month period.[20]

According to the Center, following approaches of the frequency testing are used for MARPs:

- Individuals from MARPs who have constant risk behaviors, such as they use drugs by injection and often have unprotected sex, etc. are recommended to take the test on HIV/AIDS once or twice a year.
- Individuals of those MARPs who have, or are expected to have risk behavior cases such as unprotected sex with commercial sex workers or individuals who are infected with HIV/AIDS, or injection with unsterilized needle are recommended to take test on HIV/AIDS 8-10 weeks after the incident and repeat it in 6 months.
- Individuals of those MARPs who were HIV/AIDS negative on their first test, but they have high risk behaviors or they have clinical signs are recommended to take the test again in six months period, but if they do not have the clinical signs after 6 months, then the repeated test is not necessary.

[20] UNAIDS/WHOHIV/AIDS Program Strengthening health services to fight HIV/AID – Guidance on provider – initiated HIV testing and Counseling in health facilities, p.41.

Each year, thousands of MARPs are detected and tested, although their size significantly differs from the size of population that needs to be tested.

The study of tested individuals in 2009-2011 (until the 22nd of July, 2011)[21] showed that in this period from the tested 29,326 individual cases only 1,156 cases were repeated. So, there were 28,170 one-time testing cases.

According to the database of the Center, it becomes clear that in 2009-2011 the Center only conducts testing on unique cases (that have not repeated). For instance, the sum of the tested IDUs is 5,735 and number of repeated test 216 that is 3.8% of the population.

The survey conducted among the NGOS showed that the database provided by NGOs consists of the sum of the tested amount. Consequently, there is a chance that same representatives of MARPs might be tested more than once.

Repeated testing rate indicates that the repeated testing performed by the Center and NGOs don't correspond to the guidelines of WHO and UNAIDS.

This issue is especially significant considering the fact that the number of untested MARPs exceeds the total number of tested individuals. For the period of 2008-2011 only 18 194[22] (45%) IDUs have been tested out of respective risk group (approximately 40 000 IDUs).

Although, when adopting the guidelines of WHO and UNAIDS a country should consider those resources, that are accessible within the national response. When the rate of MARPs involvement in the public health program is so low, repeated testing of the same individual weakens the chance to completely cover untested MARPs, who have never been tested and their HIV/AIDS status is unknown. In these conditions while

[21] Since 22nd of July 2011, beneficiaries are registered according to their national numbers in the database, which makes it impossible to compare with the data before the 22nd of July where persons are registered by 15 digit numbers

[22] The total number of tested people by the three NGOs, HIV/AIDS Center and NCDC

complying with one specific guideline, the other not less important one (guideline to achieve high coverage) is infringed, according to which the nation should concentrate its efforts to maintain affordable testing service for MARPs and ensure higher outreach.

4.2. Post Test Counseling

Within the national response to HIV/AIDS, statistical indicator of MARPs engagement is so low that it negatively influences the epidemiological condition in the country. Each player that is involved in national response should look for opportunities to improve these indicators. In this sense, it is necessary to improve economy and efficiency of the existing condition in order to minimize the cost of resources and improve quality of the services.

HIV/AIDS voluntary counseling and testing (VCT) is offered to the visitors as a medical service in confidential environment, that consists of the following activities: pre-test counseling, HIV/AIDS testing, and post-test counseling.

According to the WHO and UNAIDS, post-test counseling is a significant part of the testing process. During the counseling, the physician explains to the patient cohabitation rules, risks of getting infected and existing treatment methods.

Post-test counseling is especially important in case of a positive HIV/AIDS cases. Voluntary Counseling and Testing (VCT) specialist informs the patient about the test result, updates on epidemiological regime, tries to determine existing contacts with other people in order to test them afterwards, offers to contact appropriate facilities for clinical/medical research and surveillance. The information is crucial to engage HIV/AIDS positive patients in the program.

In Post-test counseling when test result is HIV/AIDS negative, physician informs the tested individual on test results, risk factors of getting infected and preventive measures to consider in the future.[23]

Besides the guidelines of WHO and UNAIDS, there is a research of the European Center for Disease Prevention and Control, according to which post-test counseling has less influence on risk behaviors.[24]

Various countries implemented alternative methods for post-testing counseling, for example, transmitting information in a written form, audio and video counseling etc. By considering alternative methods, it can be possible to save more resources, and using simpler and innovative ways that will replace currently existing post-test counseling.

Instead of post-test counseling, that provides information to the patient and the people who have contact with them, HIV/AIDS negative test results can be delivered in a written form, without counseling with the physician. Written information can provide answers on the frequently asked questions.

By implementing innovative alternative methods for post-test counseling financial resources can be saved and used for encouraging the better engagement of MARPS in the program.

By July 22nd 2011, the post-test counseling cost was 6.00 GEL, which was reduced to 4.20 GEL. In 2011, within the scope of public health program, countrywide post-test counseling reached to 12 780 cases and it cost 66 826 GEL. Out of 12 780 cases 12 115 was HIV/AIDS negative and 665 confirmation tests have been conducted. The post-test counseling cost from the state budget totaled 63 258 GEL.

[23] HIV surveillance report and action plan of Georgia

[24] European Center for Disease Prevention and Control: HIV Testing: Increasing Uptake and Effectiveness in the European Union: Evidence Synthesis for Guidance on HIV Testing.

In 2011, by adopting the alternative methods for post-test counseling, 63 258 GEL could have been saved and testing of 5 596 additional people could have been possible with the screening method.

