2011

Georgia National HIV/AIDS Monitoring and Evaluation Framework, Operations Manual&Operationalization plan February 2011

Tbilisi, Georgia
DRAFT
February 2011

Contents

Figures and tables

1 Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMT	Agonist Maintenance Therapy
ANC	Antenatal clinics
ART	Antiretroviral treatment
BSS	Behavioural Surveillance Survey
CCM	Country Coordinating Mechanism
CSW	Commercial Sex Worker
GHSPIC	Georgia Health and Social Projects Implementation Center
GRIA	Georgian Research Institute on Addiction
GHPP	Georgia HIV Prevention Project
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDU	Injecting Drug User
M&E	Monitoring and Evaluation
MARA	Most at risk Adolescents
MARP	Most at risk Population
MCLA	Ministry of Corrections and Legal Assistance
MoE&S	Ministry of Education and Science
MoF	Ministry of Finance
MoLHSA	Ministry of Labor, Health and Social Affairs
MSM	Men having sex with men
NASA	National Aids Spending Analysis
NCDCPH	National Center of Disease Control and Public Health
NGO	Non-governmental organization
NSP	National Strategic Plan
PEP	Post Exposure Prophylaxis
PIT	Provider Initiated Testing
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-to-child Transmission
STI	Sexually Transmitted Infections
TGF	Global Fund to Fight Aids, Tuberculosis and Malaria
TWG	Technical Working Group
UA	Universal Access
UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS	The United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counseling and testing

Introduction

This document outlines HIV/AIDS monitoring and evaluation (M&E) system for Georgia. It contains three separate sections : (1) HIV national M&E system design; (2) M&E operations manual, which describes how individual components of the national M&E system will be implemented and (3) operationalization plan, which provides a detailed overview of the priority activities to be undertaken within the first three years of establishing the system. The document complements and should be read in conjunction with the National HIV/AIDS strategic plan for 2011-2016.

The HIV/AIDS M&E framework with accompanied operations manual and operationalization plan were developed with participation of multiple stakeholders under the auspices of the CCM and with financial and technical support from the UNAIDS. The technical working group (TWG) was established composed of independent experts from different organizations involved in implementation of the national response to HIV/AIDS. Experts on the TWG consulted various international manuals[1,2] and standardized methodologies on development of HIV/AIDS M&E systems, conducted site visits and key-informant interviews to gain better insight of HIV/AIDS M&E needs in the country.

Consultative meetings were conducted to agree on a core set of indicators and institutional arrangements targeted to improve coordination of the M&E system. The M&E framework document was finalized based on stakeholders' feedback and submitted to the CCM for endorsement in March of 2011.

A. Background

Despite a relatively low prevalence rate, the HIV/AIDS epidemic remains a significant public health concern in Georgia. There were 2236 HIV cases registered in the country by the end of 2009.[3] The HIV epidemic is largely concentrated among males (75% of cases) and high-risk groups such as IDUs, MSM and CSW. Estimated HIV prevalence ranged from 0 to 4.5% among IDUs, and 0,8%-1,8% among CSWs, depending on locality. Among MSM is Tbilisi, the HIV prevalence was estimated at 3,7%. High-risk groups are the primary drivers of the epidemic. Based on 2008 data, injecting route for HIV transmissions contributed to more than half (58.6%) of HIV cases. Although the recent trend reveals some shift towards heterosexual transmission, the latter being responsible for 35% of cases in 2009 as compared to 27% in 2004, it should be noted that the majority of those infected via heterosexual transmission were in sexual relationship with the high-risk group individuals.[4] HIV prevalence among pregnant women and blood donors is much lower (0.02% and 0.013% respectively) than in general population (0.038% in 2009).

Since 1989 the number of newly detected HIV cases has been growing annually. A dramatic increase in the number of newly detected HIV cases observed between 2000 and 2006 can partially be explained by improved availability to HIV tests provided through the TGF financing. Despite the improved access to diagnostic procedures, the problem of late detection of disease

1.The National AIDS Councils: Monitoring and Evaluation Operations Manual, UNAIDS/02.47E (English original, August 2002)
2. Organizing Framework for a Functional National HIV Monitoring and Evaluation System, UNAIDS, 2008
3. UNGASS, Georgia Country Progress Report, Reporting Period: 2008-2009 Calendar years
4. Georgia National HIV/AIDS Strategic Plan for 2011-2016, May 2010

has not been solved. Since 2004, on average annually 45% of HIV cases are detected late with already clinically manifested AIDS. The AIDS incidence rate has significantly increased from 0.36 per 100,000 in 2000 to 5.3 per 100,000 in 2008. This places Georgia among countries with highest AIDS incidence rates in the European region.[5] High rates of injecting drug use as well as migration of Georgian population to and from neighboring countries with high HIV/AIDS prevalence rate (e.g. Ukraine and Russia) pose significant risk and may lead to further expansion of the epidemic.

In recognition of the increasing health burden associated with HIV/AIDS the Government of Georgia (GoG) has utilized various mechanisms and resources to mitigate the impact of the epidemic. Coordinated involvement of various national and international stakeholders, as well as the civil society has been deemed as pivotal in effective HIV response. The National AIDS Coordinating Authority (CCM) has been operational since 2003 with a multisectoral mandate for coordinating the national response. One agreed strategic plan of action has also been elaborated to guide the national response. However, establishment of one agreed monitoring and evaluation system and framework that would allow for evaluating the effectiveness of the national response could not be achieved.

Currently there are many organizations involved in collection, analysis, dissemination and use of HIV/AIDS related data. However, data is not always collected in a systematic and well-coordinated way. Progress reports have never been compiled at the national level and consequently have limited value for policymaking and strategic planning. Moreover, HIV is left behind the health system performance appraisal framework with none of HIV related indicators included in a core set of measures.[6] Programmatic M&E data collection mainly focuses on activities and fails to address program impact and outcomes (e.g. behavior change, coverage and utilization of services). A lack of common quality standards on services makes it difficult to compare programmatic data from different implementing partners. Furthermore, there is little operational research data that adequately addresses major HIV/AIDS related issues e.g. stigma and discrimination, effectiveness of preventive interventions and etc. No economic evaluation data is available to allow for judgment whether planned activities are a worthwhile undertaking.

Many institutions involved in the HIV/AIDS national response lack a technical capacity to conduct regular monitoring and evaluation of interventions they offer. There are M&E officers following predefined and agreed M&E plans within the TGF and USAID financed large-scale projects. However, not all stakeholders share this arrangement that may result in a significant variation in practice of data collection and analysis.

Considerable progress has been made since 2007 in terms of the development of the HIV/AIDS surveillance system that incorporates three main components: (1) Routine surveillance; (2) Sentinel surveillance and (3) Bio-behavioral surveillance studies among high-risk groups. The National Center for Disease Control and Public Health has been identified as an agency responsible for coordinating HIV/AIDS surveillance. The national surveillance plan featuring the standard data collection forms and a methodological manual for data analysis has been elaborated. This new system has been successfully launched with the TGF support. The Ministerial order #217/o as of July 23, 2010 was issued to support institutionalization of this arrangement. However, limited availability of the state funding and reliance on the donor support have been a cause for concern. Government spending to support HIV surveillance

5. The European Center for Disease Prevention and Control, HIV/AIDS surveillance in Europe 2008
6 . Georgia Health System Performance Assessment, WHO, 2009

system in 2006-2008 amounted only to 2% of the total spending with the rest covered by the TGF and other donors support.[7]

Organizations with HIV/AIDS monitoring and evaluation functions and their current roles are outlined in annex 1.

B. Georgia National HIV/AIDS Strategic Plan for 2011-2016

Georgia has one agreed HIV/AIDS National Strategic plan, which was endorsed in 2006. It defined priority areas for action for the period of 2006-2010. The plan was subsequently revised in 2007. This was followed by the initiative aimed at developing a new national strategic plan (NSP) for 2011-2016 supported by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the ASAP (the Aids Strategy & Action Plan service) of the World Bank (WB). The new NSP has been devised through broad consultations with national stakeholders led by the CCM and peer reviewed by international experts.

The goal of the new NSP is to restrain epidemic growth primarily within the most-at-risk populations and improve health outcomes for PLHIV, through improved coordination and strengthened advocacy of the national response. The plan identifies five priority areas, which include a results framework, indicators, and targets to be achieved in the next six years.

Strategic area 1: Enhance coordination and advocacy efforts of the national response envisions three strategic objectives: (i) Increasing capacity of the CCM's secretariat and enabling it with the required systems/instruments that assure effective implementation of the coordinating function. This includes equipping CCM with the needed regulations (to be reflected into the new CCM bylaws) required for effective execution of its role; strengthening capacity of CCM's secretariat; and developing one agreed monitoring and evaluation framework and supporting its implementation (ii) Assuring adequate financing of HIV/AIDS interventions, to guarantee quality prevention, diagnosis and treatment services. (iii) Carrying out necessary advocacy to create conducive environment for national response. This advocacy will aim at reducing legal and regulatory barriers for drug users and prisoners; mounting advocacy to minimize stigma and discrimination, primarily among healthcare providers; and encouraging greater involvement of people living with or affected by HIV/AIDS.

Strategic area 2: Improve quality and scale of preventive interventions envisions a comprehensive set of preventive interventions aimed at preventing HIV spread among most-at-risk populations including IDUs, CSWs, MSM, prisoners and MARA. In addition, a set of activities are proposed to prevent spread of infection within health care settings, avoid mother-to child transmission and reduce youth vulnerability to HIV.

Strategic area 3: Maintain access to ART and improve treatment outcomes will be achieved through: (i) Maintaining and, if possible, increasing current access level to ART; (ii) Improving treatment adherence among patients on ART; (iii) Strengthening ART management capacity; (iv) Scaling up management of opportunistic infections and other co-morbidities in HIV positive patients.

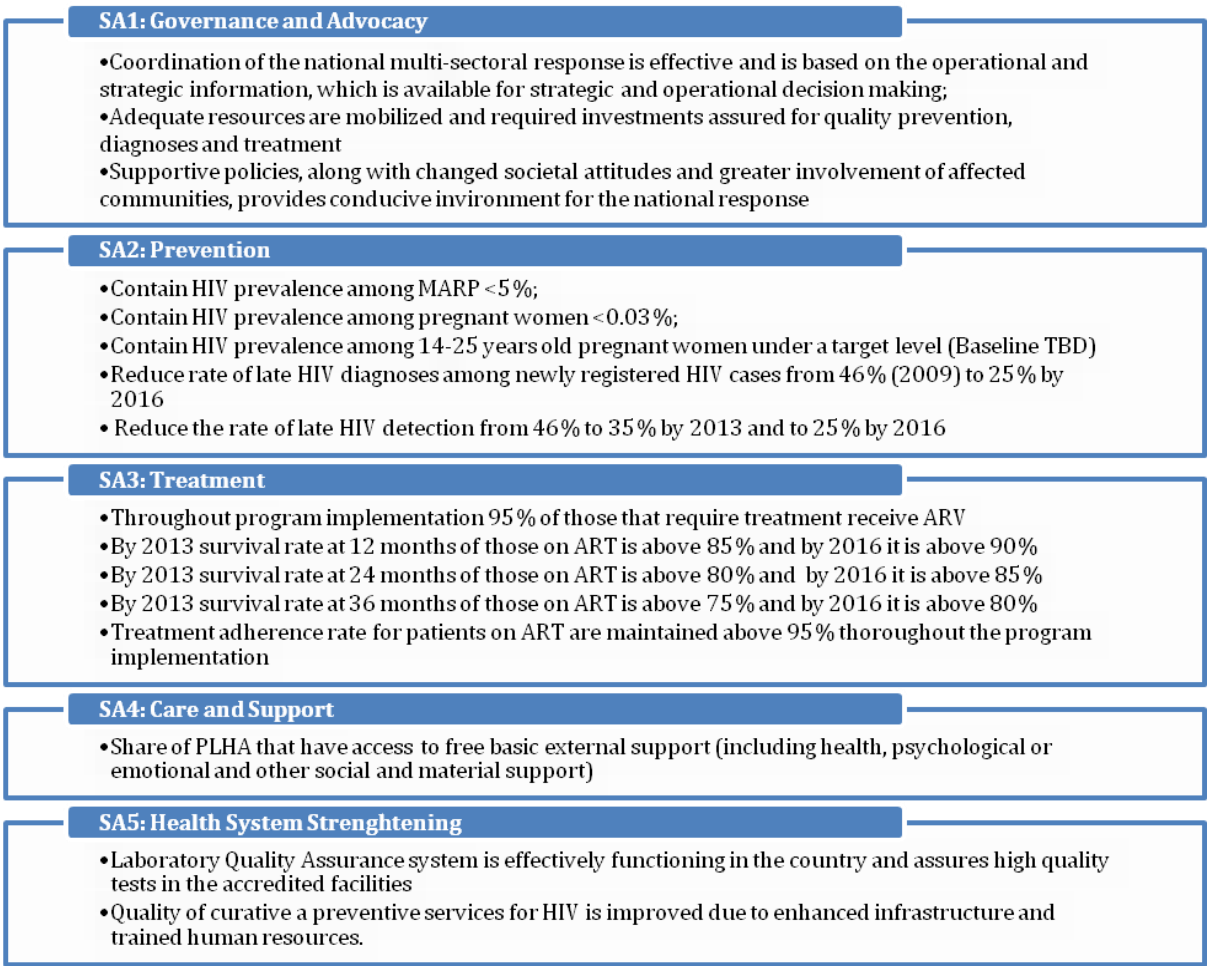
7 .Data are derived from a financial analysis work conducted in 2010 to inform HIV national strategic planning for 2011-2016.

Strategic area 4: Assure adequate care and support for the PLHA will be achieved through providing psychological assistance, nutritional support and palliative care by adequately trained personnel.

Strategic area 5: Strengthen Health System capacity for effective HIV response will focus on two strategic priorities: (i) strengthening regulatory system to assure higher quality services in the health care settings and (ii) assuring the necessary investment in human resources and infrastructure. Figure 1 outlines priority areas and expected outcomes of the HIV/AIDS NSP for 2011-2016.

The NSP is accompanied by the monitoring and evaluation framework that proposes detailed indicators against strategic objectives. Indicators in the NSP M&E framework have been incorporated in a set of core national indicators that is an integral component of the M&E system.

Figure 1 Strategic areas and expected outcomes of the HIV/AIDS NSP for 2011-2016.



1. Section 1: National HIV/AIDS monitoring and evaluation framework

1.1 Rationale

In order to effectively plan, coordinate and implement the HIV/AIDS national response the Government of Georgia needs to have sufficient evidence regarding the magnitude of the problem, factors contributing to it, realistic estimates of resources required, and the scope and coverage of the programmatic interventions. Clearly, there is a need to address a broad array of questions on inputs, processes, outputs, outcomes and impact of the interventions geared towards mitigating the impact of the HIV epidemic. Adequate data collection and reporting mechanisms should be in place to ensure transparency in the implementation of national response and encourage participation of multiple local and international partners and civil society.

Undoubtedly, an appropriate and efficient M&E system is the cornerstone of a country's HIV response: it provides the data needed to make evidence-based decisions for program management and improvement, policy formulation, and advocacy, and is necessary to satisfy accountability requirements.

Such information is useful to understand the scale and outcome of implementation and can be used to secure continued funding for the expansion of HIV/AIDS programs. More importantly, it can be used locally to enhance community and health-facility-based programs. The National HIV/AIDS M&E Framework provides stakeholders with a tool for well coordinated, harmonized and functional HIV/AIDS M&E systems that allow them to efficiently assess how well HIV/AIDS interventions are contributing to achieving the national program goals.

The following reasons justify the necessity of having National HIV/AIDS M&E Framework:

(i) It provides opportunities to develop integrated national and sector specific M&E systems to guide a national response to HIV/AIDS;

(ii) It assists in responding to the international commitments and reporting requirements;

(iii) It provides the platform for partnership, networking, and collaboration between national-level and local-level stakeholders in monitoring and evaluating national and decentralized responses to HIV/AIDS.

1.2 Guiding principles in the development of framework

The M&E Framework outlined in this document has been developed and will be implemented within the context of the "three ones" principle. The M&E framework will be explicitly linked to the NSP and equip the State and coordinating mechanisms such as the CCM with effective tools aimed at informed decision-making and improved planning of evidence based interventions.

The principles that guided the development of this M&E Framework are as follows:

- The development of the framework will include broad stakeholder participation. Stakeholders are those involved in planning, coordinating, funding and implementing the HIV/AIDS national response as well as those affected by HIV/AIDS and the civil society.

- The system must be understood by, accessible to, and corresponding to the needs of all stakeholders involved in the HIV and AIDS response.
- The structure and components of the M&E system must be integrated into existing systems and endorsed by stakeholders, to ensure proper data flows from stakeholders to the CCM.
- The national set of HIV indicators, including their definitions and data collection methodology, must be harmonized across all stakeholders
- The roles and responsibilities of organizations involved in data collection must be clear and operational.
- The M&E system must avoid duplication and fill existing gaps, drawing on existing data and generating new data.
- The M&E Framework must be supported by a costed annual work plan – to prevent a situation where M&E activities to be implemented are not funded.
- The M&E Framework must strike a balance between providing a meaningful overview of every program area and providing a national operational framework for the M &E system.

1.3 Basic concepts and definitions

As mentioned above, most of the initiatives for assessing HIV/AIDS activities aimed to collect routine data on program outputs, while little was done for measuring the overall effectiveness of interventions, including the outcomes of program interventions and their impact on HIV prevalence, morbidity, and mortality. The HIV/AIDS M&E framework will emphasize the importance of both monitoring *and* evaluation and views those as discreet and complementary processes. Both are essential for measuring progress in the implementation of the HIV/AIDS National response.

Monitoring is important for the routine, daily and regular assessment of ongoing activities and progress. This includes monitoring of inputs, processes and outputs through record-keeping and regular reporting systems as well as health facility observation and patient surveys.[8] Monitoring can also include the tracking of short-term program outcome and long-term impact.

Evaluation is a periodic, in-depth analysis of program performance. It relies on data generated through monitoring activities as well as information obtained from other sources (e.g., studies, research, in-depth interviews, focus group discussions, surveys etc.). Evaluation enables to link a particular output or outcome directly to the intervention. It may cover all level of data, including outputs. Evaluation questions may be related to the program's content, degree of scale-up or coverage, together with the quality and integrity of implementation. Furthermore, evaluation may well go beyond the processes and address outcomes and impact.[9] Unlike monitoring, evaluation aims to determine why and how results were achieved and not just what activities were implemented and achieved.

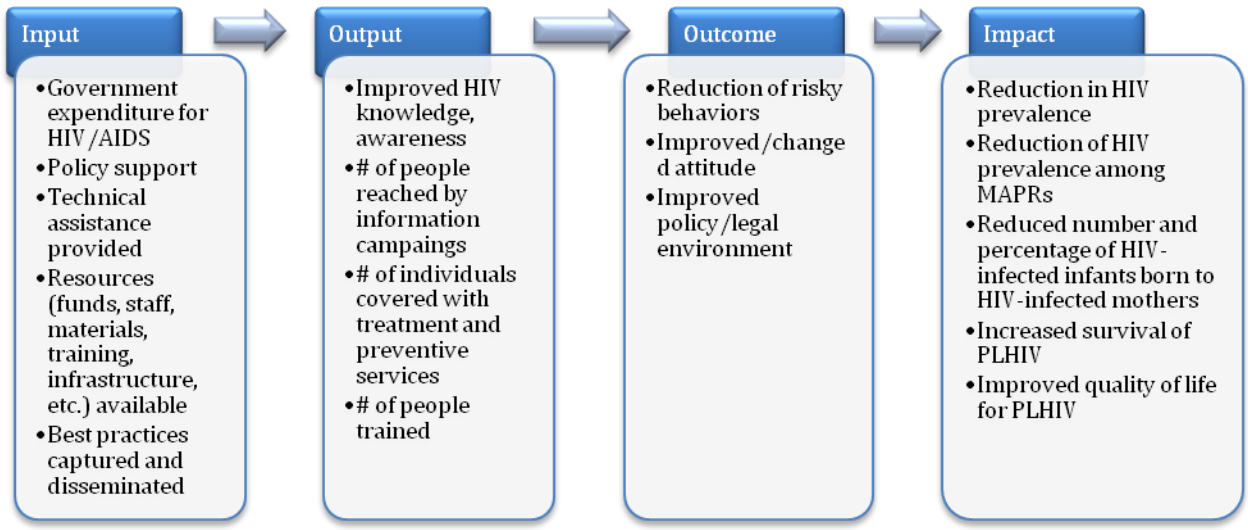
Like any monitoring and evaluation system, the framework is based on a national set of harmonized indicators. **An indicator** is a measure that is used to demonstrate performance achieved in relation to certain aims, objectives or activities. An indicator may reflect if there are changes needed to improve the situation, if there is any progress and if programs lead to expected results.

The HIV/AIDS M&E framework presented herein is based on four levels of indicators that include inputs, outputs, outcomes and impacts as described below (Figure 2). Relevant data will be gathered from existing sources, including institutions involved in HIV/AIDS routine

8. Organizing Framework for a functional National HIV Monitoring and Evaluation System, April 2008
9 . National AIDS Programmes, A Guide to Monitoring and Evaluation, UNAIDS, 2000

surveillance and those implementing various HIV interventions. It is vital to address data quality/validation issue. Tools and processes for data quality assurance such as site monitoring visits, direct observation and feedback have to be implemented regularly by institutions responsible for coordinating and supervising implementation of HIV/AIDS interventions. In addition to routine data sources, several new sources will be included in the data gathering and analyses such as sentinel and bio behavioral surveys, studies estimating size of at-risk groups, AIDS spending data, and effectiveness evaluation studies. Collected information, once analyzed, will be reflected in relevant M&E products (reports) which than can be disseminated to a wide range of stakeholders to meet their information needs. It is M&E report that makes the system visible and gives more credibility if it is effectively utilized by decision makers. Therefore, timely production of high quality reports and their use for policy development and national programmatic decision making, should be an important objective of the national M&E system and has to be supported with adequate resources and institutional arrangements (including enabling legal environment).

Figure 2. Levels of M&E indicators



1.4 HIV/AIDS M&E system design

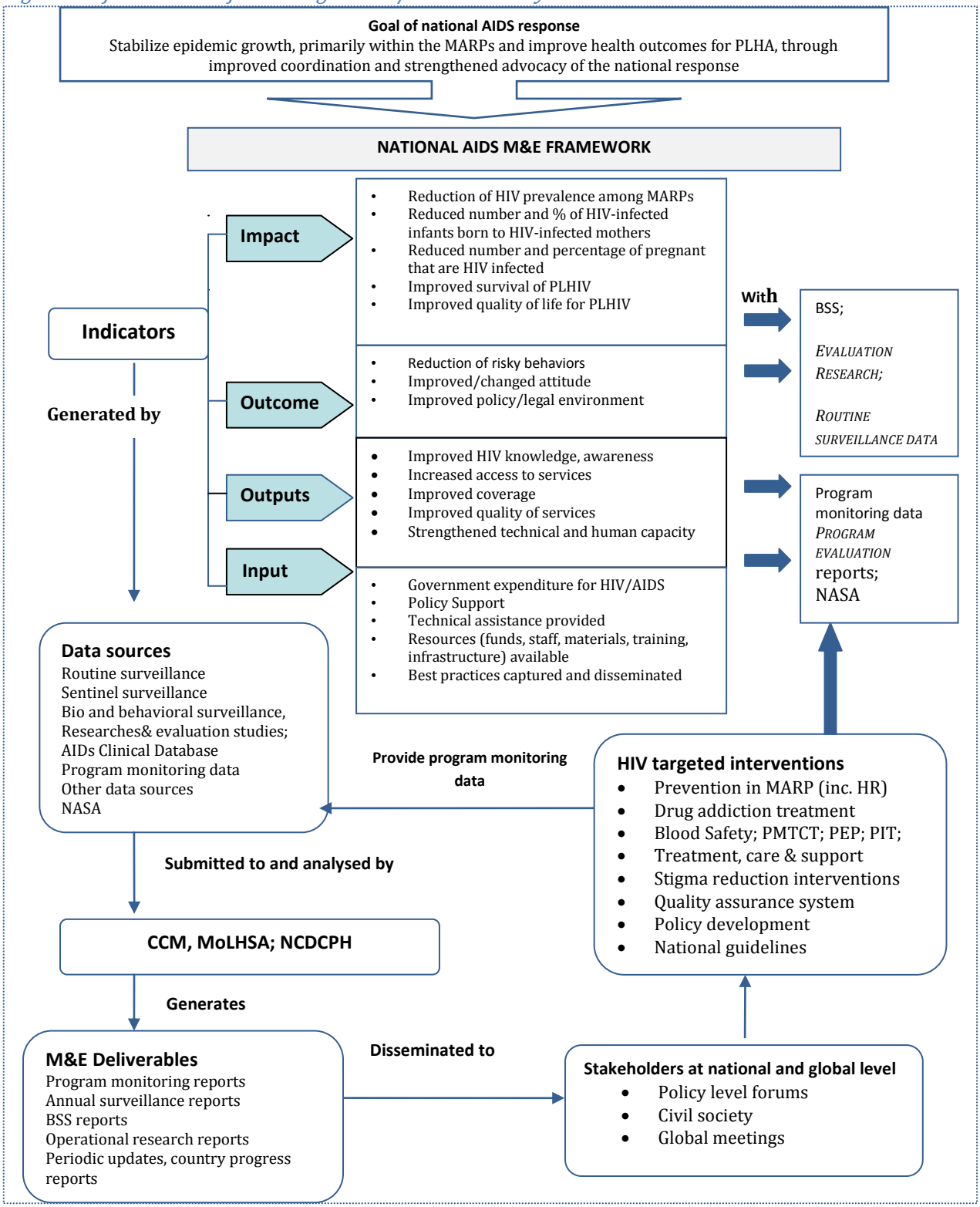
The HIV/AIDS monitoring and evaluation framework for Georgia aims to guide informed decision making on HIV interventions by providing reliable information on progress towards achieving predefined targets and objectives and in what interventions yield desired outcomes. It enables the tracking of progress in the national response to HIV/AIDS and enhances informed and sound decision making and policy for the multisectoral, decentralized HIV/ AIDS interventions.

The HIV/AIDS monitoring and evaluation framework is designed to fulfill the following objectives:

1. Describe a harmonized national set of fully defined indicators
2. Identify data sources for each indicator
3. Describe roles of organizations with HIV response M&E functions
4. Describe the key data sources to be used to gather necessary M&E data
5. Establish clear data flow channels between various institutions involved in the HIV national response
6. Monitor the progress of objectives set in Georgia's HIV/AIDS 2011-2016 NSP
7. Develop strategy to support effective dissemination of M&E findings to all stakeholders including those providing financial support for HIV programs and to PLHA

The framework for Georgia HIV/AIDS M&E system is outlined on figure 3.

Figure 3. framework for Georgia HIV/AIDS M&E system



As outlined in figure 3 the M&E system for the national response will be based on various key information sources including routine surveillance reports, biological and behavioral surveillance, program implementation reports, financial monitoring and resource flow analyses, and operational research data (see table 1 for details).

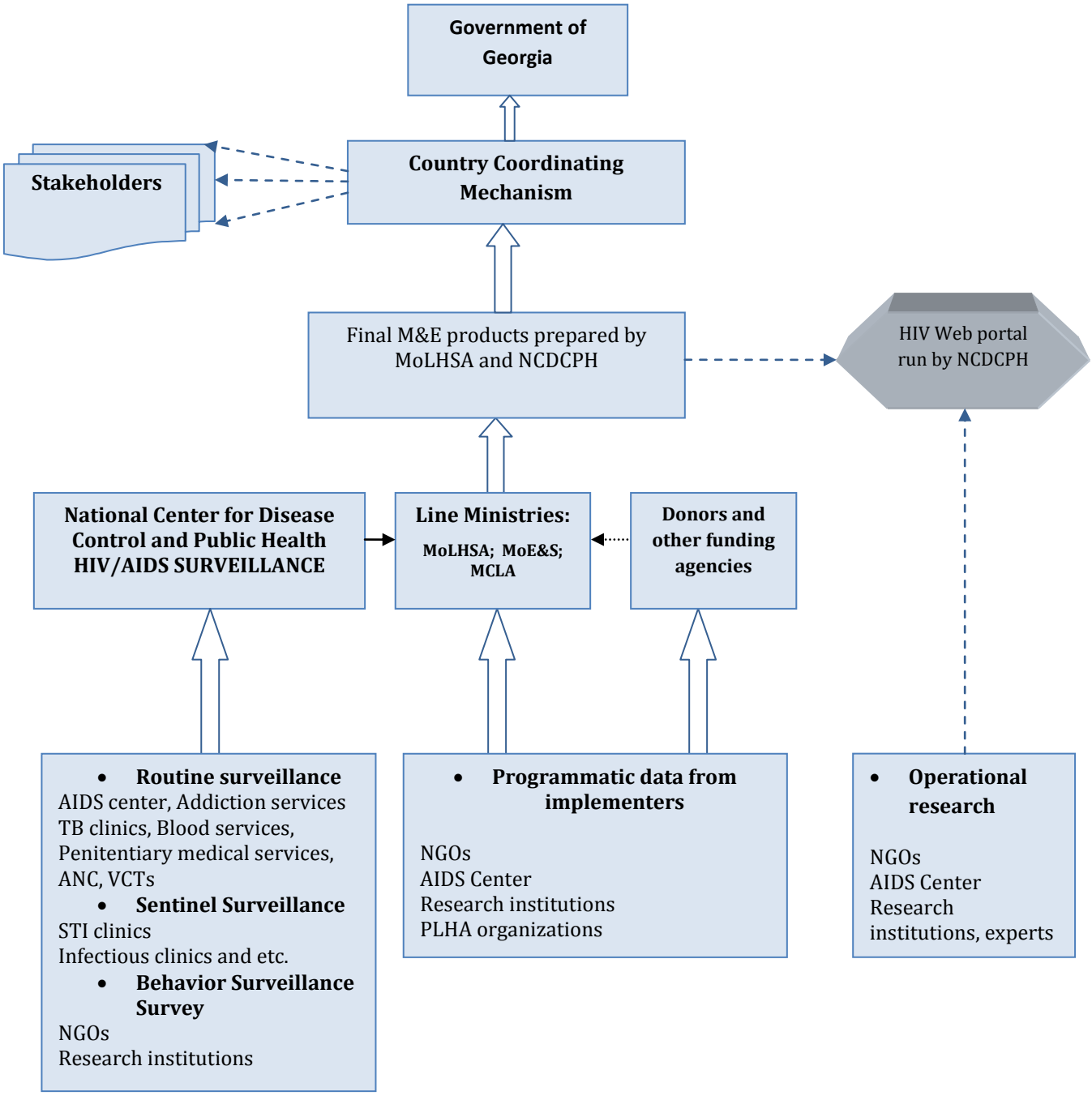
Table 1. Key elements of the HIV/AIDS M&E system in Georgia

M&E element	Description
Monitoring	
Routine surveillance reports (RSR)	Prepared and submitted by primary medical facilities to the NCDCPH. A format and frequency of submission is defined by the National surveillance plan.
Program implementation reports(PIR)	Prepared by implementing agencies. Describe progress against project objectives and financial allocations.
Sentinel Surveillance(SS)	Sentinel surveillance is considered a core activity of HIV surveillance system. It measures the prevalence of HIV infection in selected groups (not covered by routine surveillance) in serial cross-sectional studies conducted at regular intervals.
Behavioral Surveillance Surveys (BSS)	Periodical studies of the existing HIV Risk behaviors (or changes in them) among defined subpopulation (high-risk) groups by means of sociological surveys.
Evaluation	
Operational research	Focuses on whether the program design is right or optimal to achieve the desired results. OR can be thought of as a practical, systematic process for identifying and solving program-related problems.[10]
Population size estimation studies	Carried out biennially (if not planned otherwise by the HIV/AIDS NSP) on selected HIV/AIDS high risk populations.
Country progress monitoring	
UNGASS report	The purpose of UNGASS report is to monitor the progress made by countries towards achieving universal access to HIV prevention, treatment and care in 2010 and eventually in reaching the Millennium Development Goal of arresting and halting the spread of HIV by 2015. The data form the basis of a number of regular reports including the UN Secretary-General's report to the General Assembly, the UNAIDS Report on the Global AIDS epidemic and the HIV section of the annual Millennium Development Goals monitoring report.[11]
National AIDS Spending Assessment (NASA) and financial gap analyses report	NASA resource tracking the NASA resource tracking methodology was designed to describe the financial flows and expenditures using the same categories as the globally resource needs estimates.[12] NASA provides indicators of the financial country response to HIV and AIDS and to support the monitoring of resource mobilization. NASA is the tool to install a continuous financial information system within the national monitoring and evaluation framework.[13]
A national report on HIV/AIDS surveillance	This report is devoted to describing the HIV situation by its key characteristics[14], in particular: • describing the HIV/AIDS situation in the country by a certain time (the end of a calendar year) • showing trends of the HIV/AIDS epidemic in the country. The descriptive part is accompanied by data tables with main indicators as defined by the HIV/AIDS national surveillance plan.
National Health Report-HIV/AIDS subsection	This report intends to highlight the health status of the country population; evaluate resources available in health care system aimed at addressing major health problems; evaluate distribution of the key determinants of health including environmental, social, physical, mental, behavioral etc.; benchmark the trend in the status in Georgia against other countries in the European region.

10. The Global Fund and WHO M&E toolkit, 2006
11. New UNGASS Guidelines for 2010 reporting, http://www.unaids.org
12. Resource needs for an expanded response to aids in low and middle income countries. UNAIDS, August 2005.
13. National AIDS Spending Assessment (NASA):classification and definitions "UNAIDS/09.23E"
14. HIV/AIDS surveillance-national plan, 2010

Figure 4 illustrates data flow and linkages between various institutions with HIV/AIDS M&E functions.

Figure 4. Monitoring and evaluation data flow in Georgia



1.4.1 Organizational structure with HIV M&E function

Country Coordinating Mechanism

While the collection and analysis of data, as well as the preparation of M&E products will be the responsibility of implementing partners (NCDCPH, AIDS center, research institutions etc), the CCM's mandate is to coordinate the overall national response and M&E evaluation arrangements. The CCM will regularly identify M&E needs to inform the national response to HIV/AIDS and set steps for meeting those needs. The CCM will ensure that all final M&E

products and operational research reports are effectively communicated to the GoG and other stakeholders including PLHIV.

Line ministries

The line ministries (incl. MoLHSA, MoE&S, MCLA), which are responsible to oversight implementation of the national HIV/AIDS programs, should utilize M&E data to inform national program planning and track progress against the key HIV/AIDS NSP objectives. The ministries will use existing M&E sub-systems and reporting mechanisms to collect data on programmatic activities. The programmatic data will be collected and analyzed by relevant sectoral ministerial structures (e.g. NCDCPH) and reports submitted to the designated ministerial units. These units will produce M&E products in line with the national M&E system requirements and existing regulations.

Donor agencies

Donor agencies play a key role in developing and strengthening the national M&E framework. Internal technical and financial resources may not be sufficient to meet the emerging M&E system needs. Therefore, donor support will be crucial in achieving effective performance of the national M&E system and its subcategories.
On the one hand, the national M&E system should consider and satisfy donor-reporting requirements in relation to particular projects. On the other hand, donors have to ensure that their reporting requirements and formats are in line with the indicators outlined in the M&E framework. Donor agencies will be asked to participate in NASA survey and provide information according to the NASA subcategories (Annex 6).

Implementers

Agencies and organizations implementing HIV/AIDS related programs, often referred to as implementers, will perform programmatic data collection, analysis and reporting in accordance with the National M&E Framework and Operational Guidance. These guidelines will provide the basis for a standardized approach for all implementers allowing the effective utilization of programmatic data to inform decision-making at not only the program-level, but also the regional and national levels.

While elaborating their M&E plans implementers should consider indicators included in the National M&E framework, draw operational definition of the indicator from the M&E plan and use data collection instruments that conform with national and/or international standards applying to the HIV/AIDS interventions.

Considering specific program supervision needs, implementer may be required to collect more indicator data than it is required by the national M&E system – but as a minimum requirement, it should collect all of the information that is needed to measure the national indicators.

While monitoring and evaluating implementation of specific HIV/AIDS interventions (such as PMTCT, ART, VCT, Blood safety) implementers should produce relevant reports on the program resources, progress and achievements. Tools for programmatic data collection, analysis and reporting form a basis for a program level M&E arrangements. The effective utilization of the programmatic data to inform decision-making would only become possible if implementers' M&E arrangements are mainstreamed with the National HIV/AIDS M&E system. Thus, the programmatic data-collected, aggregated and analyzed in line with the national M&E framework

would enable evidence-based planning and assessment of progress in implementation and coordination of the national response.

1.5 Indicators for HIV/AIDS national response in Georgia

The HIV/AIDS NSP for 2010-2016 identifies more than 150 input, processes, output, outcome and impact level indicators. Additionally, the surveillance database includes indicators that describe behavioral targets and can be measured through special surveys and studies. All provide valuable information on various aspects of the national response. However, for the purpose of the national M&E framework, particular emphasis was made on indicators which are effective enough to measure program performance, outcome and impact. None of the process indicators (62) defined at sub-activity level were included. It should also be noted that the NSP indicators concerned with policy development, legal environment, involvement of civil society and human right are covered under the National Composite Policy Index. Therefore, those are not enumerated as distinct indicators.

A core set of indicators was selected based on the following consideration:

a) Core M&E indicators should allow for tracking progress against NSP objectives, thus indicators identified by the NSP log frame to measure key results have to be included.
b) The M&E system should generate data that allows for meeting international commitments of the Georgian government on monitoring and evaluating the HIV/AIDS national response and reporting adequate findings. Therefore, UNGASS indicators relevant to the Georgian context that can be generated by the national M&E system should be included.
c) Indicators should be clear, feasible to collect and analyze, field tested and well accepted by various stakeholders.

Fifty two indicators have been selected through a number of consultative meetings attended by the local experts and stakeholders. This does not imply that the additional data sources are not relevant or valuable, but rather that the focus of creating a functional, flexible and responsive M&E system is on ensuring that the core data sources are all well-developed and in existence.

Table 3 presents a set of core indicators, their levels, source, and means for verification, agencies responsible for data collection and analysis and the frequency of reporting.