By the calculation method that the audit team described, one can see that it would have been possible to save 200 230 GEL in 2008-2011. This amount of money would have been sufficient to test additional 16 104 MARPs.

Year	Post Test Counseling	Amount Paid (GEL)	Unit Price (GEL)	Number of Confirmation tests	HIV/ AIDS Negative	Amount could be saved	Number of Tests that additionally could be financed
2008	5 580	27 900	5	595	4 985	24 925	2 266
2009	9 451	52 265	5	754	8 697	43 485	3 345
2010	12 249	73 494	6	822	11 427	68 562	4 897
2011	12 780	66 826	4.2-6.0	665	12 115	63 258	5 596
Total	**40 060**	**220 485**		**2 836**	**37 224**	**200 230**	**16 104**

Similarly, implementing the alternative methods for post-test counseling will help to meet the objectives set by the national strategy.

In 2012, the appropriation from budget aimed to the component of MARPs voluntary testing and counseling will allow testing additional 4 800 MARPs.

The measure will support to achieve the goal and spend budget in a rational way. The costs of counseling people in medical facilities will decrease.

In 2012-2015 the objective of the national strategy, based on the WHO approach is to achieve 90% of MARPs involvement in the program. The mobilization of resources is needed to achieve this goal. However, only mobilization of resources is not sufficient since the efficient utilization of resources is also significant. In case the goal is not achieved, it will be difficult to consider national strategy to fight the HIV/AIDS as successful.

Therefore, it is crucial to focus more on the increase of the MARPs involvement rate in the program. The funds which should become available after considering adapting method for counseling would be sufficient for covering more than 19,500 MARPs for the new strategy of 2012-2015.

As mentioned above, according to the guidelines of WHO and UNAIDS, post-test counseling is an important component of the testing process. Post-test counseling is implemented in Georgia within the HIV/AIDS public health program, thus complying with the international recommendations and requirements.

However, considering exceptionally low rate of MARPs involvement in the program, the instruments to fight HIV/AIDS do not correspond to international standards.

If it is possible to increase the involvement rate by restructuring the forms of testing and delivery, the ministry will have the opportunity to undertake the measures to comply with the two mentioned important international recommendations without compromising any of them.

It is important to stress the recommendation of WHO: "HIV/AIDS guidelines and policies are developed for a global audience. It is expected that regions and countries adapt the recommendations according to their respective HIV/AIDS and TB epidemics, the strengths and weaknesses of their health systems, the availability of financial, human and other essential resources. In adapting the guidelines, countries should exercise care to avoid undermining existing programs, to protect access for the most at-risk populations and to achieve the greatest impact for the greatest number of people and ensure sustainability. WHO has also developed an adaptation guide to assist the countries in adapting WHO HIV policies and guidelines to their own context".[25]

[25] http://www.who.int/hiv/pub/national_guidelines/en/index.html

Conclusion

In order to achieve the goals of national HIV/AIDS strategy, it is important to review the methods of fighting against HIV/AIDS and to improve economy and efficiency.

Innovative forms of post-testing communication will improve the achieving the goals of the program and rational budget spending. The costs connected to the visits of people needing the information will decrease. The better involvement of the MARPs will be possible with the saved funds.

5. Internal Control System of HIV/AIDS Center and Compliance with Legislation

Till 2011 the HIV/AIDS Center used to be the leading entity within the national response and after reallocation of functions (2011) it still tends to be the key institution to combat HIV/AIDS in the country. Consequently, deficiencies of internal control system in HIV/AIDS Center impact the effective management of the National Response. Taking into the consideration the above-mentioned, audit team has studied the internal control system of the HIV/AIDS center and evaluated the compliance of the activities with the law.

5.1. Accounting of Services Provided over the Predetermined Limit

The center delivers medical services through the public medical standards as well as so called internal standards (market prices).

The ministry, under national response program of HIV/AIDS sets a monthly financial limit for the center, based on which, in order to receive funding, the center reports on the provided service. Every month, on the basis of comparison, the ministry defines the amount of finances for the provided services (limit) and also the amount of finances that is not refundable (over-limit).

The HIV/AIDS center provides medical service that exceeds the pre-determined limit which is the loss of the organization. That amount should be accounted as a loss and filled into account, first as sales and then - as losses.

The center did not recognize sales over the limits for the total amount of

1 046 368 GEL in 2008-2009. From an accounting perspective the prime cost of all sales are counted as expenses. Since reducing income also reduces gain, less tax is paid. Thus, the financial statement for the above mentioned period contains a misstatement. In 2010-2011 years amounts that are over the limit, are recognized and adjusted according to requirements of tax legislation.

5.2. Not fully Accounted Receivables from Patients

A change was made in the public health program with the adoption of a co-financing system for patients. These change resulted in a group of patients refusing (or not being able to afford) to pay their share of treatment costs.

According to economic department's data, 389 patients violated the conditions of their agreements when they refused to co-finance the service cost; in 2009-2011 the unpaid amount totaled 58 188 GEL. The center did not require patients to get promissory notes. These debtor patients are not accounted.

5.3. Not Accounted Costs

Registration of the inventory supplies is the function of the center's pharmacy. The pharmacy is responsible for providing the accounting department with this information in order to prepare financial records, provide medical departments and laboratories with requested medicines, test systems and medical materials with respective prices. This allows the financial-economic department to count direct costs on patients.