Table 3. Core Indicators

	CORE Indicators	Level	Means for verification	Responsible Agencies &partners	Time frame	Source of indicator
	Strategic Area: Governance, policy &Advocacy					
	Expenditures					
1.	Percentage of NSP needs funded	Input	Financial reports	MoLHSA	Annual	GEONSP
2.	Domestic and international AIDS spending by categories and financing sources*	Input	Financial reports	MoLHSA	Biennially	UNGASS #1
	Stigma and discrimination					
3.	Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with	Outcome	Survey reports	MoLHSA IOs NGOs	4 yearly	UNAIDS Additional
4.	Level of stigma among health care workers	Outcome	Survey reports	MoLHSA IOs/NGOs	4 yearly	GEONSP
	Policies					
5.	National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Input/outcome	NCPI questionnaire/ Key informant interviews	CCM	Biennially	UNGASS #2
	STRATEGIC AREA: PREVENTION					
	Testing and counseling					
6.	Percentage of IDUs tested on HIV and know their results during last 12 months	Output	BSS reports	CCM/MoLHSA IOs/NGOs	Biennially	UNGASS #8 (UA)#A5
7.	Percentage of FSWs tested on HIV and know their results during last 12 months	Output	BSS reports	CCM/MoLHSA IOs/NGOs	Biennially	UNGASS#8 (UA)#A5
8.	Percentage of MSM tested on HIV and know their results during last 12 months	Output	BSS reports	CCM/MoLHSA IOs/NGOs	Biennially	UNGASS#8 (UA)#A5
9.	Percentage of prisoners tested on HIV and know their results during last 12 months	Output	BSS reports	CCM/MoLHSA IOs/NGOs	Biennially	GEONSP
10.	Percentage of MARA tested on HIV and know their results during last 12 months	Output	BSS reports	CCM/MoLHSA IOs/NGOs	Biennially	UNAIDS
11.	HIV case detection rate among tested patients visiting STI clinics	Impact	Surveillance database	NCDCPH	Annual	GEONSP
12.	HIV case detection rate among patients visiting addiction services	Impact	Surveillance database	NCDCPH	Annual	GEONSP
	Women and Children-PMTCT					
13.	# of vertical transmission of HIV cases among children < 1 year <2 years	Impact	HIV/AIDS clinical database	NCDCPH	Annual	GEONSP
14.	Percentage of infants born to HIV-infected women (HIV-exposed infants) who are infected	Impact	HIV/AIDS clinical database	NCDCPH	Annual	UNGASS#25
15.	HIV prevalence among pregnant	Impact	Surveillance database	NCDCPH	Annual	UNAIDS/WHO

	CORE Indicators	Level	Means for verification	Responsible Agencies &partners	Time frame	Source of indicator
16.	Percentage of pregnant women screened on HIV	Output	HIV/AIDS surveillance database;	MoLHSA/ANC	Annual	UNAIDS additional
17.	Percentage of newborns born to HIV positive mothers receiving complete course of ART prophylaxis and social care services	Output	HIV/AIDS clinical database	MoLHSA/IOs (TGF, UN) GHSPIC / AIDS center, NGO	Annual	(UA)#I13
18.	Percentage of HIV positive pregnant women receiving complete course of ART prophylaxis	Output	HIV/AIDS clinical database	MoLHSA/IOs (TGF) / GHSPIC AIDS center	Annual	UNGASS#5 (UA)#I10
	Prevention among MARPs inc. MARA					
19.	HIV prevalence among IDUs	Impact	BSS reports/Surveillance database	NCDCPH	Biennially	UNGASS#23 UNAIDS
20.	HIV prevalence among FSWs	Impact	BSS reports/Surveillance database	NCDCPH	Biennially	UNGASS#23
21.	HIV prevalence among MSM	Impact	BSS reports/Surveillance database	NCDCPH	Biennially	UNGASS#23
22.	HIV prevalence among prisoners	Impact	BSS reports/Surveillance database	NCDCPH	Biennially	GEONSP
23.	HIV prevalence among MARA	Impact	Surveillance database	NCDCPH	Biennially	UNAIDS
24.	Percentage of FSWs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Output	BSS report	NCDCPH IOs and NGOs	Biennially	UNGASS#14
25.	Percentage of MSMs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Output	BSS report	NCDCPH IOs and NGOs	Biennially	UNGASS#14
26.	Percentage of IDUs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Output	BSS report	NCDCPH IOs and NGOs	Biennially	UNGASS#14
27.	Percentage of FSWs reporting the use of a condom with their most recent client	Outcome	BSS report	NCDCPH IOs and NGOs	Biennially	UNGASS#18
28.	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner*	Outcome	BSS report	NCDCPH IOs NGOs	Biennially	UNGASS#19
29.	Percentage of IDUs reporting the use of a condom the last time they has sex with paid for sex partners*	Outcome	BSS report	NCDCPH IOs/NGOs	Biennially	UNGASS#20
30.	Percentage of IDUs reporting the use of sterile injecting equipment the last time they injected*	Outcome	BSS report	NCDCPH IOs NGOs	Biennially	UNGASS#21
31.	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Outcome	BSS report	MoE&S MoLHSA NCDCPH IOs NGOs	Biennially	UNGASS#13

	CORE Indicators	Level	Means for verification	Responsible Agencies &partners	Time frame	Source of indicator
32.	# of opioid-dependent people covered by AMT	Output	Program data	MoLHSA/ IOs (TGF, USAID), GHSPIC,NGOs;	Annual	GEONSP
33.	# of drug dependent people covered by drug dependence treatment services	Output	Program data	MoLHSA/ IOs (TGF, USAID), GHSPIC,NGOs;	Annual	GEONSP
34.	Percentage of injecting drug users (IDU) reached with HIV prevention programs in the last 12 months	Output	BSS data	MoLHSA/ IOs (TGF, USAID), GHSPIC,NGOs;	Biennially	UNGASS#9 (UA)#C4a
35.	Number of syringes/needles distributed per injecting drug user per year	Output	Program data	MoLHSA/ IOs (TGF, USAID), GHSPIC,NGOs;	Annual	(UA)#C3
36.	Percentage of sex workers (SW) reached with HIV prevention programs in the last 12 months	Output	BSS data	MoLHSA/ IOs (TGF, USAID), GHSPIC,NGOs;	Biennially	UNGASS#8
37.	Percentage of men who have sex with men (MSM) reached with HIV prevention programs in the last 12 months	Output	BSS data	MoLHSA/ IOs (TGF, USAID), GHSPIC,NGOs;	Biennially	UNGASS#8
	Healthy life-style Education					
38.	Percentage of schools providing integrated drug and HIV prevention training course	Output	Program reports	Ministry of Education and Science; MoLHSA IOs	Biennially	Modified UNGASS
	Prevention in healthcare setting					
39.	HIV prevalence among donors	Impact	Surveillance database	MoLHSA	Annual	GEONSP
40.	Percentage of voluntary donors	Output	HIV Surveillance database	MoLHSA/IOs	Annual	GEONSP
41.	Percentage of blood units screened for HIV in a quality assured manner	Output	Program reports	MoLHSA	Annual	UNGASS#3
	Strategic Area: TREATMENT					
	Antiretroviral therapy					
42.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Outcome	HIV/AIDS clinical database	AIDS center	Annual	UNGASS#24
43.	Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	Outcome	HIV/AIDS clinical database	AIDS center	Annual	(UA)#G3a
44.	Percentage of adults and children with HIV known to be on treatment 36 months after initiation of antiretroviral therapy	Outcome	HIV/AIDS clinical database	AIDS center	Annual	(UA)#G3b
45.	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Output	HIV/AIDS clinical database	AIDS center	Annual	UNGASS#4 (UA)#G2

	CORE Indicators	Level	Means for verification	Responsible Agencies &partners	Time frame	Source of indicator
	HIV and TB					
46.	HIV prevalence among TB patients	Impact	Surveillance database	NCDCPH	Annual	WHO/GTA
47.	Percentage of HIV/TB patients who received treatment for both TB and HIV	Output	Clinical data	MoLHSA AIDS center TB center	Annual	UNGASS#6 (UA)#E1
48.	Percentage of HIV patients with LTBI who received prophylaxis for TB	Output	Clinical data	MoLHSA AIDS center TB center	Annual	GEONSP
	Sexually transmitted infections					
49.	Proportion of women accessing antenatal care (ANC) services who are tested for syphilis in the last 12 months	Output	Programmatic data	NCDCPH	Annual	WHO/UA
50.	Prevalence of syphilis among sex workers	Impact	BSS	NCDCPH	Biannually	UA
51.	Prevalence of syphilis among men who have sex with men	Impact	BSS	NCDCPH	Biannually	UA
	STRATEGIC AREA: CARE AND SUPPORT					
	Care					
52.	Percentage of PLHA that have access to free basic external support (including health, psychological or emotional and other social and material support)	Output	Program reports	AIDS center	Annual	GEONSP

1.6 Performance Assessment of the M&E system

The proposed framework considers regular assessment of the M&E system as an important activity to ensure its strengthening and improvement. The CCM will ensure that adequate financial resources are secured to support periodic assessment (every two year) of the national monitoring and evaluation system to review the implementation status of the national M&E plan, to identify weaknesses and to build on achievements. Such assessment will primarily address: (i) the strength of the M&E plan; (ii) the capabilities that are established to collect, analyze and report data related to the implementation of the programs; (iii) the strengths of the data-collection and reporting systems per program area; including the ability to report valid, accurate and high-quality data related to implementation. The assessment process will be planned and conducted according to the 12 Components Monitoring and Evaluation System Strengthening tool that is internationally adopted and provides comprehensive assessment of all components of the M&E system.[15]

An overall HIV M&E system assessment will be undertaken as part of the national strategic planning and implementation cycle, it will be coordinated by the CCM. Broad stakeholder participation in assessment of the M&E system will be encouraged so that different views are shared and consolidated. Broad participation will help to identify opportunities for improvement and for integration of HIV related information into the health information systems that go beyond HIV/AIDS. This information will contribute essential information to the annual planning of the HIV work plan in order to ensure continued development and improvement of the system.

15. 12 Components Monitoring & Evaluation System Strengthening Tool/ Geneva, UNAIDS 2009a

The NSP indicators identified to capture progress in the M&E system development and evaluate its performance will provide a basic understanding of the system (table 4). However, more in depth analysis would be required to explore various aspects and domains of the system that would help to identify M&E capacity gaps and relevant strengthening measures, guide investments in M&E, and improve the quality of programmatic data to enhance program planning and management.

Table 4. Basic indicators to assess M&E system performance as planned by the NSP

#	M&E development objectives and activities	Indicators
SO1.1.3.	**Develop, implement and fully operationalize one M&E framework**	**National Annual M&E report published by the end of August**
A. 1.1.3.1.	**Assure sustainable functionality of the national HIV/AIDS surveillance program, which renders critical epidemiological and programmatic information about national response.**	**Integrated annual HIV/AIDS surveillance report published**
A.1.1.3.1.1	Routine HIV/AIDS surveillance is underway	Up to date data produced by HIV/AIDS surveillance database
SA 1.1.3.1.2 -1.1.3.1.10	Conduct BSS among MARPs and population size estimation studies as planned by NSP	Studies implemented
A 1.1.3.2.	**Develop national M&E framework and its implementation arrangements**	National M&E framework concept document and operational manual available
SA1.1.3.2.1.	Provide technical assistance to the MoLHSA in elaborating national M&E framework and operational manual.	Technical assistance solicited
SA1.1.3.2.2.	Conduct necessary trainings to build M&E skills among involved parties	# of people trained
A.1.1.3.3.	**Conduct required operational research to inform policies and practice related to the functioning of the M&E system**	# of Operational researches commissioned

1.7 Verification of M&E data

Central to the performance of the M&E system is the production of data that are of high quality. This implies that data produced should be valid, reliable, comprehensive, and timely. The existence of multiple HIV/AIDS data sources and lack of standardized data collection procedures often lead to inadequate data production practice-characterized by missing data, inconsistency in reporting and double counting. This in turn might seriously affect the ability of M&E system to provide plausible answers to many important questions concerning national response to HIV/AIDS. Therefore, the establishment of data verification processes throughout the M&E system including major subcategories (e.g. surveillance database, clinical database etc.) and individual service providers should be treated as high priority. The following tools and approaches are to be utilized to ensure data verification:

- Guidelines[16] for supervising routine data collection at HIV/AIDS service delivery sites have to be introduced to facilitate standardization of data management practice.
- Organizations responsible for coordinating M&E systems or supervising the program implementation should develop adequate capacity and secure financial resources to conduct routine supervision visits and periodic data auditing.

16. The Global Fund to Fight Aids, Tuberculosis and Malaria, Office of the Global AIDS Coordinator, PEPFAR, USAID, WHO, UNAIDS, MEASURE Evaluation., Routine Data Quality Assessment Tool, July 30 2008.

- Development of electronic data management systems has to be encouraged that would simplify identification of data processing errors.
  Table 5 offers a simple set of indicators aimed at measuring M&E system performance in the production of quality data.

Table 5. M&E system performance indicators in production of quality data

Area of interest	Indicators
Completeness	% of monitoring reports that are complete
Timeliness	% of monitoring reports that are timely
Data quality assurance tools and systems in place	% of M&E products meeting quality standards % of service delivery sites passing data audits % of reporting units with procedures to prevent double counting
Use of standard indicator definitions and reporting forms	Percentage of implementers that use harmonized indicator definitions and methodologies.

2. Section 2: M&E Operational Manual

This section elaborates details on the implementation of the individual components of the national M&E system, including the roles and responsibilities of national stakeholders. Data acquisition protocols, indicator passports and a standard format for final and intermediate information products are key components of this operational manual and can be found in annexes 2 to 7.

2.1 Roles and responsibilities of national stakeholders

2.1.1. Functions of the CCM

Overall Coordination of the HIV/AIDS response is a role of the CCM. For this function, including the coordinating HIV National M&E system, the CCM will be supported by the National HIV M&E Coordinator positioned at the National Center for Disease Control and Public Health (See sub-section 2.1.3). The national M&E coordinator will accomplish all assigned technical tasks that would enable the CCM and the key national stakeholders to be fully informed on the status and performance of the national M&E system and ensure that M&E products are delivered timely and in a quality manner. More specifically the coordinating role of the CCM will include the following functions:

- Review and endorse an overall and annual M&E plan
- Coordinate with all line ministries and other partners to ensure collection and reporting of relevant data on core indicators
- Advocate for strengthening national HV M&E resources
- Share and disseminate M&E data to national and international stakeholders
- Review M&E performance assessment reports and plan for improvements

2.1.2. Role of line ministries

Ministry of Labor, Health and Social Affairs

The main functions of MoLHSA will be preparation and delivery of the final M&E products, which will contain information on all core indicators as well as present analysis of lessons learned and identify shortfalls and barriers to the implementation.

The department of health of the MoLHSA will prepare:

a) **HIV/AIDS sub-section to be included into the annual national health report**. Preparation of the report is regulated under the GoG order # 229 as of August 10, 2010. This report intends to highlight the health status of the country population; evaluate resources available in health care system aimed at addressing major health problems; evaluate distribution of the key determinants of health including environmental, social, physical, mental, behavioral etc.; benchmark the trend in the status in Georgia against other countries in the European region. The report structure is subject to change annually. Annex 3 outlines key elements of the HIV/AIDS subsection of the report, which should present a narrative description of the epidemic, current trends, achievements, failures and recommendations on future actions aimed at strengthening national response.

b) **The National Aids Spending Assessment** will be conducted according to the UNAIDS guidelines and tools. The National AIDS Spending Assessment (NASA) will describe financial flows and expenditures using the same categories as the globally estimated resource needs. A data collection form to support the National Aids Spending Assessment is presented in annex 6. The data will be collected electronically using the Excel spreadsheet that will

simplify data analyses. The NASA will be conducted biennially in parallel with UNGASS reporting periods.

The ministerial staff with adequate experience and skills will coordinate preparing of aforementioned reports. Thus, these activities will be incorporated into the workload of the ministerial staff. However, additional technical input may be required to ensure that the technical reports are of adequate quality.

M&E staff positions at MoLHSA and description of roles and responsibilities can be found in annex 8.

Ministry of Education and Science

Implementation of HIV interventions aimed at youth will require active involvement of MoE&S in coordinating these efforts. Besides providing ongoing monitoring and evaluation of HIV and life style education activities, the MoE&S will contribute towards preparation of the UNGASS report by obtaining information on availability of drug and HIV prevention training courses at schools during the reporting period. Annex 5b presents a data collection form that may facilitate data collection on indicator #38-"Percentage of schools providing integrated drug and HIV prevention training course" (Modified UNGASS). The MoE&S will coordinate the data collection and submit this information to the designated department of MoLHSA.

Ministry of Corrections and Legal Assistance

MCLA will facilitate collection of required data on core indicators (e.g. Indicator #9) to track the progress in implementation of HIV interventions in prisons. In close collaboration with MoLHSA, NCDCPH, NGOs and research institutions the MCLA will be involved in planning and coordinating Behaviour Surveillance Surveys among prisoners.

2.1.3. Role of the National Center for Disease Control and Public Health

The role of NCDCPH in monitoring and evaluating HIV national response will be twofold as described below.

(1) NCDCPH will serve as a technical arm for the CCM to ensure effective functioning of the national HIV M&E system. A position of the national HIV M&E coordinator will be introduced at NCDCPH. The M&E coordinator, in close collaboration with the CCM technical secretariat, will be responsible for the overall coordination on the various data flows and the availability and easy access to the data. The NCDCPH M&E coordinator will use a national HIV/AIDS database as a warehouse to store monitoring and evaluation information, to undertake periodic and/or specific analysis of available data, and make the M&E Products easily available to stakeholders as required. Specific tasks to be accomplished by the NCDCPH M&E coordinator are outlined in annex 8.

(2) A core function of NCDCPH will be to coordinate the national HIV/AIDS surveillance system. The center through its HIV surveillance unit will fulfill the following functions:

- Oversight timeliness and quality of data obtained from entities participating in HIV/AIDS surveillance
- Identify shortcomings of the surveillance system and submit recommendations for improvement
- Analyse data (through appropriate IT infrastructure and software administration)
- Control quality of the information flow and provide digitalization of data
- Based on data analysis, generate reports, and conduct regular assessment and analyses of the epidemiological situation

- Identify needs for modifying data collection forms and any changes in data flows, and prepare recommendations for improvement
- Prepare recommendations on revisions needed to modify variables, indicators or definitions for epidemiological analysis.
- Prepare terms of reference and procure necessary services for updating HIV surveillance methodology as required.
- Run **the HIV National web portal** to ensure that all M&E products are collected and are easily available to all stakeholders. This will serve as a common platform at the country level for storage of M&E documents and publications. The national web portal will be housed at the NCDCPH and contain the following information:
    - Data from surveys and surveillance (Final reports)
    - Up-to-date registration information or a contact list of organizations involved in HIV programs and M&E
    - Data on available resources
    - Inventory of HIV research and researchers
    - Information on ongoing major HIV state of donor financed projects
    - Information on HIV capacity building activities
    - Information on HIV M&E advocacy and communication activities

M&E staff positions at NCDCPH and description of their roles and responsibilities are presented in annex 8.

2.2. Software options for M&E database management

There are various software options available, which are designed to support countries' monitoring and evaluation systems. The UNAIDS encourages use of the Country Response Information System (CRIS), which was originally designed to support UNGASS reporting but then evolved to more sophisticated tool which allows to facilitate the collection, reporting and analysis of program/projects' financial and indicator data related to the national response to HIV/AIDS. Some countries use CRIS to monitor national response. Others use it for UNGASS reporting or monitoring HIV response at local or programmatic level. The recent evaluation[17] of CRIS revealed the tool to be effective in terms of facilitating data collection and analyses, improving the quality of the data collected. Furthermore, it may facilitate programmatic planning and result-base decision making.

Despite noticeable advantages of CRIS over other databases (e.g. ability to capture non-clinical data and harmonize indicators across different sources and databases, flexibility to monitor a variety of indicators) its implementation may be prevented due to a lack of funds, lack of IT and M&E, lack of IT technologies and high turnover of trained staff. The most popular alternatives to CRIS include a country's own national monitoring system, Excel, SPSS, Access, or a paper-based system.

In Georgia, the CRIS has been implemented and used to facilitate preparation of the UNGASS report. The existence of separate databases such as the surveillance database, clinical database,[18] donor database and harm reduction network database makes the need for establishing effective linkages between all date sources more than obvious. In these circumstances installment of the CRIS at national level may seem promising it terms of achieving synergy and facilitating greater information exchange. However, the movement towards the development of health management information systems that is currently a top priority of the Georgian healthcare reform may open new opportunities for integration of HIV M&E mechanisms into the overall

17. Evaluation of CRIS for UNAIDS, EnCOMPASS, 2010. Retrieved from http://cris3.org/downloads/evaluation
18. based on the PostgreSQL tools

HMIS. Therefore, stakeholders agree that at this stage, when overall characteristics of the HMIS system are not fully defined, additional investment in IT and human resources to support the implementation of CRIS can hardly be justified. The HIV/AIDS database management needs should be addressed specifically in the National HMIS proposal. Meanwhile, the simple electronic tools (e.g. Google excel spreadsheets) will be used to facilitate data exchange between different national institutions and entities.

2.3. Indicator passports

Annex 2. presents a detailed description of each indicator (numerator and denominator if applicable, interpretation) and data sources in terms of responsibility for provision, recurrence and funding sources.

2.4. Production of M&E products

2.4.1. Data acquisition

This manual is not concerned with raw data collection and processing methodologies that are required for generating intermediate M&E products (table 7).[19] Whereas, it describes how already packed information on selected key indicators should reach individuals/entities responsible for elaborating final M&E products.

(a) A national HIV surveillance report that has to present findings on surveillance indicators will be prepared by the designated staff at NCDCPH. The report preparation should be guided by the HIV/AIDS national surveillance plan. Indicative outline for this report is also presented in annex 3b of this manual. The report should be finalized and submitted to the MoLHSA and CCM no later than March 31st of the next calendar year.

(b) HIV/AIDS M&E report presented as a **subsection**[20] of the national health report will be produced by the department of health of MoLHSA. This report intends to present a comprehensive set of information on achievements, shortfalls and lessons learned in implementation of the national response during the reporting period. The GoG order # 229 as of August 2010 will serve as a legal framework for this work and ensure that required data is timely provided by all relevant stakeholders. Table 6 presents major areas of interest to be reflected into the annual M&E report and data acquisition details.

Table 6. Data acquisition for producing an annual HIV M&E report

Area of interest	Data acquisition	Data flow	Submission deadlines
Preventive interventions	See protocol 4a- in annex 4 and data collection format for programmatic indicators in annex 5	From NCDCPH; MoE&S; MoCLA To MoLHSA	March 31st
Treatment, care and support	See protocol 4b and table T1 in annex 4	From AIDS center To MoLHSA	March 31st
Annual spending per NSP categories	See Annex 7	From Relevant donor agencies To MoLHSA	January 31st

19 . Consult National HIV surveillance plan (2010) and BSS methodological manual (2010) prepared with TGF support

20. It would be at discretion of CCM to prepare and publish the national HIV M&E report as a discrete piece of work

(c) As a signatory to the 2001 Declaration of Commitment on HIV/AIDS Georgia is required to submit **Country Progress report** to the UNAIDS Secretariat every two years. The UNGASS report represents most comprehensive set of standardized data on the status of the epidemic and progress on the HIV response. The UNAIDS provides detailed reporting requirements and instructions that should guide the report preparation. UNGASS report preparation requires participation of a wide range of stallholders and sound technical input to ensure that the final product is of high quality. The UNGASS report preparation will be coordinated by the CCM. The CCM with support of the NCDCPH national HIV M&E coordinator will organize stakeholder consultations and mobilize adequate financial and technical resources necessary for report writing.