Information on medicines and materials consumed for each patient by medical department is a source of information for the financial-economic department to calculate direct costs. A physician sets the prices for all the above-mentioned supplies according to documentation from the pharmacy. Then it's recorded manually in the financial-economic department program.

This program is not integrated with the supply registering module of the pharmacy and the price and the quantity for supplies are not set automatically. The financial-economic department does not control whether the prices are correctly written in the physician's receipt. There is no structural unit that controls a diagnosis document from qualitative and quantitative perspective.

Consequently, the above-mentioned system is not sound in terms of software and it lacks internal control mechanisms.

The audit team chose the dispensary and stationary patients' medical histories – beneficiaries of the public health program and tested them in order to get assurance on the accuracy of appendixes and value appreciation. To ensure accuracy the calculation records were compared to the diagnosis and actual examinations (laboratory journals).

Testing revealed that calculations are not done correctly and accurately. They sometimes contain several medical examinations with the requests for funds from the budget which were not appointed by the physician and did not actually take place. There are some occasions when a different high cost medical examinations are mentioned instead of the one prescribed by the physician, which also did not occure. Additionally, some of the researches done according to the calculations are not documented or do not correspond the answers of examinations.

5.4. Incompletely Accounted Inventory

The audit revealed that the center does not follow the policy of registering the inventory.

- Center **does not control medical waste,** spending material, reactive, reagents transferred from the pharmacy to medical departments and laboratories. **They do not regularly conduct an inventory.**
- The accounting department records the cost of medicines and materials as an expense not at the moment of actual consumption, but at the moment of transferring from the pharmacy to departments. Consequently, instead of registering received material as supplies in medical departments, **they dispose total amount of price** at the pharmacy. This makes impossible to monitor consumption of each medicine and material.
- According to the pharmacy, the requests from medical institutions should contain relevant purchasing prices. The audit checked the prices by random selection and revealed that they do not follow pricing and inventory recognizing

policy. They don't describe the change in prices of medicines and materials during the different periods of time. The current inventory recognizing method will cause a needless **rise in expenses** for both the state and patients when market prices on the medicines rise up. If prices go down, **the entity will have a loss.**

The audit team selected medical departments in order to make an inventory of supplies, in terms of non-existent control.

1. As a result of audit, lack of 2 400 X-ray papers was revealed at the X-Ray room. This shows that they provide service for unregistered patients. The usual price for X-ray service is 20 GEL, in some very rare cases, 40 GEL. Only the quantity of X-ray sessions without the price in the report of X-ray room is mentioned. Correspondingly, it is impossible to define the quantity of 40 GEL sessions.

See below the actual and reported data on consumed X-ray papers:

	2008	**2009**	**2010**	**2011**	**Total**
Consumed X ray papers for registered patients in total	1 369	2 030	2 119	2 506	**8 024**
Received X ray papers in supplies in total	1 700	2 500	2 700	3 600	**10 500**
The quantity of registered patients in total	***331***	***470***	***581***	***1 094***	**2 476**

2. The audit team calculated the total value of service that could be offered with the value of the X ray papers that were missing and the result showed that the service worth of 49 5000 GEL could be offered additionally in 2008-2011. Within the economic activites, center offers medical and laboratory services to the patients, who are not beneficiaries of the public health program with the prices that are set based on the internal standards. In order to offer the above mentioned services, center buys medicines; laboratory test systems and spending material using own resources.

During the audit process, two laboratories were selected out of nine – immunology lab and virology lab. In order to get assertions on existence of diagnostic tools and test-systems received from the pharmacy, the audit group made an inventory for four types of test-systems (CD3/CD4/CD8/CD45, CD3/CD16+56/CD19, HIV-PCR Saccade and AIDS Quantitative PCR Tagman). By means of these supplies one can test a person for HIV/AIDS (HIV-PCR) and examine the absolute number for lymphocytes, percentage of it as well. During the inventory process, lack of the following consumables was observed:

The flow of goods	Laboratory of Immunology /mc/lit/		Laboratory of Virology /test/	
Name of the Test	CD3/CD4/CD8/ CD45	CD3/CD16+56/ CD19	HIV-PCR Tagman	HIV-PCR sacase
Remains (01/01/2011)	4 245	4 095	58	0
Received from the Pharmacy	4 000	2 000	313	48
Spent on research	6 745	1 975	252	48
Unexpended Funds (according to registering papers)	1 500	4 120	119	0
Unexpended Funds During the Inventory (19/07/2012)	800	2 000	118	0
Subtract = lack	700	2 120	1	0

By means of the above mentioned diagnostic tools, taking into account research with internal standard, the center would get an additionally **21 404 GEL** in income.

The name of research	Lack	Price (GEL)	Money to receive
CD3/CD4/CD8/CD45	105	22.14	2325

CD3/CD16+56/CD19	848	22.14	18775
HIV-PCR Tagman	1	304.00	304
Total			**21404**

5.5. Optimization of the Stationary

The center provides services for patients with infectious diseases in the following departments:

- Intensive Care Unit (ICU)
- Neurological Infectious Diseases Department
- II Department (Gut Infectious Diseases)
- III Department (Hepatitis)
- IV Department (Hepatitis)
- V Department (Hepatitis)
- N1 divided department (mixed and very dangerous infectious diseases)

The audit team examined the capacity of inpatient department beds:

- Whether the beds are fully utilized and whether the expenses are efficient;
- Whether the number of beds is reasonably defined.

According to the data of statistics department, the audit team calculated actual occupancy rate (Actual patient/days vs. Available patient/days) of ***infectious*** diseases inpatient department:

#	Actual figure for beds at the	2008	2009	2010	2011	Average actual figure for departments
1	Intensive Care Unit (ICU)	**63%**	71%	62%	49%	**61%**

2	Neuro-Infectious Diseases Department	29%	32%	25%	30%	**29%**
3	II Department (Gut Infectious Diseases)	**36%**	26%	28%	23%	**28%**
4	III Department (Hepatitis)	**35%**	27%	24%	29%	**29%**
5	IV Department (Hepatitis)	55%	41%	41%	46%	**46%**
6	V Department (Hepatitis)	58%	52%	42%	47%	**50%**
7	N1 divided department(mixed and very dangerous infectious diseases)	55%	56%	61%	61%	**58%**
	Annual average in-patient service	***47%***	***44%***	***40%***	***41%***	

The audit group also analyzed the indicators of actual occupancy for HIV/AIDS inpatient service. The results were the following:

	2008	2009	2010	2011
Actual figure for the center	42%	59%	70%	60%
In patient service (Days)	15	12	13	12

The average real rate for the stationary of infectious diseases over these four years is 45%. Taking into account the reasonable reserve for a hospital day bed, the stationary is not fully occupied. The quantity of beds over the four years has remained constant. Management does not make decisions in order to optimize it, to save resources or/and use them according to other priorities.

On the other hand, formal and actual figures may not the same and the stationary might really serve to more patients. Thus, we may consider low percentage of actual figure as one of the indicators of unregistered patients.

5.6. Overhead Costs

The prices of treatment defined according to nosology include direct and indirect costs and a profit margin. For each nosology defined by outpatient service, the center has apportioned total sums of overhead cost. However, it is included in the price of the hospital day in case of inpatient service. Annual Data accordingly is represented in the table below:

Description	Before 7 Julie 2008	From 7 Julie 2008 to the end of the year	From 1 January 2009 to the present day
Total wages	15.52	40.14	46.87
Overheads	18.00	23.50	35.00
Profit 5%	1.68		
Profit 10%		6.36	8.19
Total	**35.20**	**70.00**	**90.06**

In order to identify apportionment overheads to component of HIV/AIDS outpatient clinic/hospital, the audit team has studied the revenues and expenses for the 2010-2011 in details. Both, the income from AIDS patients' services and the

expenditures such as utility costs (electricity, gas, water and disinfestation) were allocated by their proportion to the total area of the center, while the rest of the overheads - by their proportion to the volume of the gross income. After that, the identified costs were apportioned to the outpatient component according to the visit numbers of patients and to the hospital stationary component according to the spent hospital bed days. It was revealed, that according to the actual expenditures in 2010-2011 the center has incorrectly apportioned overheads to the outpatient/inpatient service tariffs, and consequently, the exceeded amount requested from the budget is 246 626 GEL in total, annual data is represented below:

Description	2010			2011			Incorrectly required amount from the state budget
	Qty	Incorrectly added amount to the overhead rate	Total Amount	Qty	Incorrectly added amount to the overhead rate	Total Amount	
Outpatient treatment	5,534	12	64,471	7,597	17	129,908	194,379
Per patient day in hospital				3,870	14	52,245	52,245
Total			**64,471**			**182,153**	**246,624**

Income part of the hospital in the total revenues of the center is 26%, in total

1 205 008 GEL. This data was used as an indicator for audit team could count the percentage of the operating costs for hospital. Expenses amounted to 367 878 GEL. In 2011, the center was able to save 217 050 GEL overhead costs by proper management and optimization of hospital.

5.7. Optimization of laboratories

Center has 9 active laboratories. The table below shows the data defined by the work completed, variety of examinations and revenues:

№	Title	Income 2011	Variety of researches	The number of unique researches
1.	Laboratory №1 of clinical diagnostics	47 481	6	**0**
2.	Laboratory of biochemistry	226 819	34	3
3.	Clinical biochemical Laboratory	92 446	24	3
4.	Laboratory of serology	142 173	8	1
5.	Laboratory of clinical virolgy	603 309	151	151
6.	Laboratory №2 of clinical diagnostics	418 439	40	40
7.	Bacteriological laboratory	215 619	40	40
8.	Laboratory of clinical immunology	411 432	55	55
9.	Laboratory of AIDS diagnostic	257 520	3	3

By studying the performance of the laboratories it was stated that in 2011 laboratories #1, #2 and #3 from the table above carried out 59,198 examinations and 55,308 (93%) of them are identical to the analysis conducted by #6 - the laboratory of clinical diagnostics.

The laboratory of serology carried out 11 576 laboratory examinations in 2011 and out of those 9 485 is identical to the analysis held by #5 laboratory of clinical virology.

The laboratories in the center conduct the same examinations and therefore the center uses its resources inefficiently and not in an economic way. Optimization of laboratories will possibly reduce the expenses. Particularly:

1. One laboratory can spend **less reagents or chemicals** on bigger amount of patients, as far as there is a blood serum placed in special equipment for each research from couple patients. Each new placed blood serum needs additional expenses of reagents/chemicals, because the equipment and the examination require a control in order the final result to be reliable:

2. **Saving overhead costs**

3. **Optimization of the salaries** in the laboratories.