(d) **National Aids Spending Assessment report**, which provides indicators of the financial country response to AIDS will be prepared biennially. The MoLHSA department of health will collect financial information according to the NASA categories. A data collection format is allocated in annex 6.

2.4.2. Key M&E products

The national HIV M&E system will generate a set of comprehensive M&E reports on the status of the epidemic and the progress on national response such as (a) A national report on HIV/AIDS surveillance; (b) National HIV/AIDS monitoring and evaluation report (to be integrated into the National Health report) and (c) UNGASS report. Those will be based on a number of intermediated M&E products e.g. routine and sentinel surveillance reports, operational research reports and etc. Key HIV M&E information products, frequency of production, responsible entities and related legal and administrative arrangement are outlined in table 7.

Table 7 Key information products

Information product	Frequency	Produced by	Methodology&Format	Related legal/administrative arrangements
Final				
A national report on HIV/AIDS surveillance	Annually (by April 1st of the next calendar year)	NCDCPH	HIV/AIDS National Surveillance Plan Outline is presented in annex 3b	The Ministerial order #217/o as of July 23, 2010
National Health Report-HIV/AIDS subsection	Annually (By June 1st of the next calendar year)	MoLHSA	Outline is presented in annex 3a	Regulated within the GoG order # 229 as of August 10, 2010
UNGASS report	Biennially	Commissioned by CCM, technical work coordinated by the NCDCPH M&E coordinator	UNGASS reporting guidelines as provided by UNAIDS	United Nations General assembly Declaration of Commitment on HIV/AIDS (2001 "Global Crisis-Global Action)
NASA	Biennially	Commissioned by CCM, technical work coordinated by the MoLHSA	UNAIDS NASA publications and tools	United Nations General assembly Declaration of Commitment on HIV/AIDS (2001 "Global Crisis-Global Action)

Information product	Frequency	Produced by	Methodology&Format	Related legal/administrative arrangements
Intermediate				
Routine surveillance reports (RSR)	Monthly	Primary medical facilities	HIV/AIDS National Surveillance Plan	The Ministerial order #217/o as of July 23, 2010
Program implementation reports(PIR)	Quarterly if not otherwise defined by a funding agency	Program implementers	To be defined at discretion of a funding agency	Relevant Grant Agreements Accountability requirements as defined by contractual arrangements
Sentinel Surveillance(SS) Report	Annual (As defined by the HIV/AIDS surveillance plan(Ministerial order as of July 23, 2010)	NCDCPH in cooperation with NGOs	HIV/AIDS National Surveillance Plan	The Ministerial order #217/o as of July 23, 2010
Behavior Surveillance Surveys (BSS)	Carried out biennially (if not planned otherwise by the HIV/AIDS NSP) on selected HIV/AIDS high risk populations.	NCDCPH in cooperation with NGOs, research institutions, AIDS center	HIV/AIDS National Surveillance Plan BSS methodological manual (2010)	The Ministerial order #217/o as of July 23, 2010 HIV/AIDS NSP for 2011-2016 (Adopted by the CCM)
Operational research reports	According to the national HIV research agenda for 2011-2016	Commissioned by CCM, implemented by NGOs&RIs	Outline is presented in annex 3c	HIV/AIDS NSP for 2011-2016 (Adopted by the CCM)
Population size estimation reports	Biennially (if not planned otherwise by the HIV/AIDS NSP	Commissioned by CCM implemented by NGOs& RIs	Outline is presented in annex 3c	HIV/AIDS NSP for 2011-2016 (Adopted by the CCM)

2.5. Dissemination of M&E products

All final M&E products as well as BSS and operational research reports will be publicly available and disseminated through the following sources:

1. HIV web portal at NCDCPH

The designated department of MoLHSA responsible to oversee the implementation of the national strategy will submit the national program implementation reports to the web administrators annually. Researchers and organizations working in the area of HIV/AIDS will be invited to register at the HIV national web site and submit completed research and/or programme implementation reports, which should be uploaded regularly. The HIV surveillance unit at NCDCPH will ensure that the national surveillance reports are available electronically to the web administrators. The web portal will be updated monthly.

2. Printed publications

Besides publishing M&E reports in the electronic format, there should printed copies available for those individuals who may have limited access to internet or find it difficult to navigate through digital resources. Entities responsible for producing final M&E products, BSS and operational research reports will be expected to make a limited amount of printed copies available. Printed copies should be stored at NCDCPH library and distributed to all interested parties on request. A request form will be available at NCDCPH HIV web-site.

3. Dissemination workshops

It is CCM's mandate to coordinate the dissemination and use of M&E data and information for national response. The CCM will organize national dissemination workshops attended by high level decision makers and other national and international stakeholders. These workshops will be devoted to discussing achievements, lessons learned and challenges faced on the way of implementation of the HIV national response.

3. Section 3: Georgia HIV/AIDS Monitoring and Evaluation System Operationalization Plan

This section focuses on the process of establishing and rolling out the national M&E system in Georgia and provides a detailed overview of the priority activities to be undertaken by all partners in the first three years of establishing the system. The plan intends to provide a common vision for all stakeholders and a single operational framework within which individual organizations can develop their approach and detailed working plans.

The operationalization plan groups activities into five major categories:

1. Coordination of National M&E system
2. Building and strengthening the technical capacity of the staff responsible for implementing the national M&E system
3. Phased implementation of specific surveillance activities
4. Evaluation and research
5. Advocacy and communication efforts

3.1. Coordination of National M&E system

In order to successfully accomplish its coordinating role it is highly desirable that the CCM systematically receives adequate technical support from the M&E Coordinator based at NCDCPH. An M&E coordinator should have adequate skills and competencies to fulfill all functions as described in the M&E framework and operational plan (see Annex 8 for details). Beside other responsibilities, the M&E coordinator will ensure that the M&E operationalization plan is reviewed and updated annually. In addition technical assistance will be solicited to support performance assessment of the national M&E system biennially. This assessment will help to analyze the M&E system implementation experience and to come up with a plan for improvements (see section 3.5. for details).

3.2. Need for capacity building

The National HIV M&E plan builds on existing structures and relies on the capacity of implementing partners to adequately coordinate, conduct and assess M&E activities. Capacity building of staff responsible for M&E at each partner organizations (including governmental and non-governmental agencies or private institutions) should include (1) organizing training courses as required; (2) providing technical assistance for developing M&E strategies and tools; (3) securing access to printed and electronic media sources on HIV M&E systems and data nationally and internationally; (4) participating in M&E reports dissemination events and conferences.

Although, operationalization of HIV M&E framework will be coordinated by the CCM (with technical support of the NCDCPH M&E coordinator) and managed by staff at designated departments of MoLHSA and NCDCPH, additional technical support may be required to deliver high quality M&E products. At a minimum, technical assistance should be solicited to support UNGASS report preparation including National AIDS Spending Assessment and financial gap analysis report. Other areas for potential technical input in developing key M&E elements described in table 1 (M&E framework) should be identified per request of responsible institutions if their capacity is considered inadequate.

3.3. Phased implementation of planned surveys and operational research

Besides routine surveillance system and programmatic data collection tools the national HIV M&E system will utilize surveys and operational research to monitor national response, evaluate coverage and quality of services and design new, more effective interventions. The NSP 2011-2016 identifies a comprehensive list of studies, which are essential for informing the national response. This includes:

- Throughout epidemiological research/analysis using routine surveillance data and other data sources (e.g. safe blood database, etc.) to derive conclusive evidence about the HIV/AIDS epidemic and its drivers
- Bio-BSS among high risk groups according to the national surveillance plan:
    - Bio-BSS among IDUs combined with size estimation studies
    - Bio-BSS among FSW
    - Bio-BSS among MSM
    - Bio-BSS among Prisoners
- Operational research to identify factors associated with HIV treatment outcomes
- Operational research to identify factors affecting adherence to ART
- Operational research to identify factors associated with late HIV diagnosis
- Operational research to evaluate MPTCT program implementation bottlenecks
- MPTCT coverage and quality assessment study combined with the Multiple Indicator Cluster Survey & and Women's Reproductive Health Surveys
- Operational research to identify barriers for IDUs (including female IDUs in accessing VCT services
- Operational research aimed at identifying key factors related to stigma and develop recommendations for evidence based interventions
- HIV Vulnerability study for labor migrants (mobile populations)
- Economic evaluation of selected curative and preventive interventions (e.g. economic evaluation of regional level laboratory staff performance under the curative program; peer-driven interventions among IDUs)

The following is the list of studies to be undertaken if sufficient funding is secured:

- Bio-BSS among MARA
- Population size estimation studies among FSWs and MSM
- Operational research on integration of HIV, TB and drug treatment services
- Assessment of care and support services
- Evaluate effectiveness of existing Behavior Change Communication interventions targeting MARPs in Georgia

The surveillance studies and operational research will be undertaken as scheduled within the NSP action plan for 2011-2013. The budget also includes additional funds to support operational research for topics that may emerge later throughout the implementation of the NSP.

3.4. Advocacy and communication for HIV/AIDS M&E

Effective advocacy and communication are integral elements for Georgia HIV/AIDS M&E framework and will require adequate operational support and funding. Advocacy efforts to influence and motivate senior-decision makers will be coordinated by the CCM. Line ministries will be responsible for communication and advocacy efforts that relate to HIV M&E for their

respective sectors. NCDCPH will lead communication and advocacy activities focused on effective implementation of the National HIV/AIDS Surveillance plan.

Basically, HIV/AIDS M&E advocacy and communication activities will include: (1) meetings and interactions with various stakeholders aimed at creating general understanding on the National HIV/AIDS M&E framework and plan; (2) setting and regularly updating National HIV/AIDS M&E webpage at NCDCPH website; (3) posting national HIV M&E reports at MoLHSA website annually; (4) printing and disseminating key M&E products including UNGASS, HIV annual surveillance, BSS and operational research reports to key audiences.

3.5. Needed funding

Budget for the HIV M&E operationalization plan is based on unit costs for M&E activities, which were used for NSP 2011-2016 cost calculations (See table 6).

Total estimated need for the three-year period amounts to US$1,797,193. Sixty percent of these funds will be devoted to supporting routine surveillance and behavior surveillance surveys. Almost one third of the budget will cover costs of operational research and the remaining 10% will be allocated to ensure adequate coordination of the national HIV M&E system (6%), human resource capacity building (1%) and advocacy and communication efforts (3%).

Estimated summary budget to support M&E activities in 2011-2013 in presented in table 8. Description of specific activities, responsible entities and implementing partners, as well as detailed costs and funding source can be found in annex 9.

Table 8. Unit Cost per different interventions

Cost item	Unit cost (US $)
Training in Tbilisi per participant per day	200
Training in Region per participant per day	88
Workshop/roundtable per day	185
Local Technical Assistance per month	4,100
International Technical Assistance per month	26,775
International conference/study tour per person	4,000
Web page maintenance per year	14,706
printing of flyers (per flyer)	0.10
Operational research and other surveys per OR	25,000
HIV/AIDS routine surveillance per year (2011)	80,806
HIV/AIDS routine surveillance per year (2012)	80,859
HIV/AIDS routine surveillance per year (2013)	80,912
BSS among IDUs combined with population size estimation studies (including test kits, injection supplies, field cost, data analysis, report preparation) per survey	40,000
BSS among CSWs per survey	25,000
BSS among MSMs per survey	30,000
BSS among prisoners per survey	15,000
BSS among MARAs per survey	20,000
KAP among Youth per survey	25,000
Population size estimation among CSWs and MSMa	45,000
Sentinel Surveillance among STI (including test kits, injection supplies, salaries, data reporting, transportation, confirmation)	12,500
printing of M&E reports	5

Table 9. Summary Budget-HIV M&E operatenatiozation plan for 2011-2013

	Activity	2011	2012	2013	Total cost (US $)
1	Coordination of national M&E system	**24,000**	**50,775**	**24,000**	**98,775.00**
2	Human resource capacity building	**8100**	**16300**	**8100**	**32,500.00**
3	Assure sustainable functionality of the national HIV/AIDS surveillance program	395,806	235,859	370,912	**1,002,576.47**
4	Conduct HIV/AIDS related operational research to inform policies and practice	188,430	181,455	94,404	**464,289.00**
5	Communication and Advocacy	17,946	15,446	15,446	**48,837.65**
	TOTAL	**634,282**	**499,835**	**512,862**	**1,646,978**
	TOTAL adjusted to inflation[21]	**665,996**	**551,068**	**593,701**	**1,810,765.08**

3.6. Financial Gap Analysis

For financial gap analyses the budget required for operationalization of the national M&E plan in 2011-2013 was compared with the available resources. The TGF round 10 Georgia grant and USAID/GHPP support will allow conducting all BSSs as planned. While routine surveillance costs should be mobilized from the state budget. Funding sources have yet to be identified for a majority of operational research activities and M&E coordination efforts. Funding shortfall depending on the operational research envelope ranges from 22 to 32% (US$ 390,700-575,700). Significant advocacy will be required to mobilize needed financial resources and to fill the existing gap.

21. At 5% inflation rate

Annexes

Annex 1. Organizations with HIV/AIDS monitoring and evaluation functions and M&E products generated currently

Organizations with M&E functions	Current M&E products
CCM	
• **Monitors ongoing the Global Fund's projects and other programs in relation with AIDS and Tuberculosis within the country, evaluates achievements and provides relevant recommendations.[22]** • **Utilizes M&E data for strategic planning** • **Identifies information gaps and set steps for meeting data requirement**	• UNGASS report prepared biennially
Ministry of Labor Health and Social Affairs	
• **Uses information for HIV/AIDS state health program planning** • **Monitors progress against HIV/AIDS programs objectives**	• Reports of HIV state programs implementation submitted to the MoF annually • National Health Accounts (incl. HIV/AIDS section) submitted to the GoG and WHO annually • Annual National Health Report (incl. HIV/AIDS section)
GHSPIC	
Monitors implementation of the Global Fund financed HIV/AIDS, TB and Malaria programs	Program implementation reports submitted to MoLHSA and CCM
Infectious disease, AIDS and Clinical Immunology Research Center	
• **Provides confirmatory testing and routine surveillance** • **Runs Country response information system database (CRIS)**	• Reports on implementation of the state health programs submitted to MoLHSA monthly • Report on implementation of the TGF financed projects to GHSPIC • Monthly reports to the NCDCPH according to the standardized surveillance procedures
National Center for Disease Control and Public Health	
• **Oversight timeliness and quality of data participating in HIV/AIDS surveillance** • **Identify shortcomings of the surveillance system and submit recommendations for improvement** • **Analyse data (IT infrastructure and software administration)** • **Controls quality of the information flow and provides digitalization of data** • **Based on data analysis, generate reports, and conducts regular assessment and analysis of the epidemiological situation** • **Identify needs for modifying data collection forms and any changes in data flows, and prepares recommendations for improvement** • **Prepare recommendations on revisions needed to modify variables, indicators or definitions for epidemiological analysis.** • **Prepare terms of reference and procure necessary services for updating HIV surveillance methodology as required.**	HIV/AIDS section for the Annual Health Statistics published by the NCDCPH.
Primary medical facilities[23] inc. Blood banks, addiction (narcology) services and STI services, medical services of the penitentiary system, hospital, ANC and VCTs etc.	
• **Provide routine and/or sentinel surveillance**	Monthly reports to the NCDCPH according to the standardized surveillance procedures
Non-governmental organizations	
(a) Conduct HIV testing to support surveillance **(b) Implement BSS** **(c) Implement HIV/AIDS prevention programs and generate program implementation reports**	(a) A behavioral surveillance study reports are submitted to the NCDCPH according to the standardized surveillance methodology (b) BSS report prepared (c) Program reports submitted to the funding agency and to the relevant department of MoLHSA and CCM(on request)
Donor agencies	
(a) Fund interventions aimed at mitigating the impact on HIV/AIDS **(b) Prepare program implementation reports**	Reports on financial allocations and program results are submitted to the MoLHSA and CCM

22. CCM ToR approved by the minister of labor, health and Social Affairs order N144/O of 01/05/2007
23. A full list and detailed descriptions of the roles of primary medical facilities is presented in the National HIV/AIDs Surveillance Plan.

Annex 2. Indicator passports

Strategic Area: Governance, policy &Advocacy

INDICATOR #1: Percentage of NSP needs funded

DESCRIPTION

Purpose: To monitor the flow of funding from all sources as a measure of financial commitment

Definition: The proportion of actual spending for the HIV national response in relation to the estimated NSP funding needs annually.

Numerator: Actual spending for HIV/AIDS national program annually

Denominator: Estimated funding needs for NSP annually

Unit of measure: Local currency (GEL); International Dollar (ID)

Disaggregated by: Strategic priorities; SDAs as per NSP

INTERPRETATION

This indicator provides a criteria to measure economic commitment of national and international partners for strengthening HIV national response.

PLAN FOR DATA ACQUISITION

Data Source(s): National and International funding agencies

Data Collection Method: Financial reports collected monthly and aggregated annually. (See Annex 7)

Frequency of Data Acquisition: Annual

Responsible Entities: MoLHSA

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Percentage of NSP needs funded	-	-

Location of Data Storage: MoLHSA

Indicator #2 :Domestic and international AIDS spending by categories and financing sources

DESCRIPTION

Purpose: To collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced

Definition: Domestic and international AIDS spending by categories and financing sources

Numerator: N/A

Denominator: N/A.

Unit of measure: Local currency (GEL); International Dollar (ID)

Disaggregated by: Strategic priorities; Service Delivery Areas; Funding sources (domestic, external)

INTERPRETATION

The financial data entered in the National Funding Matrix must be actual expenditures, not budgets or commitments. They must also include AIDS expenditures that were made as part of broader systems of service provision. The funding matrix should include spending by all major strategic areas in compliance with UNGASS reporting requirement.

PLAN FOR DATA ACQUISITION

Data Source(s): National/International funding agencies

Data Collection Method:

Resource Flow Survey

Data will be collected in compliance with the National AIDS Spending Assessment (NASA) methodology (see annex 6)

Frequency of Data Acquisition: Biennially

Responsible Entity: MoLHSA

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)**		**Target (2016)**	
AIDS spending by public sources	US $ 2,232,703	24.1%	-	%
AIDS spending by International sources (All)	US $ 6,154,005	66.5%	-	%
AIDS spending by private sources	US $ 866,661	9.4%	-	%

** *See UNGASS Georgia 2009 report for further details*

Location of Data Storage: MoLHSA

Reference: UNGASS indicator #1

Stigma and Discrimination

INDICATOR # 3: Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with HIV

DESCRIPTION

Purpose: To assess the attitudes of adult population toward HIV-positive individuals

Definition: The percent of people expressing accepting attitudes towards people with HIV, of all people surveyed aged 15-49

Numerator: number of women and men aged 15-49 who report accepting attitudes towards people living with HIV

Denominator: All respondents aged 15-49 who have heard of HIV

Unit of measure: Percentage.

Disaggregated by: sex and age (15–19, 20–24 and 25–49 years); and education level

INTERPRETATION

This indicator describes the general population attitude toward the HIV-infected, though may not be very sensitive in low prevalence populations. As such, this measure can track the success of media and education campaigns and can inform these ongoing efforts, in addition to care, treatment, and support programs within the same communities. Slow, absent, or negative change in attitudes highlight the need for more concerted or improved programs to change the community environments.

This indicator does not measure behaviors associated with attitudinal changes. While respondents might express a willingness to support the HIV-infected within their communities, actions anticipated with positive (or negative) answers are not measured with this indicator.

PLAN FOR DATA ACQUISITION

Data Source(s): Population-based survey report.

Data Collection Method: Respondents in a general population survey are asked a series of questions about people with HIV, as follows:

1. If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?
2. If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from them?
3. If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?
4. If a member of your family became infected with the AIDS virus, would you want it to remain a secret?

Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator. The denominator is all people surveyed who reported that they have ever heard of HIV.