In 2011, the center has inefficiently spent resources of 92 346 GEL in the component of overhead costs and salary expenses, which was calculated based on overhead costs for laboratories and laboratory staff salaries. Calculation method is presented in the table below:

№	Title	Occupied area	Salary expenses	Percentage of the labs in total costs	Total cost
1.	Laboratory №1 of clinical diagnostics	61.5	13 382.05	8 360.73	21 742.77
2.	Laboratory of biochemistry	72.35	25 027.02	10 218.67	35 245.68

3.	Clinical biochemical Laboratory	37.24	21 305.90	4 644.85	25 950.75
4.	Laboratory of serology	25.1	5 691.45	3 715.88	9 407.33
		196.19	**65 406.42**	**26 940.12**	**92 346.53**

The audit team was not able to define what amount of financial resources would be saved by optimization of reagents and chemicals expenses, because the laboratories do not fill out the forms with the history of patients and consequently do not have a database. The database would make it possible to conduct examinations with optimal intervals and quantity and to improve the service quality and deliver the answers of the examinations in a timely manner.

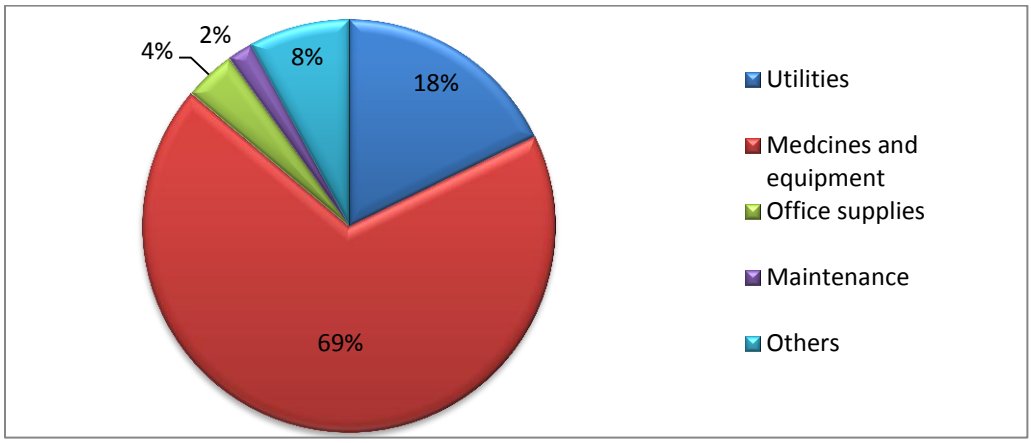
5.8. Implemented Procurements of the Center

The procurement of services and goods necessary for medical services delivered to beneficiaries has major impact on the principles of efficient and economic management of public health program.

In those cases when the national health program is managed by the public enterprise-treatment center, there is a high risk of procuring goods not in an economic way since the conflict of interests can take place.

In order to check the compliance with the law of the procurements, the audit team has examined procurements with the budgetary resources and funds owned by the HIV/AIDS Center, which aims to procure special medical materials. These materials are used in frames of the public health program for treatment and other medical procedures.

In 2008-2011 the center conducted 770 procurements, which totaled 10 333 348 GEL. Significant amount – 7 114 454 GEL was used for procurement of materials for medical activities that covers 69% of total purchases.



Acquisition of test-systems, which were used for detecting different types of viruses and infections are represented as specific procurements. Test-systems and supplementary materials have amounted 3 533 183 GEL. That has been 50% of procured materials of medical activities. According to the materiality by value, audit team has examined economy of the procurement of test-systems and supplementary materials.

35 companies participated in procurement of medical materials implemented by the center during 2008-2011. The basic suppliers of the center of above mentioned goods are:

1. L.T.D. "Irise";
2. L.T.D. "Mirco";
3. L.T.D. "Imuna".

The Center uses four types of diagnostic examinations with different methods to determine HIV/AIDS, hepatitis and other infections:

1. Rapid and quick testing
2. Immunoenzyme analysis
3. Blotting analysis
4. Polymerase Chain Reaction Method – PCR analysis

Mainly, test-system suppliers of the Center are the same companies.

The center purchased diagnostic test-systems for conducting rapid and immunoenzyme analysis from L.T.D "IRISE" in 2008-2011. The total cost paid for test-systems was 811 200 GEL that states 28% of center purchases.

The center, on the other hand, implements AIDS diagnostic examination using a method of immune-blotting in AIDS diagnostic laboratory. Also, the center provides Blotting analysis of Hepatitis C, for which test-systems are supplied by L.T.D "IMUNA".

Supplied test systems for Blotting Analysis counts 297 600 GEL that covers 10% of total test-systems. Average price for per-unit blot test is 62 GEL. Also, the center purchased single set of test-systems by United Electronic System of procurement for 62 GEL in 2011. Accordingly, the price does not change within years.

3. The audit team has examined tender for purchasing medical materials within the public health program on HIV implemented by other public agencies to make a comparison of prices of test-systems.

Testing within the AIDS/HIV program is implemented by NCDC since July 2011.

In 2011, the NCDC has announced tender for purchasing test-systems, including HIV/AIDS blotting test-system. Only one company – L.T.D "GPC" participated in tender.

Unit cost of test-systems purchased was 44 GEL, when the HIV/AIDS center has been purchasing test-systems at an average price of 62 GEL over the years. In particular,

the center announced electronic tender to purchase test-system of HIV immunoblotting from L.T.D "Imuna" in 2008-2010 and L.T.D "Prima-Medi" on August 2011 year.

It is important, that despite the high market competition, similar companies participated in tender announced for purchasing HIV immunoblotting test-systems.

On 5th of June 2012, The NCDC announced tender for purchasing pharmaceutical goods. Only one company participated in tender – the L.T.D GPC which supplied unit test – system of HIV immunoblotting to the NCDC for 61.45 GEL, with total value of 17 206 GEL.

According to Analysis of procurement of HIV/AIDS imunoblotting test–system, HIV/AIDS center was supplied by the unit test-systems at the same cost of 62 GEL over the years. Different price appeared only in 2011, when L.T.D GPC was replaced by L.T.D Imuna and Prima Medi that means 44 GEL was only disposable price Next year, as a result of implemented tender GPC returned the price to its initial cost.

Only associated companies took part in tenders arranged by the HIV/AIDS center. Therefore, they violate the principle of fair competition and set biased price for HIV/AIDS imunoblotting test–system.

It is worth mentioning that after NCDC has become a responsible body for the first component of HIV/AIDS program, 3rd generation of test-systems were purchased. However, several years have passed since 4th generation of test-systems replaced 3rd generation systems. The period of HIV/AIDS detection (the human body needs time interval since infection invasion till virus detection time) is lower in 4th generation test-systems than in 3rd generation test-systems.

In 2008-2010, the first research failed to explore **4** HIV/AIDS positive pregnant women, whose infants were infected by mother-to-child transmissions. In 2011-2012 the number of above mentioned cases has been increased and **9** HIV/AIDS positive pregnant were detected. As a result **5** infected infant were born. In 2008-2010 there was

no HIV/AIDS positive detection from the source of blood transfusion. In 2011-2012 7 HIV/AIDS positive blood donors were revealed and as a result 5 blood recipients were infected[26].

According to the modern guidelines and practice, the use of 4th generation of test-systems is recommended. It is important to purchase test-systems in lower price in order to make savings, however the quality if test-systems is more important. It is especially significant, considering the fact that the treatment of the people that were infected by the mistake requires enormous funds from the budget. It is also important to take social factors into account and risks of the inherent diseases.

4. The Global Fund purchased equipment for medical research named COBAS TAQMAN 48 from L.T.D Mirco in 2006 and gave it to the center for medical-clinical research using polymerization method of chain reaction. The lab equipment serves to the virology laboratory. Necessary test-systems are supplied to the center by L.T.D Mirco.

On May 25th 2012, the center announced tender for pharmaceutical product procurement. The center has noted in the technical specification that the necessary test-system must be compatible to the analyzer of COBAS TAQMAN 48.

The specific requirement resulted in participation of only one company in the tender process, namely the L.T.D Mirco which didn't change the tender value. Accordingly, signed a contract of 186 900 GEL.

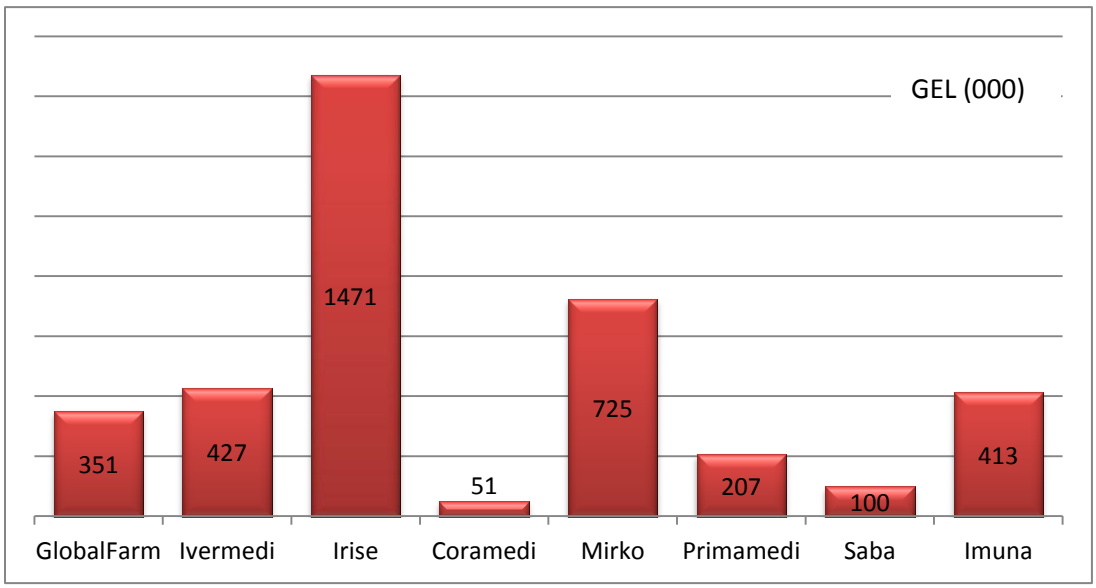
By analyzing the procurement process of the test-systems for the medical devices in the center it became known that according to the certificate of the procured device from L.T.D Mirco, the center noted in tender announcement that test-system must to be compatible with COBAS INTEGRA 400 plus. Analysis showed that above mentioned devices are not freely supplied on the market for obvious reasons and they are

[26] Information source: HIV/AIDS Center

compatible only with the specific test-systems. Accordingly, only L.T.D "Mirco" has participated in tender.

Therefore, it is recommended to consider future value and purchase conditions when selecting supplier and purchasing specific analyzer, in order to determine the full price of service (analyzer and relevant test-system prices).