Frequency of Data Acquisition: Every four years

Responsible entities: To be commissioned by CCM, the research to be implemented by NGOs/Universities

OTHER NOTES

Notes on Baselines/Targets:

	Baseline(2009)	Target(2016)
Percentage of women and men aged 15-49 expressing accepting attitudes towards people living with HIV	-	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

INDICATOR # 4: Level of stigma among health care workers

DESCRIPTION

Purpose: To assess the attitudes of healthcare workers toward HIV-positive individuals

Definition: Percent of people working in institutions/facilities (e.g., managers, health care workers) who are uncomfortable working with or treating PLHA.

Numerator: number of surveyed health care workers who disagree with at least three out of 6 statements (see below)

Denominator: total number of surveyed health workers.

Unit of measure: Percentage.

Disaggregated by: sex and age(25-45; >45); geographical location-By regions

INTERPRETATION

High level of stigma among health care workers may limit access to quality services for those infected with HIV. This indicator permits to measure the magnitude of the problem of stigma in health care settings and inform interventions to tackle it.

PLAN FOR DATA ACQUISITION

Data Source(s): KAP survey among health workers

Data Collection Method: Respondents are asked if they disagree with each statement:

I am comfortable assisting or being assisted by a colleague who is HIV infected.

I am comfortable performing surgical or invasive procedures on clients whose HIV status is unknown.

I am comfortable providing health services to clients who are HIV-positive.

I am comfortable sharing a bathroom with a colleague who is HIV-infected.

Clients who are sex workers deserve to receive the same level and quality of health care as other clients.

You avoid touching the clothing and belongings of clients known or suspected to have HIV for fear of becoming HIV-infected.

Frequency of Data Acquisition: 4 yearly

Responsible entities: MoLHSA, IO, NGOs

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2011)	Target (2016)
Level of stigma among health care workers	TBD	TBD after baseline

Location of Data Storage: NCDCPH (HIV Web Portal)

Policies

INDICATOR #5: National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)

DESCRIPTION

Purpose: Monitor compliance of HIV/AIDS national programs to the approved policy and strategy.

Definition: National Composite Policy Index: assesses progress in the development and implementation of national level HIV and AIDS policies, strategies and laws

Numerator: N/A

Denominator: N/A

Unit of measure: N/A.

Disaggregated by:N/A

INTERPRETATION

This indicator provides information on compliance of ongoing interventions aimed at HIV/AIDS with national policies and strategies.

PLAN FOR DATA ACQUISITION

Data Source(s): NCPI questionnaire

Data Collection Method: Assessment tool

The National Composite Policy Index questionnaire is divided into two parts, which cover the following areas:

Part A - to be administered to government officials

I. Strategic plan
II. Political support
III. Prevention
IV. Treatment, care and support
V. Monitoring and evaluation

Part B - to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations

I. Human rights
II. Civil society involvement
III. Prevention
IV. Treatment, care and support
Frequency of Data Acquisition: biennially.

Responsible Entities: CCM

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
NCPI	UNGASS Georgia report for 2008- 2009	NA

Location of Data Storage: CCM

Reference: UNGASS indicator #2

Strategic Area: Prevention

Testing and Counseling

INDICATOR # 6: Percentage of IDUs tested on HIV and know their results during last 12 months

DESCRIPTION

Purpose: To assess progress in HIV testing programs targeted at IDUs

Definition: Percentage of IDUs who received an HIV test in the last 12 months and who know the results.

Numerator: Number of IDUs respondents who have been tested for HIV during the last 12 months and who know the results

Denominator Number of IDUs included in the sample

Unit of measure: Percentage.

Disaggregated by: Age (<25; ≥25); Gender.

INTERPRETATION

This indicator allows receiving data on up-take of testing and counseling programs by IDUs.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: **Bio -** BSS standard questions:

Have you been tested on HIV during last 12 months?

If yes, did you receive the answer on test result?

Frequency of Data Acquisition: Biennially

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	Target (2016)
IDUs	5.7%	35%

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #8

Georgia National HIV Surveillance Plan, 2010, indicator #16

INDICATOR # 7: Percentage of FSWs tested on HIV and know their results during last 12 months

DESCRIPTION

Purpose: To assess progress in HIV testing and counseling programs targeted at FSWs

Definition: Percentage of FSWs who received an HIV test in the last 12 months and who know their results

Numerator: Number of FSWs respondents who have been tested for HIV during the last 12 months and who know the results

Denominator Number of FSWs included in the sample

Unit of measure: Percentage.

Disaggregated by: Age (<25; ≥25);

INTERPRETATION

This indicator allows receiving data on up-take of testing and counseling programs by FSWs. However, this group is hard to track due to high mobility and due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: **Bio -** BSS standard questions:

Have you been tested on HIV during last 12 months?

If yes, did you receive the answer on test result?

Frequency of Data Acquisition: Biennially

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
FSWs	27.5% Tbilisi; 23.3% Batumi	15% increase compared to baseline

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #8

Georgia National HIV Surveillance Plan, 2010, indicator #34

INDICATOR # 8: Percentage of MSM tested on HIV and know their results during last 12 months

DESCRIPTION

Purpose: To assess progress in HIV testing and counseling programs targeted at MSM

Definition: Percentage of MSM who received an HIV test in the last 12 months and who know their results

Numerator: Number of MSM respondents who have been tested for HIV during the last 12 months and who know the results

Denominator Number of MSM included in the sample

Unit of measure: Percentage.

Disaggregated by: Age (<25; ≥25);

INTERPRETATION

This indicator allows receiving data on up-take of testing and counseling programs by MSM. However, this group is hard to track due to high mobility and due to mobility and the hard-to-reach nature of these populations with many groups being hidden populations. Thus, information about the nature of the sample should be reported in the narrative to facilitate interpretation and analysis over time.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: **Bio -** BSS standard questions:

Have you been tested on HIV during last 12 months?

If yes, did you receive the answer on test result?

Frequency of Data Acquisition: Biennially

Responsible Entities): NCDCPH, NGOs

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2010)	**Target (2016)**
MSM	TBD	TBD after baseline

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #8
Georgia National HIV Surveillance Plan, 2010, indicator #45

INDICATOR # 9: Percentage of prisoners tested on HIV and know their results during last 12 months

DESCRIPTION

Purpose: To assess progress in HIV testing and counseling programs targeted at prisoners

Definition: Percentage of prisoners who received an HIV test in the last 12 months and who know their results

Numerator: Number of surveyed prisoners who have been tested for HIV during the last 12 months and who know the results

Denominator Number of prisoners included in the sample

Unit of measure: Percentage.

Disaggregated by: Age(<25; ≥25); Gender.

INTERPRETATION

This indicator allows receiving data on access to and up-take of testing and counseling programs by prisoners.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: **Bio -** BSS standard questions:

Have you been tested on HIV during last 12 months?

If yes, did you receive the answer on test result?

Frequency of Data Acquisition: Every 3 years (as planned according to the NSP)

Responsible entities(s): MCLA, MoLHSA

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2008)	**Target (2016)**
Prisoners	0.9%	60%

Location of Data Storage: NCDCPH (HIV Web Portal)

INDICATOR # 10: Percentage of MARA tested on HIV and know their results during last 12 months

DESCRIPTION

Purpose: To assess progress in HIV testing and counseling programs targeted at prisoners

Definition: Percentage of MARA who received an HIV test in the last 12 months and who know their results

Numerator: Number of MARA respondents who have been tested for HIV during the last 12 months and who know the results

Denominator Number of MARA included in the sample

Unit of measure: Percentage.

Disaggregated by: geographical location (By cities and by regions); gender; age groups (15–19, 20–24 and 15–24 years)

INTERPRETATION

This indicator allows receiving data on access to and up-take of testing and counseling programs by MARA.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: **Bio -** BSS standard questions:

Have you been tested on HIV during last 12 months?

If yes, did you receive the answer on test result?

Frequency of Data Acquisition: Biennially

Responsible Individual(s): NCDCPH, NGOs

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2012)	**Target (2016)**
MARA	TBD	TBD after baseline

Location of Data Storage: NCDCPH (HIV Web Portal)

INDICATOR # 11: HIV case detection rate among tested patients visiting STI clinics

DESCRIPTION

Purpose: To assess progress on reducing HIV prevalence among STI patients

Definition: Percentage of patients visiting STI clinics who are HIV positive

Numerator: Number of patients visiting STI clinics who test positive for HIV.

Denominator Number of patients visiting STI clinics tested on HIV

Unit of measure: Percentage.

Disaggregated by: Geographical location (By regions, and by cities); Age (<25; ≥25); Gender.

INTERPRETATION

There is substantial evidence of the bi-directional relationship between HIV infection and STI. This indicator allows to estimate HIV prevalence in high risk population attending STI clinics. Thus, it helps to improve the understanding of the epidemic.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV Surveillance database.

Data Collection Method: Routine surveillance

Frequency of Data Acquisition: Annually

Responsibleentities(s): NCDCPH

NOTES

Notes on Baselines/Targets:	**Baseline (BSS 2009)**	**Target (2016)**
HIV prevalence among tested patients visiting STI clinics	not available	-

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: Georgia National HIV Surveillance Plan, 2010, indicator #8

INDICATOR # 12: HIV case detection rate among tested patients visiting addiction services

DESCRIPTION

Purpose: To assess progress on reducing HIV prevalence among patients visiting addiction services.

Definition: Percentage of patients visiting addiction services who tested positive.

Numerator: Number of patients/clients visiting addiction services who tested positive

Denominator Number of patients/clients visiting addiction services who have been tested for HIV.

Unit of measure: Percentage.

Disaggregated by: geographical location (By regions, and by cities); age (<25; ≥25); gender.

INTERPRETATION

This indicator allows estimating HIV prevalence in high-risk population attending addiction services. Thus, it helps to improve the understanding of the epidemic.

PLAN FOR DATA ACQUISITION

Data Source(s):HIV Surveillance database.

Data Collection Method: Routine surveillance

Frequency of Data Acquisition: Annually

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline	**Target (2016)**
HIV prevalence among tested patients visiting addiction services	-	-

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: Georgia National HIV Surveillance Plan, 2010, indicator #8

Women and Children-PMTCT

Indicator 13: Number of vertical transmission of HIV cases identified among children < 1 year; and < 2 years;

DESCRIPTION

Purpose: To assess progress in preventing mother-to child transmission of HIV

Definition: This indicator measures the number of HIV positive children aged <1 ; <2 who were born to HIV positive mothers.

Numerator: Number of HIV positive children born to HIV positive mothers

Denominator: N/A

Unit of measure: number

Disaggregated by: Geographical location (By regions)

INTERPRETATION

This indicator permits to track progress in implementing PMTCT programs.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV Clinical Database

Data Collection Method: Data should be collected continuously at facility level and aggregated annually

Information will be collected about infants who were born to HIV positive mothers and tested positive by PCR method at least 2 times.

Frequency of Data Acquisition: data are collected continuously and analyzed annually.

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:	**Baseline (2009)**	**Target (2016)**
Number of vertical transmission of HIV cases among children < 1 year	1 child	0

Location of Data Storage: NCDCPH national HIV surveillance database (HIV Web Portal)

Note: Diagnosis should be confirmed according to the National guideline on HIV/AIDS

INDICATOR 14: Percentage of infants born to HIV-infected women (HIV-exposed infants) who are infected

DESCRIPTION

Purpose: To assess progress towards eliminating mother-to-child HIV transmission

Definition: This indicator describes the percent of infants born to HIV infected mothers and are HIV positive

Numerator: Number of infants born to HIV infected mother who are HIV infected

Denominator: Total number of infants born to HIV positive mothers

The indicator will be estimated based on SPECTRUM modeling.

Unit of measure: Percentage.

Disaggregated by: age group: those who received ARV therapy; treatment naïve group;

INTERPRETATION

This indicator focuses on prevention of mother-to-child transmission of HIV through increased provision of antiretroviral drugs. It should be noted that this indicator does not take into consideration the effect of breastfeeding on mother-to-child transmission of HIV. As a result, the indicator may yield underestimates of true rates of mother-to-child transmission in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of mother-to-child transmission of HIV (e.g., caesarean section) are widely practiced, the indicator will typically provide overestimates of mother-to-child transmission.

For further information on this indicator consult the following website: http://www.unaids.org/en/HIV_data/Methodology/defaut.asp

PLAN FOR DATA ACQUISITION

Data Source(s): Surveillance database

Data Collection Method: Data should be collected continuously at facility level and aggregated annually

Frequency of Data Acquisition: Annually

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
Percentage of infants born to HIV-infected women (HIV-exposed infants) who are infected*	0%	0

Location of Data Storage: NCDCPH national HIV surveillance database (HIV Web Portal)

Reference: UNGASS indicator #25

INDICATOR 15: **HIV prevalence among pregnant women**

DESCRIPTION

Purpose: To assess progress towards reducing HIV prevalence among pregnant

Definition: Share of HIV positive pregnant women in the total number of pregnant women of the same age tested during one year

Numerator: number of HIV positive pregnant women detected during one year

Denominator: total number of pregnant women who have got tested during one year

Unit of measure: Percentage.

Disaggregated by: Geographical location; age groups

INTERPRETATION

This indicator is a good proxy for describing the overall scale of the epidemic driven by a heterosexual mode of transmission in a state of a generalized epidemic. Therefore, the indicator is less reliable when the prevalence of the epidemic is low and the infection is mainly concentrated in MARPs.

PLAN FOR DATA ACQUISITION

Data Source(s): Routine and sentinel Surveillance database

Data Collection Method: HIV sero-sentinel surveillance

Frequency of Data Acquisition: Annual

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
HIV prevalence among pregnant women	0.02%	<0.03%

Location of Data Storage: NCDCPH (HIV Web Portal)

Georgia National HIV Surveillance Plan, 2010, indicator #12

INDICATOR 16: Percentage of pregnant women screened on HIV

DESCRIPTION

Purpose: To assess utilization of PMTCT services

Definition: This indicator describes the proportion of pregnant women who undergo screening on HIV antibodies during the pregnancy.

Numerator: Number of pregnant women who undergo screening on HIV during the pregnancy.

Denominator: Pregnant women registered at ANCs during the reporting period

Unit of measure: Percentage.

Disaggregated by: geographical location (By regions)

INTERPRETATION

This indicator provides a broad measure of service provision and gives an idea of coverage of ANC settings where PMTCT interventions are available. For PMTCT to be effective, it is necessary to know a woman's sero-status in order to tailor prevention and care to her needs. A successful PMTCT program will reach as many pregnant women as possible, and manage to convince them to take the test.

PLAN FOR DATA ACQUISITION

Data Source(s): Surveillance database

Data Collection Method:

For numerator information should be collected from antenatal clinics and other facilities where pregnant women undergo testing on HIV:

For denominator information should be collected about estimated number of pregnant women in the country based on ANC programme data

Frequency of Data Acquisition: Annually **Responsible Entities:** MoLHSA

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
% of pregnant women screened on HIV	100%	100%

Location of Data Storage: NCDCPH National HIV surveillance database (HIV Web Portal)

Reference: Georgia National HIV Surveillance Plan, 2010, indicator #13

INDICATOR 17: Percentage of newborns born to HIV positive mothers receiving complete course of ART prophylaxis

DESCRIPTION

Purpose: To assess progress in preventing vertical transmission of HIV

Definition: This indicator demonstrates percentage of newborns born to HIV positive mothers, who received complete course of ART prophylaxis

Numerator: number of newborns born to HIV positive mothers, who received complete course of ART prophylaxis during the reporting period (1 year).

Denominator: total number of newborns born to HIV-infected mothers during the reporting period (1 year)

Unit of measure: Percentage.

Disaggregated by: Regions

INTERPRATETION

The indicator permits monitoring trends in access to treatment services for HIV positive pregnant.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV clinical database.

Data Collection Method:

For numerator data includes the number of newborns born to HIV positive mothers which accessed ART during pregnancy. Data should be collected continuously from patient records and program reports and aggregated annually.

For denominator: Actual number of children born to HIV positive mothers.

Frequency of Data Acquisition: continuously

Responsible Entities: AIDS center

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Percentage of newborns born to HIV positive mothers receiving complete course of ART prophylaxis	100%	100%

Location of Data Storage: HIV/AIDS clinical database (AIDS center)& (HIV Web Portal)

INDICATOR 18: Percentage of HIV positive pregnant women receiving complete course of ART prophylaxis

DESCRIPTION

Purpose: To assess progress in preventing vertical transmission of HIV.

Definition: Percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis (according to the national ART protocol) to reduce MTCT in the last12 months.

Numerator: Number of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the likelihood of MTCT in accordance with nationally approved treatment protocol in the last 12 months.

HIV-infected women receiving any antiretroviral therapy, including specifically for prophylaxis, meet the definition for the numerator.

Denominator: Estimated number of HIV-infected pregnant women giving birth in the last 12 months

Two methods are possible for generating the estimate for the denominator.

1.Estimates generated by a projection model such as Spectrum;

2. Multiplying:

(a) The total number of women who gave birth in the last 12 months, which can be obtained from the Central Statistics Office estimates of births.

(b) The most recent national estimate of HIV prevalence in pregnant women, which can be derived from HIV surveillance antenatal clinic estimates.

Unit of measure: Percentage.

Disaggregated by: geographical location: age; regimen type

INTERPRETATION

This indicator permits monitoring trends in antiretroviral drug provision that addresses prevention of mother-to-child transmission.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV/AIDS clinical database

Data Collection Method: program monitoring records;

Frequency of Data Acquisition: Data will be collected continuously and aggregated annually

Responsible Entities: HIV/AIDS clinical database (AIDS center)& (HIV Web Portal)

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Percentage of HIV positive pregnant women receiving complete course of ART prophylaxis (estimated)	57.1%	100%
Percentage of HIV positive	96%	100%

pregnant women receiving complete course of ART prophylaxis (actual)		

Location of Data Storage: National Clinical Database (AIDS center) (HIV Web Portal)

Reference: UNGASS indicator #5

Prevention among MARPs including MARA

INDICATOR # 19: HIV prevalence among IDUs

DESCRIPTION

Purpose: To assess progress on reducing HIV prevalence among IDU population

Definition: Percent of IDU who test HIV positive

Nominator: number IDUs who test positive for HIV

Denominator: number of IDUs tested for HIV

Unit of measure: Percentage.

Disaggregated by: Age (<25/≥25) Gender.

INTERPRETATION

Prevalence rate among target groups/populations would provide information on the trend of HIV epidemic within these populations.

PLAN FOR DATA ACQUISITION

Data Source(s): BSS report

Data Collection Method: HIV antibody testing with confirmation

Frequency of Data Acquisition: Biannually

Responsibleentity(s): NCDCPH

OTHER NOTES

Notes on Baselines/Targets:	**Baseline (BSS 2009)**	**Target (2016)**
IDU	2.2%	<5%

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #23

Georgia National HIV Surveillance Plan, 2010, indicator #32

INDICATOR # 20: HIV prevalence among FSWs

DESCRIPTION

Purpose: To assess progress on reducing HIV prevalence among FSWs.

Definition: Percent of FSWs who test HIV positive

Numerator: number of FSWs who test positive for HIV

Denominator: number of FSWs tested for HIV

Unit of measure: Percentage.

Disaggregated by: Age (<25/≥25).

INTERPRETATION

Prevalence rate among target groups/populations over the year would tell us the trend of HIV epidemic within these populations.

PLAN FOR DATA ACQUISITION

Data Source(s): BSS reports

Data Collection Method: HIV antibody testing with confirmation

Frequency of Data Acquisition: Biennially

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
HIV prevalence among FSWs	Tbilisi 1.8%; Batumi 0.8%	<2%

Location of Data Storage: NCDCPH Surveillance Database(HIV Web Portal)

Reference: UNGASS indicator #23

Georgia National HIV Surveillance Plan, 2010, indicator #33

INDICATOR # 21: HIV prevalence among MSM

DESCRIPTION

Purpose: To assess progress on reducing HIV prevalence among MSM population

Definition: Percent of MSM who test HIV positive

Numerator: number of MSM who test positive for HIV

Denominator: number of MSM tested for HIV

Unit of measure: Percentage.

Disaggregated by: age (<25/≥25);

INTERPRETATION

Prevalence rate among target groups/populations over the year would provide information the trend of HIV epidemic within these populations.

PLAN FOR DATA ACQUISITION

Data Source(s): BSS reports

Data Collection Method: HIV antibody testing with confirmation

Frequency of Data Acquisition: Biennially

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2007)	**Target (2016)**
HIV prevalence among MSM	3.7%	<5%

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #23

Georgia National HIV Surveillance Plan, 2010, indicator #44

INDICATOR # 22: HIV prevalence among prisoners

DESCRIPTION

Purpose: To monitor needs of HIV prevention programs in prisons.

Definition: Proportion of prisoners who test HIV positive

Numerator: number of prison inmates who test positive for HIV

Denominator: number of prisoners tested for HIV

Unit of measure: Percentage.