5. Due to the fact that the same companies signed procurement contracts of test-systems, the audit team selected eight companies which totaled 54 % of all procurements implemented by the center. Audit team studied the companies as related parties of the Center. The figure below depicts the volume of funds transferred to these vendors.



Audit revealed that for one out of eight company shareholders – L.T.D Imuna is related to the center. Founders of L.T.D Imuna are directors of virology and clinical immunology lab departments.

Only two laboratories from other nine are subject of external quality control for receiving appropriate license for which the center purchases serum control from L.T.D Imuna with support of the Global fund. Procurement of the serum control in 2009-2011 counted 43 586 GEL.

6. In 2010, the Center procured analyzer GeneXpert IV-1 site desktop system valued at 61 400 GEL from L.T.D. Imuna. Purpose of the equipment is to identify TB bacteria in biological materials and determination of Rifampicin resistance. The Analyzer serves to the Clinical Virology Laboratory which is headed by one of the founder of L.T.D. Imuna.

Also, the National Center for Tuberculosis and Lung Diseases of Tbilisi has the same analyzing device in ownership. It is significant for the center to increase testing rates with high tech-equipment and improving quality of offered services for the patients.

In order to follow principle of efficiency and make the reasonable decision regarding the purchasing of expensive medical equipment and assets at the same time, one should conduct and prepare the sales budget and learn the output capacity of the equipment and ensure that relevant cost - benefit analysis is done. For the period of 2010-2012 the additional gross profit earned using the analyzing device is below 748 GEL, while the investment made to purchase the equipment is 6000% up and equals 61 400 GEL. It is essential to have operational plan of financing this kind of project that would define the projected revenue and guarantee targeted and reasonable procurement.

Audit identified that the main suppliers increased the cost of pharmaceutical products, by reselling the product to each other with set mark-ups and then ultimately selling it to the HIV/AIDS Center. This trade scheme made pharmaceutical products much expensive for the buyer.

For instance the L.T.D. Imuna has supplied different kinds of pharmaceutical products to the L.T.D. Irise paid 112 400 GEL for supplied goods. Later the L.T.D. Irise has supplied this product to the center for 121 173 GEL.

Audit team studied the cost of 41% of imported pharmaceutical goods by Imuna. The research showed that after importing in Georgia until supplying to the center the profit margins had been increased artificially by 57%. It means that Imuna has increased the price by 50%, and then Irise has increased the price by 7%.

In 2005-2011 L.T.D "Imuna" received **640 681.80** GEL from HIV/AIDS center.

The risk of detection of increased prices in the HIV/AIDS Center procurements has increased. In order to address these risks, the audit team has studied profit margins of the related companies.

Audit team studied that that in 2008-2011 according to the 10% data of supplied test-systems to the center by L.T.D. Mirco mark-up is 42%. According to the 54% of the procurement implemented by the center with L.T.D. Imuna mark-up is 26%. The audit team also examined L.T.D. Irise profit margins and the mark-up of the company is 37%.

Company Name	Average Mark-up
L.T.D "IMUNA"	26%
L.T.D "MIRCO"	42%
L.T.D "IRISE"	37%

It has to be mentioned, that from 2011 L.T.D "Imuna" is not center supplier any more.

Conclusion

The weaknesses the audit has revealed in the internal control of the center impair its capacity to carry out its tasks efficiently. As far as center is the key service provider in the country, sound internal control system would guarantee reasonably spending of public funds and compliance with applicable laws and regulations.

Conclusions and Recommendations

Audit Findings

What SAO found

1. The size of MARP is unknown.

MARPs are not fully identified. Estimated number of people by whom HIV/AIDS is unknown so far. Only few (although important) estimated MARPs are known such as IDUs and MSMs. The study about these groups was limited and was available only in few cities.

This means that the quality of information about the size of researched population in national response is low. The information is not complete and precise. Strategies of

international organizations and national strategy of Georgia anticipates the improvement of the epidemiological situation in response to certain percentage of population, however achieving this objective without qualitative and quantitative information is impossible.

2. Reallocation of responsibilities has been detrimental to effectiveness. In 2011, ministry has significantly changed the management of the National Response for number of its components. The functions of HIV/AIDS prevention and control were delegated among specialized entities. Above-mentioned functions belonged only to the HIV/AIDS Center before.

After the functions have been reallocated among specialized entities, searching and screening procedures of IDUs has been decreased. Since 2012 IDUs have not been tested, due to this fact the detection rate decreases which raises the risk of faster infection transmission. Moreover, IDUs has been the main source of the prevalence and the biggest MARP. Since 2012, State program doesn't involve screening research of MSM and Commercial Sex Workers.

These kinds of changes can have negative influence on response to HIV/AIDS.

Specialized entities that take measures for the program after the reallocation of functions should be equipped with the relevant professional knowledge, abilities and experience that is essential to achieve the aims of combating HIV/AIDS

Thus, after the reallocation of functions it is important that all of specialized agencies have relevant technical skills and knowledge. The medical staff should be acquired with the proper professional knowledge, skills and experience in order to complete their new functions. Only in this case can the specialization improve the results. The indicators for above mentioned risk are described in the audit report.

3. Insufficient coordination among entities of national response.

National response covers different instruments to fight against HIV/AIDS that are implemented by public, private and civil sectors. For the disease prevention it is crucial to detect and treat the infected citizens. These activities are carried out by all the three sectors according to their own responsibilities, capabilities, and goals. However, there is no data-exchange between them during the planning and implementation stages.