Disaggregated by: Sex; Age (<25/≥25);

INTERPRETATION

Prevalence rate among target groups/populations over the year would provide information on the trend of HIV epidemic within these populations.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report

Data Collection Method: HIV antibody testing (BSS reports)

Frequency of Data Acquisition: Biennially

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
HIV prevalence among prisoners	1.4%	<2%

Location of Data Storage: NCDCPH (HIV Web Portal)
Georgia National HIV Surveillance Plan, 2010, indicator #10

INDICATOR # 23: HIV prevalence among MARA

DESCRIPTION

Purpose: To assess progress on reducing HIV prevalence among MARA population

Definition: Proportion of MARA who test HIV positive

Numerator: number of MARA who test positive for HIV

Denominator: number of MARA tested for HIV

Unit of measure: Percentage.

Disaggregated by: Sex and age (15-19 and 20-24 years);

INTERPRETATION

Prevalence rate among target groups/populations would provide information on the trend of HIV epidemic within these populations.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report

Data Collection Method: HIV antibody testing (BSS reports)

Frequency of Data Acquisition: Baseline in 2012, Every 4 years

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2011)	**Target (2016)**
HIV prevalence among MARA	TBD	TBD after baseline

Location of Data Storage: NCDCPH (HIV Web Portal)

Georgia National HIV Surveillance Plan, 2010, indicator #14

INDICATOR # 24: Percentage of FSWs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

DESCRIPTION

Purpose: To assess progress in building knowledge of the essential facts about HIV transmission among FSWs

Definition: Proportion of FSWs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Numerator: number of FSW respondents who gave the correct answers to selected questions.

Denominator: number of surveyed FSWs who gave answers, including "don't know", to all four questions.

Unit of measure: Percentage.

Disaggregated by: Age (<25/≥25);

INTERPRETATION

This indicator allows for easy measurement of incremental improvements over time in knowledge about HIV and AIDS. It is important to estimate the proportion of people who reject this and who correctly identify ways of HIV transmission. The belief that a healthy looking person cannot be infected with HIV, contributes to the further spread of the epidemic via unprotected intercourse. This indicator will specifically address a common misconception in Georgia that a person with AO type of blood cannot be infected with HIV.

For further details please consult "Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2010 reporting."

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method:

(1) BSS standard questions modified for Georgia

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?

2. Can using condoms reduce the risk of HIV transmission?

3. Can a healthy-looking person have HIV?

4. Can a person with the first blood group get infected with HIV and STI?

Frequency of Data Acquisition: Every two year.

Responsible entity: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of FSWs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS standard questions)	7.0%	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #14

Georgia National HIV Surveillance Plan, 2010, indicator #36

INDICATOR # 25: Percentage of MSMs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

DESCRIPTION

Purpose: To assess progress in building knowledge of the essential facts about HIV transmission among MSM

Definition: Proportion of MSM who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Numerator: number of MSM respondents who gave the correct answers to selected questions.

Denominator: number of surveyed MSM respondents who gave answers, including "don't know", to all four questions (National).

Unit of measure: Percentage.

Disaggregated by: Age (<25/≥25)

INTERPRETATION

This indicator allows for easy measurement of incremental improvements over time in knowledge about HIV and AIDS. It is important to estimate the proportion of people who reject this and who correctly identify ways of HIV transmission. The belief that a healthy looking person cannot be infected with HIV, contributes to the further spread of the epidemic via unprotected intercourse. This indicator will specifically address a common misconception in Georgia that a person with the A type of blood cannot be infected with HIV.

For further details please consult "Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2010 reporting."

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method:

(1) BSS standard questions modified for Georgia

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?

2. Can using condoms reduce the risk of HIV transmission?

3. Can a healthy-looking person have HIV?

4. Can a person with the first blood group get infected with HIV and STI?

Frequency of Data Acquisition: Every two year.

Responsible entity: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2007)	**Target (2016)**
Percentage of MSM who	25%	TBD

correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS)		

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #14
Georgia National HIV Surveillance Plan, 2010, indicator #33

INDICATOR # 26: Percentage of IDUs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

DESCRIPTION

Purpose: To assess progress in building knowledge of the essential facts about HIV transmission among IDUs

Definition: Proportion of IDUs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Numerator: number of IDU respondents who gave the correct answers to selected questions.

Denominator: number of surveyed IDUs who gave answers, including "don't know", to all six questions .

Unit of measure: Percentage.

Disaggregated by: sex and age (<25/≥25);

INTERPRETATION

This indicator allows for easy measurement of incremental improvements over time in knowledge about HIV and AIDS. The standard BSS questions were modified to address common misconceptions among IDUs in Georgia.

For further details please consult "Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2010 reporting."

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method:

(1) BSS standard questions modified for Georgia

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person contract HIV from sharing injection equipment?
5. Can a person contract HIV from sharing injection attributes (container/cotton swab/filter/water)

and injecting a substance from a common container, which was prepared in his absence.

6. Can an injecting drug user prevent himself from getting HIV if switches to non-injecting drug use?

Frequency of Data Acquisition: Every two year.

Responsible entity: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of IDUs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS)	37.5%	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #14
Georgia National HIV Surveillance Plan, 2010, indicator #30

INDICATOR # 27: Percentage of FSWs reporting the use of a condom with their most recent client

DESCRIPTION

Purpose: To assess progress in preventing exposure to HIV among female sex workers through unprotected sex with clients

Definition: Proportion of FSWs reporting the use of a condom with their most recent client

Numerator: number of FSW respondents who reported that a condom was used with their last client

Denominator: number of FSW respondents who reported having commercial sex in the last 12 months

Unit of measure: Percentage.

Disaggregated by: age (<25/≥25);

INTERPRETATION

This indicator reflects a safe sex behavior among FSWs.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard question:

Did you use a condom with your most recent client?

Frequency of Data Acquisition: Biennially

Responsible entities(s): NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	Target (2016)
Percentage of FSWs reporting the use of a condom with their most recent client	98.8% in Tbilisi 92.5% in Batumi	100%

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #18
Georgia National HIV Surveillance Plan, 2010, indicator #38

INDICATOR # 28: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner*

DESCRIPTION

Purpose: To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner

Definition:

Numerator: number of MSM respondents who reported that a condom was used the last time they had anal sex

Denominator: number of MSM respondents who reported having had anal sex with a male partner in the last six months.

Unit of measure: Percentage.

Disaggregated by: age (<25/≥25);

INTERPRETATION

For men who have sex with men, condom use at last anal sex with any partner gives a good indication of overall levels and trends of protected and unprotected sex in this population.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions:

Respondents are asked about sexual partnerships in the preceding six months, about anal sex within those partnerships and about condom use when they last had anal sex.

Frequency of Data Acquisition: Biennially

Responsible Entities: NCDCPH, NGOs

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2007)	Target (2016)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	61.7%	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #19

Georgia National HIV Surveillance Plan, 2010, indicator #49

INDICATOR # 29: Percentage of IDUs reporting the use of a condom the last time they had sex with paid for sex partners

DESCRIPTION

Purpose: To assess progress in preventing sexual transmission of HIV in IDU population

Definition:

Numerator: number of surveyed IDUs who reported that a condom use the last time they had sex.

Denominator: number of surveyed IDUs who report having had sexual intercourse in the last month

Unit of measure: Percentage.

Disaggregated by: sex and age (<25/≥25);

INTERPRETATION

This indicator provides partial information on the patterns of sexual mixing and condom use among injecting drug users and between injecting drug users and the wider population.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions:

Have you injected drugs at any time in the last month?

If yes: Have you had sexual intercourse in the last month?

If yes in answer to both 1 and 2: Did you use a condom when you last had sexual intercourse?

Frequency of Data Acquisition: Biennially

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of IDUs reporting the use of a condom the last time they has sex with paid for sex partners	Tbilisi 87.7%	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #20

Georgia National HIV Surveillance Plan, 2010, indicator #29

INDICATOR # 30: Percentage of IDUs reporting the use of sterile injecting equipment the last time they injected

DESCRIPTION

Purpose: To assess progress in preventing injecting drug use-associated HIV transmission

Definition:

Numerator: number of IDU respondents who report using sterile injecting equipment the last time they injected drugs.

Denominator: number of IDU respondents who report injecting drugs in the last month.

Unit of measure: Percentage.

Disaggregated by: Gender and age (<25/≥25);

INTERPRETATION

This indicator provides information on the degree to which injecting drug users use contaminated injecting equipment.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions:

Have you injected drugs at any time in the last month?

If yes: The last time you injected drugs, did you use a sterile needle and syringe?

Frequency of Data Acquisition: Biennially

Responsible entity: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of IDUs reporting the use of sterile injecting equipment the last time they injected	48.1%	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #21

Georgia National HIV Surveillance Plan, 2010, indicator #24

INDICATOR # 31: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

DESCRIPTION

Purpose: To assess progress towards universal knowledge of the essential facts about HIV transmission

Definition: The indicator reflects a level of understanding of the essential facts about HIV

Numerator: number of respondents aged 15-24 years who gave the correct answer to all selected questions

Denominator: total number of of all respondents aged 15–24.

Unit of measure: Percentage.

Disaggregated by: Gender and age (15-19 and 20-24 years)

INTERPRETATION

This indicator permits to measure knowledge about HIV and AIDS and identify major misconceptions that can result in unsafe behaviors or S&D.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions (UNGASS modified):

1) Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
2) Can a person reduce the risk of getting HIV by using a condom every time they have sex?
3) Can a healthy-looking person have HIV?
4) Can a person get HIV by sharing food with someone who is infected?

Frequency of Data Acquisition: Every three years

Responsible Entity: NCDCPH, NGOs

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2011)	**Target (2016)**
Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	TBD	TBD after baseline

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #13

INDICATOR # 32: # of opioid-dependent people covered by AMT

DESCRIPTION

Purpose: To assess progress in implementation of AMT programs

Definition: number of opioid-dependent people covered by Agonist Maintenance Therapy

Numerator: number of opioid-dependent people covered by Agonist Maintenance Therapy

Denominator: NA

Unit of measure: number

Disaggregated by: Gender and age (<25/≥25); geographical location.

INTERPRETATION

This indicator allows monitoring progress in implementation of AMT programs for opioid dependent people

PLAN FOR DATA ACQUISITION

Data Source(s): Program implementation reports

Data Collection Method: Program reports submitted to the funding agencies and to the relevant department of MoLHSA

Frequency of Data Acquisition: Annual

Responsible Individual(s): M&E Specialist, Addiction Treatment Technical Expert.

OTHER NOTES

Notes on Baselines/Targets:

	Baseline 2009)	**Target (2016)**
# of IDUs including inmate IDUs covered by AMT	1985	4100

Location of Data Storage: Addiction treatment facilities/MoLHSA (HIV Web Portal)

INDICATOR # 33: # of drug dependent people covered by drug dependence treatment services

DESCRIPTION

Definition: To assess progress in implementation of addiction treatment programs

Numerator: number of drug dependent people covered by drug dependence treatment services

Denominator: NA

Unit of measure: Number

Disaggregated by: Gender and age (<25/≥25); geographical location (By cities and by regions), By funding sources

PLAN FOR DATA ACQUISITION

Data Source(s): Administrative data

Data Collection Method: Program reports submitted to the funding agencies and to the relevant department of MoLHSA

Frequency of Data Acquisition: Annual

Responsible Individual(s): M&E Specialist, Addiction Treatment Technical Expert.

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
# of drug dependent people covered by drug dependence treatment services	900	1400

Location of Data Storage: MoLHSA (HIV Web Portal)

INDICATOR # 34: Percentage of injecting drug users (IDU) reached with HIV prevention programs in the last 12 months

DESCRIPTION

Purpose: To assess progress in implementing basic elements of HIV prevention programmes for IDUs

Definition: % of IDUs know where to get confidential test on HIV and received condoms and sterile needles/ syringes from preventive programs in the last 12 months

Numerator: Number of IDU respondents who replied "yes" to all three questions (see below)

Denominator: total number of IDUs surveyed.

Unit of measure: Percentage.

Disaggregated by: Gender and age (<25/≥25);

INTERPRETATION

This indicator permits to measure the degree to which IDUs can be reached by HIV prevention programs. However, it gives no indications on quality or comprehensiveness of services.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions:

Do you know where you can go if you wish to receive an HIV test?

In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

In the last twelve months, have you been given sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle exchange programme)?

Frequency of Data Acquisition: Biennially

Responsible entity(ies): NCDCPH, NGOs

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of injecting drug users (IDU) reached with HIV prevention programs in the last 12 months	4.6%	20%

Location of Data Storage: NCDCPH(HIV Web Portal)

Reference: UNGASS indicator #9

Georgia National HIV Surveillance Plan, 2010, indicator #17

INDICATOR # 35: Number of syringes/needles distributed per injecting drug user per year

DESCRIPTION

Purpose: To assess progress in implementation of needle exchange programs
Definition: This indicator gives an idea of the sufficient commodities to protect every injection by illicit injectors.
Numerator: number of sterile injecting equipment distributed by preventive programs during last 12 months
Denominator: Estimated total number of IDUs

Unit of measure: Number

Disaggregated by: Gender and age (<25/≥25); geographical location: by cities and by regions

INTERPRETATION

The indicator measures uptake of preventive interventions by IDUs. In, 2009 the median number of syringes distributed annually by needle and syringe programmes per injecting drug use was about 24.4 in Europe, far below the internationally recommended target of 200 syringes per injecting drug user per year. Data for this indicator are not currently available in Georgia.

PLAN FOR DATA ACQUISITION

Data Source(s): Program implementation reports

Data Collection Method: Program reports submitted to the funding agencies and to the relevant department of MoLHSA

Frequency of Data Acquisition: Annual

Responsible Entities: MoLHSA

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Number of syringes/needles distributed per injecting drug user per year by NSP	Data not available	TBD

Location of Data Storage: MoLHSA(HIV Web Portal)

INDICATOR # 36: Percentage of sex workers (SW) reached with HIV prevention programs in the last 12 months

DESCRIPTION

Purpose: To assess progress in implementing basic elements of HIV prevention programmes for FWSs

Definition: % of SWs know where to get confidential test on HIV and received condoms from preventive programs in the last 12 months

Numerator: Number of SW respondents who replied "yes" to both questions (see below)

Denominator: total number of SWs surveyed.

Unit of measure: Percentage.

Disaggregated by: age (<25/≥25);

INTERPRETATION

This indicator permits to measure the degree to which FSWs can be reached by HIV prevention programs. However, it gives no indications on quality or comprehensiveness of services.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions:

Do you know where you can go if you wish to receive an HIV test?

In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

Frequency of Data Acquisition: Biennially

Responsible Entity: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of sex workers (SW) reached with HIV prevention programs in the last 12 months	75%	80%

Location of Data Storage: NCDCPH(HIV Web Portal)

Reference: UNGASS indicator #8

Georgia National HIV Surveillance Plan, 2010, indicator #35

INDICATOR # 37: Percentage of men who have sex with men (MSM) reached with HIV prevention programs in the last 12 months

DESCRIPTION

Purpose: To assess progress in implementing basic elements of HIV prevention programmes for MSM

Definition: % of MSM know where to get confidential test on HIV and received condoms from preventive programs in the last 12 months

Numerator: Number of MSM respondents who replied "yes" to both questions (see below)

Denominator: total number of MSM surveyed.

Unit of measure: Percentage.

Disaggregated by: age (<25/≥25)

INTERPRETATION

This indicator permits to measure the degree to which MSM can be reached by HIV prevention programs. However, it gives no indications on quality or comprehensiveness of services.

PLAN FOR DATA ACQUISITION

Data Source(s): Behavior Surveillance Surveys (BSS) report.

Data Collection Method: BSS standard questions:

Do you know where you can go if you wish to receive an HIV test?

In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

Frequency of Data Acquisition: Biennially

Responsible entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2007)	**Target (2016)**
Percentage of men who have sex with men (MSM) reached with HIV prevention programs in the last 12 months	66%	TBD

Location of Data Storage: NCDCPH (HIV Web Portal)

Reference: UNGASS indicator #8

Georgia National HIV Surveillance Plan, 2010, indicator #46

Healthy life-style Education

INDICATOR # 38: Percentage of schools providing integrated drug and HIV prevention training course

DESCRIPTION

Purpose: To assess progress towards implementing integrated drug and HIV related education at schools.

Definition: % of schools with integrated drug and HIV prevention training course into Education Plan

Numerator: number of schools providing drug and HIV prevention training courses in the last academic year

Denominator: total number of schools

Unit of measure: Percentage

Disaggregated by: geographical location (by regions)

INTERPRETATION

This indicator provides information on trends in the coverage of drug and HIV education within schools.

PLAN FOR DATA ACQUISITION

Data Source(s): Ministry of Education, Program implementation reports

Data Collection Method: Program reports submitted to the funding agencies and to the relevant department of MoE&S

Frequency of Data Acquisition: Annual

Responsible entinties(s): Ministry of education and science

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Percentage of schools providing integrated drug and HIV prevention training course	N/A	20%

Location of Data Storage: Ministry of Education and Science/MoLHSA (HIV Web Portal)

Reference: UNGASS indicator modified

Prevention in healthcare setting

INDICATOR 39: HIV prevalence among blood donors

DESCRIPTION

Purpose: To assess progress in preventing transmission on HIV in healthcare settings

Definition: indicator describes the percentage of blood donors who were screened positive on HIV antibodies and results confirmed

Numerator: number of donors who were positive on HIV

Denominator: total number of donors who were screened on HIV.

Unit of measure: Percentage.

Disaggregated by: geographical location(regions); age(<25;≥25); gender.

INTERPRETATION

The indicator allows receiving the data on potential donors who tested positive for HIV.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV Surveillance database

Data Collection Method: Screening program monitoring reports

Numerator should include all donors who were screened positive on HIV and results were confirmed by Western Blot method

Denominator should include information about the number of donors who were screened on HIV from all blood banks/screening laboratories.

Frequency of Data Acquisition: annual.

Responsible Entities: M&E Specialist, MoLHSA.

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (BSS 2009)	**Target (2016)**
Prevalence among blood donors	0.013%	**TBD**

Location of Data Storage: NCDCPH (HIV Web Portal)

INDICATOR 40*:* Percentage of voluntary donors

DESCRIPTION

Purpose: To assess progress in promoting voluntary blood donorship aimed at enhanced blood safety

Definition: describes the portion of voluntary donors who gave their blood in a voluntary bases without any reimburse or other reasons (do not include family replacement donors who gave blood without any reimbursement)

Numerator: number of blood donors who gave blood without reimbursement during reporting year.

Denominator: total number of blood donors in the country during reporting year.

Unit of measure: Percentage.

Disaggregated by: Geographical location (by regions), Age (<25; ≥25) gender.

INTERPRETATION

This indicator would permit to track progress in programs aimed at blood safety. In Georgia, a share of voluntary blood donation is low and growing slowly. In 2008, commercial donors provided 85% of blood. A low HIV prevalence rate among donors shows that commercial donorship in Georgia is not affiliated with the high risk for HIV infection commonly seen in the neighboring countries. Nonetheless, the HIV NSP for 2011-2016 considers promotion of voluntary blood donation, along with QA systems for labs, as an important step for increasing blood and blood products safety.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV surveillance database.

Data Collection Method: standard screening:

Numerator should include information of all blood donors who donate blood for free all over the country (excluding paid and family replacement donors)

Denominator should include information about all donors who donate the blood during reporting period (including voluntary, paid and family replacement donors)

Frequency of Data Acquisition: Annual

Responsible Entities:, NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
% of voluntary donors	4%	30%

Location of Data Storage: NCDCPH (HIV Web Portal)

INDICATOR 41: Percentage of blood units screened for HIV in a quality assured manner

DESCRIPTION

Purpose: To assess progress in screening of blood donations in a quality-assured manner
Definition: This indicator gives an idea of the overall percentage of blood units that have been screened to sufficiently high standards that can be confidently declared as HIV free.
Numerator: Number of donated blood units screened for HIV in a quality assured manner. For the purposes of data collection screening in a quality assured manner is defined as screening performed in blood centers/blood screening laboratories that (i) follow documented standard operating procedures *and* (ii) participate in an external quality assurance (EQA) scheme.
Denominator: Total number of blood units donated (donation refers to any blood collected for the purposes of medical use. This includes all possible types of providers of blood, regardless of whether they receive remuneration or not).
Unit of measure: Percentage.
Disaggregated by: geographical location:

INTERPRETATION

If the blood screening laboratory follows documented and standardized procedures for the screening of blood, this implies a certain level of uniformity, reliability and consistency of performance by staff trained to use the standard operating procedures. If a blood screening laboratory participates in an External Quality Assurance Scheme, this implies that the quality of HIV screening performed is being assessed at regular intervals. It is important to view the percentage of screened blood units in relation to these two basic components of quality as both are required to ensure the quality of procedures.

PLAN FOR DATA ACQUISITION

Data Source(s): program reports
Data Collection Method: The information relates to data from the previous 12 months (January–December).
The following information is required to measure the indicator:
1. The total number of blood units that were donated in the country
2. For each blood centre and blood screening laboratory that screens donated blood for HIV: i. The number of units of blood donated in each blood centre/ blood screening laboratory; ii. The number of donated units screened in the blood centre/blood screening laboratory; iii. If the blood centre/blood screening laboratory followed documented standard operating procedures for HIV screening; iv. If the blood centre/blood screening laboratory participated in an External Quality Assessment Scheme for HIV screening.
This information should be available from the National Blood Transfusion Service or the officers responsible for the National Blood Program in the Ministry of Health
Frequency of Data Acquisition: Annual
Responsible Entities:, MoLHSA.

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
% of donated blood units screened for HIV in a quality assured manner	0	100%

Location of Data Storage: MoLHSA (HIV Web Portal)

Reference: UNGASS indicator #3

Strategic Area: Treatment

Antiretroviral therapy

INDICATOR 42: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

DESCRIPTION

Purpose: To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy

Definition: This indicator measures the retention on ART related to the increase in survival and willingness to continue ART. It should be produced at 12 months and then yearly after the beginning of ART. It completes program coverage by a measure of the effectiveness.

Numerator: Number of adults and children who are still alive and on ART at 12 months after initiating treatment

Denominator: Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period,* including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 12.

Unit of measure: Percentage.

Disaggregated by:; age (<15 and more than 15); gender, risk groups: MSM, FSWs, IDUs

INTERPRETATION

This indicator allows estimating the effectiveness of ARV therapy; however, change in this indicator does not explain reasons for the change. The magnitude of the effect depends on the baseline characteristics of the cohort of patients at the start of antiretroviral therapy: mortality will be higher in sites where patients accessed antiretroviral therapy at a later stage of infection.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV/AIDS clinical database.

Data Collection Method: As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at least 12 months of treatment should then be aggregated.

If the reporting period is January 1st to December 31st , the indicator includes all patients who started antiretroviral therapy from January 1st to December 31st of the previous year by checking their outcome at 12 months of the next(reporting) year .

Responsible Entities: AIDS center/Clinical database

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Percentage of adults and	81% (158/195)	>85%

children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		

Location of Data Storage: National AIDS clinical database/AIDS center(HIV Web Portal)

Reference: UNGASS indicator #24

Georgia National HIV Surveillance Plan, 2010, indicator #15

INDICATOR 43: Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy

DESCRIPTION

Purpose: To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.

Definition: This indicator measures the retention on ART related to the increase in survival and willingness to continue ART. It should be produced at 24 months and then yearly after the beginning of ART. It completes program coverage by a measure of the effectiveness.

Numerator: Number of adults and children who are still alive and on ART at 24 months after initiating treatment.

Denominator: Total number of adults and children who initiated ART who were expected to achieve 24-month outcomes within the reporting period,* including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 24.

Unit of measure: Percentage.

Disaggregated by: target groups: MSM, FSWs, IDUs; Age; Gender

INTERPRETATION

This indicator provides a good picture of the long-term effectiveness and quality of antiretroviral therapy programs.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV/AIDS clinical database.

Data Collection Method: As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at 24 months of treatment should then be aggregated.

If the reporting period is January 1st to December 31st , this indicator includes

all patients who started antiretroviral therapy from January 1st to December 31st of X year by checking their outcome at 24 months.

Responsible Entities: AIDS center

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
Percentage of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	69% (93/134)	>85%

Location of Data Storage: National AIDS clinical database/AIDS center(HIV Web Portal)

Georgia National HIV Surveillance Plan, 2010, indicator #15

INDICATOR 44: Percentage of adults and children with HIV known to be on treatment 36 months after initiation of antiretroviral therapy

DESCRIPTION

Purpose: To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.

Definition: This indicator measures the retention on ART related to the increase in survival and willingness to continue ART. It should be produced at 24 months and then yearly after the beginning of ART. It completes program coverage by a measure of the effectiveness.

Numerator: Number of adults and children who are still alive and on ART.

Denominator: Total number of adults and children who initiated ART who were expected to achieve 36-month outcomes within the reporting period,* including those who have died since starting ART, those who have stopped ART, and those recorded as lost to follow-up at month 36.

Unit of measure: Percentage.

Disaggregated by: target groups: MSM, FSWs, IDUs; Age (<15;15+); Gender

INTERPRETATION

This indicator provides a good picture of the long-term effectiveness of and quality of antiretroviral therapy programs.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV/AIDS clinical database.

Data Collection Method: As patients start antiretroviral therapy, monthly cohort data should be collected continuously for these patients. Data for monthly cohorts that have completed at 36 months of treatment should then be aggregated.

If the reporting period is January 1st to December 31st , this indicator includes

all patients who started antiretroviral therapy from January 1st to December 31st of X year by checking their outcome at 36 months.

Responsible Entities: AIDS center

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
Percentage of adults and children with HIV known to be on treatment 36 months after initiation of antiretroviral therapy*	72% (98/136)	>80%

Location of Data Storage: National AIDS clinical database/AIDS center (HIV Web Portal)

Georgia National HIV Surveillance Plan, 2010, indicator #15

INDICATOR 45: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

DESCRIPTION

Purpose: To assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection.

Definition: This indicator measures the percentage of adults and children with advanced HIV infection receiving antiretroviral therapy to assess progress towards providing antiretroviral combination therapy to all people with advanced HIV infection.

Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol at the end of the reporting period.

Consult UNGASS guidelines on construction of core indicators for further details on numerator.

Denominator: Estimated number of adults and children with advanced HIV infection. The denominator is generated by estimating the number of people with advanced HIV infection requiring (in need of/eligible for) antiretroviral therapy.

The denominator is generated by estimating the number of people with advanced HIV infection requiring (In need of/eligible for)antiretroviral therapy. This estimation must take into consideration the current number of people with HIV, current number of patients on antiretroviral therapy.

Eligibility for antiretroviral therapy will be determined on the basis on CD4<200 criterion (as specified by the national treatment guideline). This definition for the denominator will be revised if the new eligibility criterion (CD<350) is introduced.

Unit of measure: Percentage.

Disaggregated by: Age (<15; 15+); gender; target groups: MSM, FSWs, IDUs;

INTERPRETATION

This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of antiretroviral therapy or to measure the cost, quality or effectiveness of treatment provided. The degree of utilization of antiretroviral therapy will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counseling

and testing services, and perceptions of effectiveness and possible side effects of treatment.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV/AIDS clinical database.

Data Collection Method: Data should be collected continuously at the facility level.

Responsible Entities: AIDS center

OTHER NOTES

Notes on Baselines/Targets:

<table>
<tr><td></td><td colspan="2">Baseline (2009)</td><td>Target (2016)</td></tr>
<tr><td></td><td># of patients on ART</td><td>Estimated number of patients in need of ART</td><td rowspan="2"></td></tr>
<tr><td rowspan="2">Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy</td><td>655</td><td>686</td></tr>
<tr><td colspan="2">95.5%</td><td>>95%</td></tr>
</table>

Location of Data Storage: AIDS center (HIV Web Portal)

Reference: UNGASS indicator #4
Georgia National HIV Surveillance Plan, 2010, indicator #14

HIV and TB

INDICATOR 46: HIV prevalence among TB patients

DESCRIPTION

Purpose: To provide information about the epidemic of both TB and HIV.

Definition: Percent of newly registered TB patients who are HIV-positive.

Numerator: Total number of newly registered TB patients (registered over a given period of time) who are HIV-positive

Denominator: Total number of newly registered TB patients (registered over the same given time period) who were tested for HIV and included in the surveillance system.

Data type: Percentage.

Disaggregated by: age; gender.

INTERPRETATION

This indicator measures the degree of overlap in the epidemics in any given setting and, when compared with HIV prevalence in the general population, it gives an indication of the contribution that HIV is making to the TB epidemic.

PLAN FOR DATA ACQUISITION

Data Source(s): HIV/AIDS surveillance database

Data Collection Method: HIV routine surveillance

Frequency of Data Acquisition: Annually

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
HIV prevalence among TB patients	Not available	TBD

Location of Data Storage: NCDCPH(HIV Web Portal)

INDICATOR 47: Percentage of HIV/TB patients who received treatment for both TB and HIV

DESCRIPTION

Purpose: To assess progress in detecting and treating TB in people living with HIV

Definition: This indicator measures the percentage of adults and children with HIV infection receiving antiretroviral and TB therapy to assess progress in detecting and treating TB in people living with HIV.

Numerator: Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB program guidelines), within the reporting year

Denominator: Estimated number of incident TB cases in people living with HIV (calculated by WHO and available at http://www.who.int/tb/country/en.

Unit of measure: Percentage.

Disaggregated by: age (<15; 15+); gender.

INTERPRETATION

Adequate detection and treatment of TB will prolong the lives of people living with HIV and reduce the community burden of TB. This indicator provides a measure of the extent to which collaboration between the national TB and HIV programmes is ensuring that people with HIV and TB disease are able to access appropriate treatment for both diseases. However, this indicator will also be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral therapy, and poor access to TB diagnosis and treatment.

It is important that those providing HIV care and antiretroviral therapy record TB diagnosis and treatment, as this information has important implications for antiretroviral therapy eligibility and choice of antiretroviral regimen. It is therefore recommended that the date of starting TB treatment is recorded in the antiretroviral therapy register.

If possible, the number of patients started on TB treatment among those in HIV care but not yet on antiretroviral therapy should also be reported. This would capture additional cases of TB that are detected and treated among people living with HIV.

PLAN FOR DATA ACQUISITION

Data Source(s): Clinical data

Data Collection Method: Programme data and estimates of incident TB cases in people living with HIV

Frequency of Data Acquisition: : Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually

Responsible Entities: MoLHSA, AIDS center, TB center

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**

Percentage of HIV/TB patients who received treatment for both TB and HIV*	50% (19/38)	TBD

Location of Data Storage: AIDS clinical database(HIV Web Portal)

Reference: UNGASS indicator #6

INDICATOR 48: Percentage of HIV patients with LTBI who received prophylaxis for TB

DESCRIPTION

Purpose: To assess progress towards reducing TB impact among PLHA.

Definition: This indicator measures the number of adults and children enrolled in HIV care who started on treatment for latent TB infection (TB preventive therapy (TBPT), isoniazid preventative therapy (IPT)) expressed as a proportion of the total number of adults and children enrolled in HIV care over a given time period.

Numerator: Total number of adults and children enrolled in HIV care who start (given at least one dose) treatment of latent TB infection over a given time period.

Denominator: Total number of adults and children newly-enrolled in HIV care over a given time period.

Unit of measure: Percentage.

Disaggregated by: Age (<25: ≥25); gender.

INTERPRETATION

TB preventive therapy is given to individuals with latent TB infection to reduce the likelihood of progression to active disease. As HIV-infection is the most powerful know risk factor for progression from latent infection to active disease, preventive therapy should be part of a package of care for people living with HIV/AIDS. This indicator permits to assess the progress in implementation of TB preventive activities among PLHA.

PLAN FOR DATA ACQUISITION

Data Source(s): Clinical data

Data Collection Method: The data needed for this indicator is collected from HIV care service sites , HIV-positive clients should be screened for TB. Those clients found *not* to have evidence of active TB will be offered TBPT according to nationally determined guidelines. All those accepting TBPT and receiving at least the first dose of treatment should be recorded. This information is being recorded in an extra column in the HIV care registers.

Frequency of Data Acquisition: Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually.

Responsible Entities: AIDS center

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
Percentage of HIV patients with LTBI who received prophylaxis for TB	Not available	TBD

Location of Data Storage: Clinical database/AIDS center(HIV Web Portal)

Sexually transmitted infections

INDICATOR 49: Proportion of women accessing antenatal care (ANC) services who are tested for syphilis in the last 12 months

DESCRIPTION

Purpose: To assess progress in implementation of STI prevention programs among risk groups.

Definition: Percentage of pregnant women attending antenatal clinical who are screened for syphilis

Numerator: Number of pregnant women having syphilis test done during their antenatal visit

Denominator: Total number of women attending ANC services during the reporting period (12 months)

Unit of measure: Percentage.

Disaggregated by: Age (14-25; ≥25)

INTERPRETATION

This indicator describes access to and up-take of STI preventive services by pregnant.

PLAN FOR DATA ACQUISITION

Data Source(s): ANC clinics

Data Collection Method: Facility survey

Frequency of Data Acquisition: Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually.

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	Target (2016)
Proportion of women accessing antenatal care (ANC) services who are tested for syphilis in the last 12 months	-	TBD

Location of Data Storage: NCDCPH(HIV Web Portal)

INDICATOR 50: Prevalence of syphilis among sex workers

DESCRIPTION

Purpose: To follow the risk of STI among sex workers

Definition: Proportion of sex worker diagnosed with syphilis

Numerator:. Number of SW diagnosed with syphilis

Denominator: Number of SW surveyed tested for syphilis

Unit of measure: Percentage.

Disaggregated by: Age (<25;≥25)

INTERPRETATION

Syphilis is indicative of a risky sexual behavior in the recent past and the latter is an important factor in terms of HIV transmission. Therefore, measures of STI prevalence are a good guide to recent trends in sexual risk behavior.

PLAN FOR DATA ACQUISITION

Data Source(s): Surveillance database

Data Collection Method: BSS

Frequency of Data Acquisition: Biannually

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Prevalence of syphilis among sex workers	-	-

Location of Data Storage: NCDCPH(HIV Web Portal)

INDICATOR 51: Prevalence of syphilis among men who have sex with men

DESCRIPTION

Purpose: To follow the risk of STI among MSM.

Definition: Proportion of MSM diagnosed with syphilis

Numerator:. Number of MSM diagnosed with syphilis

Denominator: Number of MSM surveyed tested for syphilis

Unit of measure: Percentage.

Disaggregated by: Age (<25;≥25)

INTERPRETATION

Syphilis is indicative of a risky sexual behavior in the recent past and the latter is an important factor in terms of HIV transmission. Therefore, measures of STI prevalence are a good guide to recent trends in sexual risk behavior.

PLAN FOR DATA ACQUISITION

Data Source(s): BSS

Data Collection Method: BSS

Frequency of Data Acquisition: Biannually

Responsible Entities: NCDCPH

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Prevalence of syphilis among men who have sex with men	-	-

Location of Data Storage: NCDCPH(HIV Web Portal)

Care

INDICATOR 52: Percentage of PLHA that have access to free basic external support (including health, psychological or emotional and other social and material support) Note: *this is currently been revised by the UNAIDS team*

DESCRIPTION

Purpose: To assess progress in implementation of care and support services for PLHA

Definition: Proportion of PLHA who accessed free basic external support services (any of the following palliative care services or psychological counseling or social/material support)

Numerator: number of PLHA who accessed free basic external support services during the reporting period (12 months)

Denominator: total number of PLHA registered in the country

Unit of measure: Percentage.

Disaggregated by: Age, gender, geographical location, by type of service

INTERPRETATION

This indicator permits to measure coverage with basic external support services including health care aimed at palliation of suffering, psychological and material support.

PLAN FOR DATA ACQUISITION

Data Source(s): Programme reports

Data Collection Method: TBD

Frequency of Data Acquisition: Data should be collected continuously at the facility level. Data should be aggregated periodically, preferably monthly or quarterly, and reported annually.

Responsible Entities: MoLHSA/National AIDS center

OTHER NOTES

Notes on Baselines/Targets:

	Baseline (2009)	**Target (2016)**
Percentage of PLHA that have access to free basic external support (including health, psychological or emotional and other social and material support)	TBD	TBD

Location of Data Storage: MoLHSA/National AIDS center/Clinical database(HIV Web Portal)

Annex 3. Standard format for key information products

3.a. HIV/AIDS monitoring and evaluation chapter outline for the National Health Report

	Structure	A core set of indicators and issues to be covered
1.	**Overview of the epidemic**	I#19-23; I#15
2.	**Summary of monitoring and evaluation findings for each SDA**	
2.1.	Governance, Policy &Advocacy	I#1-5
2.2.	Prevention	I#11,12, 13,14, 16,17,18-Annually I#6-19 Biennially
2.3.	Treatment	I#32-40 I#42-45 Annually I#24-31 Biennially
2.4	Care and Support	I#52
2.5.	Monitoring and evaluation	Progress made against M&E plan objectives (# of researches undertaken; if a national report on HIV/AIDS surveillance was published)
3.	**Key successes**	Identify core areas where a considerable progress has been achieved
4.	**Failures and implementation bottlenecks**	Barriers to access Programs being ineffective (operational research data) Low uptake of preventive and curative interventions
5.	**Conclusions**	Identify a priority areas for further actions.
6.	**The way forward**	Recommendation on how stakeholders can act to address the gaps and obstacles to scale up the response.
7.	**Bibliography/References**	Incorporated into the full reference list for the National Health Report
	Note: This section should be limited to 5 pages narrative and 2 pages for figures and tables if necessary.	

3.b. HIV/AIDS national surveillance report outline

Structure	Issues to be covered
Descriptive section	
Reported cases of HIV/AIDS	• HIV incidence (laboratory-confirmed HIV cases irrespective of the clinical stage) • AIDS incidence (clinical stage) • Mortality The trends are given for 3- or 5-year period according to the following characteristics: HIV and AIDS incidence by sex, age and region, shares of different modes of HIV transmission by years. In addition to the above-mentioned disaggregation variables a breakdown by causes of death –a disease/condition associated with AIDS or a cause not associated with AIDS - is given for the mortality rate. Additionally, the most frequent causes of death (e.g. TB, brain lymphoma, hepatic insufficiency, stroke and so on) can be singled out separately.
Antiretroviral (ARV) treatment	(1) ARV coverage rate; (2) survival rate of patients on ARV treatment (3)management of HIV/TB co-infection
Sentinel surveillance	HIV and AIDS prevalence in the following sentinel populations: • Pregnant women [presents key indicators associated with preventing mother to child transmission along with the description of HIV prevalence in this category] • Individuals infected with STIs • Individuals with Hepatitis B and Hepatitis C
Testing for HIV	HIV testing coverage in sentinel sub-populations with the: • Only the sub-populations whose size is known will be described: pregnant women, prisoners and TB patients. • In addition, the number of HIV testing and detected HIV positive cases among donors will be presented.
Bio-behavioral surveillance	The subchapter summarizes key findings of the bio-behavioral surveillance surveys carried out among high-risk populations: • HIV prevalence • Knowledge about preventing HIV transmission • Risk behaviors
Tables section	This will contain 29 tables described in the HIV/AIDS surveillance plan/Annex 1 (approved by the Ministerial decree #217/o as of July 23, 2010)

3.c. Operational research and BSS reports outline

Structure and key elements
Title of the research project
Name and designation of **(a)** Principle investigators **(b)** Co-investigators
Address of the research institution: Name: Postal address: Email address:
Declaration of interests
Acknowledgments
Introduction: A brief write up on usefulness of the project and its application to clinical setting.
Executive summary
Background information: A summary of present knowledge/literature on the subject
Research objectives
Detailed Methodology **(a)** Study design **(b)** Sampling (simple random, cluster etc) **(c)** Sample size **(d)** Selection of samples **(e)** Definitions and procedures **(f)** How analysis will be carried out
Results
Discussion (including study limitations)
Summary and conclusions
Recommendations
Bibliography
Annexes: **(a)** Data tables **(b)** Study forms if any **(c)** Questionnaire if any

Annex 4. Data acquisition protocols

4.a. Protocols for acquiring data on preventive interventions

Service Delivery Area	**Prevention**															
Indicator ID and collection frequency																
Annually																
ID in M&E manual	11	12	15	16												
Indicator ID in the surveillance database	8	8	12	13												
Biennially																
ID in M&E manual	6	7	8	9	10	19	20	21	22	23	24	25	26	27	28	29
Indicator ID in the surveillance database	*16*	*34*	*45*	*15*	*15*	*32*	*33*	*44*	*10*	*14*	*36*	*47*	*30*	*38*	*49*	*29*
ID in M&E manual	30	31	34	36	37	50	51									
Indicator ID in the surveillance database	*24*	*BSS*	*17*	*35*	*46*	*BSS*	*BSS*									
Disaggregation	According to the national surveillance plan and as defined in the indicator passports															
Data Source	Routine surveillance Sentinel surveillance BSS															
Responsible for data collection and analyses	National Center for Disease Control and Public Health HIV surveillance Unit															
Responsible for data provision	Head of the HIV epidemiological unit, NCDCPH															
Data submitted to	MoLHSA Department of health															
Data submitted by	Data for the previous calendar year should be submitted by April 15th of the current year.															
Format of the data submission	(a) Electronically in Excel spreadsheet (Consult HIV surveillance plan for table formats for each indicator)															
Frequency of data submission	Annually (see above an indicator ID) Biennially (see above an indicator ID)															

4.b. Protocol on treatment, care& support indicators

Service Delivery Area	Treatment &Care and support											
Indicator ID	13	14	17	18	42	43	44	45	47	48	52	
Indicator ID in surveillance data base	-	-	-	-	*15*	*15*	*15*	*14*	-	-	-	
Disaggregation	As defined in the indicator passport											
Data Source	National AIDS Clinical Database											
Responsible for data collection	National AIDS Center											
Responsible for data provision	HIV clinical database administrator											
Data submitted to	MoLHSA Department of health											
Data submitted by	Data for the previous calendar year should be submitted by March 31st of the current year.											
Format of the data submission	Electronically in Excel spreadsheet (See table T1)											
Frequency of data submission	Annually											

Table #T1 Data collection format for treatment&Care and Support indicators [To be completed by any organization implementing treatment, care and support programs]

ID	Indicator	Female		Male		High risk groups			TOTAL
		15-24	≥25	15-24	≥25	MSM	FSW	IDU	
17N	Number of newborns born to HIV positive mothers, who received complete course of ART prophylaxis during the reporting period (1 year).								
17D	Total number of newborns born to HIV positive mothers during the reporting period (1 year)								
18N	Number of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the likelihood of MTCT in accordance with nationally approved treatment protocol in the last 12 months.								
18D	Estimated number of HIV-infected pregnant women giving birth in the last 12 months [Spectrum]								
42N	Number of adults and children who are still alive and on ART at 12 months after initiating treatment								
42D	Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period								
43N	Number of adults and children who are still alive and on ART at 24 months after initiating treatment.								