Consequently, insufficient coordination causes the inefficiency of the fight against HIV/AIDS.

4. Methods to outreach the HIV/AIDS positive individuals need to be improved.

The audit showed that a timely outreach of the HIV/AIDS positive people is a significant problem. Based on the obtained evidence, this is largely due to the limited financial resources. However, it is possible to expand the MARPS coverage employing existing resources. Namely, by providing services of testing for more citizens by abiding to the international guidelines, for reasonable and economical redistribution of screening components, which will slow down the annual growth trends of the disease prevalence and facilitate the early detection of the infected.

5. Insufficient internal control and weaknesses in the center.

The Center as a public enterprise has not established internal control unit which is an important component of management. This causes the high risk to lose the revenue and the flow of unregistered patients. Audit revealed facts that serve as evidence for such occurrences. Apart from the absence of control, the structure of the Center and the services are not optimally organized. As a result, operating expenses increase significantly.

6. Weaknesses in economic spending of financial resources.

Funds received from the national budget and revenue is used for procurement of required medical materials and medicines. The basic requirements of legislation to rationally spend public funds in procurements are not met. Absence of determination to preserve integrity and conflict of interest exist between shareholders of main suppliers and the management of the HIV/AIDS Center.

Recommendations

Based on the audit results, the State Audit Office has worked out the following recommendations:

1. **The CCM** according to the guidelines developed by UNAIDS to ensure gradual establishment and implementation of Monitoring and Evaluation system. **The CCM** to encourage and **The Ministry** should ensure improving the coordination between national response entities. The specific directions of activities should be determined in order to improve the prevention and control of HIV/AIDS prevalence with the joint efforts of the public, private and civil sectors according to their goals and responsibilities.

2. In order to determine the estimated number of MARPs, **the Ministry** should give priority to quantitative and qualitative research of MARPs. The Ministry should plan and ensure the implementation of the research with national response entities. Also, this kind of research is to be planned in a long term perspective.

The Ministry and the NCDC should timely respond with appropriate measures to structural changes of dominant ways in the prevalence of infection (IDUs by the unprotected sex contact) in order to intensify the response on the reduced segment and on the other hand, to direct additional resources to risk behavior of the MARPs segment which is the largest one according to the statistics. The results of the research have special importance to implement National response to HIV/AIDS.

3. **The Ministry and NCDC** together with the agencies which carry out Testing and other detecting activities throughout the country should develop the strategy and action plan that will facilitate an expansion of the MARPs involvement that will insure active detecting measures for those, who have never been tested on HIV/AIDS throughout the country. The cost for the unit detection of the MARPs should be calculated. In order to finance intensive detection measures it is possible to use the finances that are unutilized over the years but were assigned in frames of the program from the budget.

   The Ministry with other agencies should develop strategy plan and resume the testing of IDUs, Commercial Sex Workers and MSM.

   It is recommended to establish unified system that will promote cooperation between Medical Institutions and NGOs that are carrying out detecting work of MARPs. It is recommended to establish united standards that will promote work cooperation in order to increase undetermined population of MARPs. Accordingly, the focus will be directed on undetermined population. The HIV/AIDS infected people should be registered in the database according to the unique identification numbers.

   The united system will promote increasing efficiency and determining the weak link of the system.

4. **The Ministry and the NCDC** should review the detecting measures - the medical service components and find innovative ways to improve their efficiency.

   Implementing of post-test counseling component of the program will promote achieving goals that are set for the National Strategy of HIV/AIDS. In 2012 budget allocation of state HIV/AIDS program component that covers voluntary counseling and testing will enable 4 800 MARPs to be screened.

   Implementing the recommendation will promote achieving program purposes and rational spending of public resources. The expenses of informing people who visit hospitals for post-test counseling will be decreased. Therefore financial resources will be saved, that can be used for increasing coverage of MARPs.

5. **The Ministry and the NCDC** should provide appropriate measures based on international knowledge and experience for the responsible entities for the outreach of MARPs in order to strengthen the institutional capacity. This should be resulted in improving outreaching and detecting of MARPs. It is especially important in order to maintain sustainability of the national response after the re-allocation of functions.

6. **The Center** should review the management system, organization and structure. It is necessary to implement all components of the internal control to achieve compliance with the legislation, higher performance, as well as prevention of the resources' loss. The Center should minimize risks of irrational spending of public resources.

Glossary:

ISSAI - International Standards of Supreme Audit Institutions

The SAO – State Audit Office of Georgia

The Ministry - Ministry of Health, Labor and social affairs

The NCDC - National Centre for Disease Control

The Center - Georgian AIDS and Clinical Immunology Research *Center*

The CCM - Country Coordination Mechanism/National coordination council on HIV/AIDS, Tb and Malaria

Medical Facilities – Hospitals providing service for HIV/AIDS patients

UNAID - The Joint United Nations Program on HIV/AIDS

Spectrum - UNAID Analytical tool to support the decision making process

WHO – World Health Organization

Global Fund - Public-private partnership and international financing institution dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, TB and malaria

Incidence – the rate at which a certain event occurs as a number of new cases of a specific disease occurring during a certain period in a population

Prevalence - the total number of cases of a disease in a given population at a specific time

FSWs – Female Sex Workers

STI – Sexually Transmitted Infections

MSMs –Men Who Have Sex with Men

MARPs – Most At Risk Population

IDUs – Injecting Drug Users

HIV/AIDS – Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

ART – Antiretroviral Treatment

PLWA – People living with HIV/AIDS