43D	Total number of adults and children who initiated ART who were expected to achieve 24-month outcomes within the reporting period								
44N	Number of adults and children who are still alive and on ART.								
44D	Total number of adults and children who initiated ART who were expected to achieve 36-month outcomes within the reporting period								
45N	Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol at the end of the reporting period.								
45D	Estimated number of adults and children with advanced HIV infection								
47N	Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB program guidelines), within the reporting year								
47D	Estimated number of incident TB cases in people living with HIV								
48N	Total number of adults and children enrolled in HIV care who start (given at least one dose) treatment of latent TB infection over a given time period.								
48D	Total number of adults and children newly-enrolled in HIV care over a given time period.								
52N	Number of PLHA who accessed free basic external support services during the reporting period (12 months)								
52D	Total number of PLHA registered in the country								

Annex 5. Data collection format for programmatic indicators

(A) For all registered programme implementers (health care providers, blood services, social care services/NGOs)

Name of the organization _____
Name of the programme _____
Contact person _____
Contact information: (e-mail, phone number) _____
Address _____
The form completion date (day/month/year) _____
Total program budget per year _____

Please fill out the following form and provide information that has routinely being collected within your program.

		Total	Female		Male	
			15-24	≥25	15-24	≥25
I#32	# of opioid-dependent people covered by AMT					
I#33	# of drug dependent people covered by drug dependence treatment services					
I#38N	Number of syringes/needles distributed to injecting drug users during the year					
I#39N	Number of blood units screened for HIV in a quality assured manner					
I#39D	Number of all blood units screened for HIV					
I#49N	Number of pregnant women having syphilis test done during their antenatal visit					
I#49D	Total number of women attending ANC services during the reporting period					
I#52N	Number of PLHA who accessed free basic external support services during the reporting period					

The form needs to be completed and submitted to the MoLHSA ..... by March 31st,
The data should be verified and approved by the local programme director. Once this form has been completed it should be submitted to:
The form completed by .....
Data verified by .....

Note: Electronic submission of the form in Excel spread sheet format is highly encouraged.

B. For schools

Name of the organization _____
Name of the programme _____
Contact person _____
Contact information: (e-mail, phone number) _____
Address _____
The form completion date (day/month/year) _____
Total program budget per year _____
Funding source _____

I#38N	Has your school been providing drug and HIV prevention training courses in the last academic year	Yes	No

The form needs to be completed and submitted to the Ministry of Education and Science department of . . . . . by March 31th.
The data should be verified and approved by the school director. Once this form has been completed it should be submitted to:
The form completed by . . . . . .
Data verified by . . . . . .

Note: Electronic submission of the form in Excel spread sheet format is highly encouraged.

Annex 6. A format for NASA data collection

Name of the organization _____

Contact person _____

Contact information: (e-mail, phone number) _____

The form completion date (day/month/year) _____

Please fill out the following funding matrix electronically using the provided excel spreadsheet and return it back to this e-mail address (xxx@moh.gov.ge) contact person: . . . . . .

PERIOD - YEAR RESULTS ARE STATED FOR CALENDAR YEAR	Public Sources	International Sources	Private Source	Sources has to be specified (e.g. WB, UN Agencies, TGF and etc)
AIDS Spending Categories				**Excel Sheet**
1. Prevention (sub-total)				
1.01 Communication for social and behavioural change				
1.02 Community mobilization				
1.03 Voluntary counselling and testing				
1.04 Risk-reduction for vulnerable and accessible populations				
1.05. Prevention - Youth in school				
1.06 Prevention - Youth out-of-school				
1.07 Prevention of HIV transmission aimed at people living with HIV				
1.08 Prevention programmes for sex workers and their clients				
1.09 Programmes for men who have sex with men				
1.10 Harm-reduction programmes for injecting drug				
1.11 Prevention programmes in the workplace				
1.12 Condom social marketing				
1.13 Public and commercial sector male condom provision				
1.14 Public and commercial sector female condom provision				
1.15 Microbicides				
1.16 Prevention, diagnosis and treatment of sexually transmitted infections				
1.17 Prevention of mother-to-child transmission				
1.18 Male Circumcision				
1.19 Blood safety				
1.20 Safe medical injections				
1.21 Universal precautions				
1.22 Post-exposure prophylaxis				

1.98 Prevention activities not disaggregated by intervention				
1.99 Prevention activities not elsewhere classified				
2. Care and Treatment (sub-total)				
2.01 Outpatient care				
2.01.01 Provider- initiated testing and counselling				
2.01.02 Opportunistic infection outpatient prophylaxis and treatment				
2.01.03 Antiretroviral therapy				
2.01.04 Nutritional support associated to ARV therapy				
2.01.05 Specific HIV-related laboratory monitoring				
2.01.06 Dental programmes for people living with HIV				
2.01.07 Psychological treatment and support services				
2.01.08 Outpatient palliative care				
2.01.09 Home-based care				
2.01.10 Traditional medicine and informal care and treatment				
2.01.98 Outpatient care services not disaggregated by intervention				
2.01.99 Outpatient Care services not elsewhere classified				
2.02 In-patient care				
2.02.01 Inpatient treatment of opportunistic infections				
2.02.02 Inpatient palliative care				
2.02.98 Inpatient care services not disaggregated by intervention				
2.02.99 In-patient services not elsewhere classified				
2.03 Patient transport and emergency rescue				
2.98 Care and treatment services not disaggregated by intervention				
2.99 Care and treatment services not-elsewhere classified				
3. Orphans and Vulnerable Children (sub-total)				
3.01 OVC Education				
3.02 OVC Basic health care				
3.03 OVC Family/home support				
3.04 OVC Community support				
3.05 OVC Social services and administrative costs				
3.06 OVC Institutional care				
3.98 OVC services not disaggregated by intervention				
3.99 OVC services not-elsewhere classified				
4. Program Management and Administration				
4.01 Planning, coordination and programme management				
4.02 Administration and transaction costs associated with managing and disbursing funds				
4.03 Monitoring and evaluation				
4.04 Operations research				
4.05 Serological-surveillance (Serosurveillance)				
4.06 HIV drug-resistance surveillance				
4.07 Drug supply systems				
4.08 Information technology				
4.09 Patient tracking				
4.10 Upgrading and construction of infrastructure				
4.11 Mandatory HIV testing (not voluntary counselling and testing)				
4.98 Program Management and Administration Strengthening not disaggregated by type				

4.99 Program Management and Administration Strengthening not elsewhere classified				
5. Human resources (sub-total)				
5.01 Monetary incentives for human resources				
5.02 Formative education to build-up an HIV workforce				
5.03 Training				
5.98 Incentives for Human Resources not specified by kind				
5.99 Incentives for Human Resources not elsewhere classified				
6. Social Protection and Social Services excluding				
6.01 Social protection through monetary benefits				
6.02 Social protection through in-kind benefits				
6.03 Social protection through provision of social services				
6.04 HIV-specific income generation projects				
6.98 Social protection services and social services not disaggregated by type				
6.99 Social protection services and social services not elsewhere classified				
7. Enabling Environment				
7.01 Advocacy				
7.02 Human rights programmes				
7.03 AIDS-specific institutional development				
7.04 AIDS-specific programmes focused on women				
7.05 Programmes to reduce Gender Based Violence				
7.98 Enabling Environment and Community Development not disaggregated by type				
7.99 Enabling Environment and Community Development not elsewhere classified				
8. Research excluding operations research which is				
8.01 Biomedical research				
8.02 Clinical research				
8.03 Epidemiological research				
8.04 Social science research				
8.05 Vaccine-related research				
8.98 Research not disaggregated by type				
8.99 Research not elsewhere classified				

Annex 7. Data collection format to track annual spending per NSP strategic priorities

Name of the organization _____
Name of the programme _____
Contact person _____
Contact information: (e-mail, phone number) _____
Address _____
The form completion date (day/month/year) _____
Total program budget per year _____
Funding source _____
Total program budget _____
Total spending during the reporting period _____

SDA and strategic priorities	Spending per SDA during the reporting period
Governance, Policy and Advocacy	
SP 1.1.Improved coordination (support to the CCM's secretariat)	
SP1.1.Monitoring and evaluation	
SP 1.2 Advocacy	
SP 1.3. Creating conducive legal environment	
Monitoring and evaluation	
Prevention	
SP:2.1. Prevention among MARPs and MARA	
SP: 2.2Prevent HIV transmission within healthcare settings	
SP 2.3. Prevent Mother-to-child HIV transmission	
SP 2.4. Reduce Youth Vulnerability to HIV	
Treatment	
SP:3.1. ART	
Care and Support	
SP 4.1. Provision of care and support services	
Health system strengthening	
SP 5.1. Strengthen regulatory system and assure higher quality services in the health care settings	
SP 5.2. Assure necessary investments in the infrastructure and human resources	

Note: Cost should include salaries per each category

The form needs to be completed and submitted to the Ministry of Labor, Health and Social Affairs department of . . . . . by January 31th,
The data should be verified and approved by the local programme director.
The form completed by . . . . . .
Data verified by . . . . . .
Note: Electronic submission of the form in Excel spread sheet format is highly encouraged.

Annex 8 M&E staff

M&E Position	Position Location	Role / Responsibility
M&E coordinator	NCDCPH	• Prepare an overall and annual M&E plan • Prepare technical specifications for each M&E component and contract external agencies to manage each component • Supervise the quality and timeliness of M&E products contracted out • Review contracted M&E products, distil, and communicate their implications for program implementation, including modifications in geographic priorities, target groups, interventions and implementing partners • Per request of the CCM, commission regular performance assessment of the M&E system • Ensure that programmatic and epidemiological HIV data are available to national decision makers and used to inform evidence-based planning and assessment of progress in implementation and coordination of the national response.
Head the HIV epidemiologic unit	NCDCPH	• Oversee the implementation of the national HIV surveillance plan • Prepare HIV surveillance report • Plan, organize and analyze HIV related operational research • Conduct onsite training of M&E staff • Conduct supportive supervision to sentinel sites
HIV surveillance database administrator (Specialist)	NCDCPH	• Obtain relevant data and control their quality • Conduct supportive supervision to sentinel sites
Senior specialist	NCDCPH	Obtain and analyse relevant data
Assistant staff (2)	NCDCPH	Obtain and analyse relevant data
HIV web administrator	NCDCPH	HIV web maintenance
Senior specialist (National Health Report)	Department of health, MoLHSA	Obtain data on relevant indicators according to the data acquisition protocols (see annex 4). Prepare HIV national program monitoring and evaluation chapter for the National Health Report.
Senior specialist (NASA)	Department of health, MoLHSA	Obtain financial data according to the data collection form presented in annex 6.
Clinical Database administrator	AIDS center	Obtain and analyse relevant data
Head of the epidemiologic unit	AIDS center	• Oversee the routine data collection • Provide data on selected indicators to be included in the annual national health report (see annex 4 for treatment and care)

Annex 9

Georgia HIV/AIDS operationalization plan for 2011-2013

			2011			2012			2013						
	Activities	**Measurement Unit**	**# Units**	**Unit cost**	**Total cost**	**Number of Units**	**Unit cost**	**Total cost**	**# Units**	**Unit cost**	**Total cost**	**Total cost**	**Responsible organization**	**Implementing partners**	**Funding source**
1	**Coordination of national M&E system**				**24,000**			**50,775**			**24,000**	**98,775**			
1.1.	NCDCPH M&E coordinator	1 full time equivalent staff/month	**12**	**2,000**	**24000**	**12**	**2,000**	**24000**	**12**	**2,000**	**24000**	**72,000**	CCM	NCDCPH	TBI
1.2.	Performance appraisal of the M&E system and review of the national M&E plan	# month of ITA				**1**	**26,775**	**26775**				**26,775**	CCM	International organizations	TBI
2	**Human resource capacity building**				**8100**			**16300**			**8100**	**32500**			
2.1.	Conduct necessary trainings to build M&E skills among involved parties	# of professionals trained	**20**	**200**	**4000**	**20**	**200**	**4000**	**20**	**200**	**4000**	**12000**	CCM	Line ministries, NCDCPH, NGOs	TBI
2.2.	Provide technical assistance to the MoLHSA in preparing UNGASS report	# - month of LTA			**0**	**1**	**4100**	**4100**			**0**	**4100**	CCM	MoLHSA, NCDCPH	UNAIDS
2.3.	Provide TA to MolHSA for National AIDS Spending Assessment and Financial Gap analyses to inform policy decisions (incl. UNGASS reporting)	# of month of LTA/per year				**1**	**4100**	**4100**				**4100**	CCM	MoLHSA, NCDCPH	UNAIDS
2.4.	Provide TA to MolHSA for preparing national M&E report/or relevent section of the National Health Report	# of month of LTA/per year	**1**	**4100**	**4100**	**1**	**4100**	**4100**	**1**	**4100**	**4100**	**12300**	MoLHSA	-	TBI

			2011			2012			2013						
	Activities	**Measurement Unit**	**# Units**	**Unit cost**	**Total cost**	**Number of Units**	**Unit cost**	**Total cost**	**# Units**	**Unit cost**	**Total cost**	**Total cost**	**Responsible organization**	**Implementing partners**	**Funding source**
3	**Assure sustainable functionality of the national HIV/AIDS surveillance program, which renders critical epidemiological and programatic information about national response**				**395,806**			**235,859**			**370,912**	**1,002,576**			
3.1.	Routine HIV/AIDS surveillance is underway	HIV/AIDS routine surveillance	1	80,806	80,806	1	80,859	80,859	1	80,912	80,912	**242,576**	NCDCPH	AIDS center VCT centers, ANCs, STI clinics NGOs	State budget
3.2.	Conduct BSS among IDUs combined with population size estimetion studies	# of studies	6	40,000	240,000			-	6	40,000	**240,000**	**480,000**	NCDCPH	NGOs	Global Fund Round 10
3.3.	Conduct BSS among FSW	# of studies	2	25,000	50,000			-	2	25,000	**50,000**	**100,000**	NCDCPH	NGOs	Global Fund Round 10
3.4.	Conduct BSS among MSM	# of studies			-	1	30,000	30,000			**-**	**30,000**	NCDCPH	NGOs	Global Fund Round 10
3.5.	Conduct BSS among Prisoners	# of studies			-	1	15,000	15,000			**-**	**15,000**	NCDCPH	NGOs	Global Fund Round 10
3.6.	Conduct KAP survey among youth	# of studies	1	25,000	25,000			-			**-**	**25,000**	NCDCPH	NGOs	USAID/GHPP
3.7.	Conduct BSS among MARA	# of studies			-	1	20,000	20,000			**-**	**20,000**	NCDCPH	NGOs	TBI-will be conducted if sufficient funding is secured
3.8.	Conduct Population size estimation for CSWs and MSM	# of studies			-	2	45,000	90,000			**-**	**90,000**	NCDCPH	NGOs	TBI-will be conducted if

	Activities	Measurement Unit	2011 # Units	2011 Unit cost	2011 Total cost	2012 Number of Units	2012 Unit cost	2012 Total cost	2013 # Units	2013 Unit cost	2013 Total cost	Total cost	Responsible organization	Implementing partners	Funding source
															sufficient funding is secured
4	**Conduct HIV/AIDS related operational research to inform policies and practice**				**188,430**			**181,455**			**94,404**	**464,289**			
4.1.	Undertake through epidemiological research/analysis using routine surveillance data and other data sources (e.g. safe blood database, etc.) to derive conclusive evidence about the HIV/AIDS epidemic and its drivers	# month consultansy of LTA	3	4,100	12,300			-	3	4,100	12,300	**24,600**	CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs	TBI
4.2.	Conduct OR to identify factors associated with HIV treatment outcomes	# studies conducted			-	1	25,000	25,000			-	**25,000**	CCM / MoLHSA	Research institutions, AIDS center	TBI
4.3.	Conduct OR to identify factors affecting adherence to ART [conduct operational research on ART adherence and clinical outcomes among HIV positive IDUs]	# studies conducted	1	26,130	26,130	1	26,130	26,130	1	32,104	32,104	**84,364**	CCM / MoLHSA	AIDS center	Global Fund Round 10
4.4.	Conduct OR to identify factors associated with late HIV diagnosis	# studies conducted	1	25,000	25,000			-			-	**25,000**	CCM / MoLHSA	Research institutions, AIDS center	TBI
4.5.	Conduct OR to evaluate MPTCT program implementation bottlenecks	# studies	1	25,000	25,000			-			-	**25,000**	CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs	TBI
4.6.	Conduct MPTCT coverage and quality assessment study combined with the Multiple Indicator Cluster Survey & and Women's Reproductive	# studies	1		-			-			-	**-**	CCM / MoLHSA	Research institutions, NCDCPH, AIDS center, NGOs	no additional cost; it is linked to MICS

			2011			2012			2013						
	Activities	**Measurement Unit**	**# Units**	**Unit cost**	**Total cost**	**Number of Units**	**Unit cost**	**Total cost**	**# Units**	**Unit cost**	**Total cost**	**Total cost**	**Responsible organization**	**Implementing partners**	**Funding source**
	Health Surveys														
4.7.	Conduct OR to identify barriers for IDUs (including female IDUs in accessing VCT services	# studies	1	25,000	25,000			-			-	**25,000**	CCM / MoLHSA	Research institutions, NGOs	TBI
4.8.	Conduct baseline HIV Vulnerability study for labor migrants (mobile populations)	# studies	1	25,000	25,000			-			-	**25,000**	CCM / MoLHSA	Research institutions, NGOs	TBI
4.9.	Conduct OR upon emerged need	# studies							2	25,000	50,000	**50,000**	CCM / MoLHSA	Research institutions, NGOs	TBI
4.10.	Economic evaluation of selected curative and preventive interventions (e.g. economic evaluation of regional level laboratory staff performance under the curative program; peer-driven interventions among IDUs)	# of month of ITA/per year				3	26,775	80,325				**80,325**	CCM / MoLHSA	Research institutions, NGOs	TBI
4.11.	Conduct operational research aimed at identifying key factors related to stigma, develop recommendations for evidence-informed interventions.	# studies conducted	1	25,000	25,000							**25,000**	CCM / MoLHSA	Research institutions, NGOs	Global Fund Round 10
4.12.	Conduct OR on integration of HIV, TB and drug treatment services	# studies conducted	1	25,000	25,000			-			-	**25,000**	CCM / MoLHSA	Research institutions, NGOs	TBI-will be conducted if sufficient funding is secured

			2011			2012			2013						
	Activities	**Measurement Unit**	**# Units**	**Unit cost**	**Total cost**	**Number of Units**	**Unit cost**	**Total cost**	**# Units**	**Unit cost**	**Total cost**	**Total cost**	**Responsible organization**	**Implementing partners**	**Funding source**
4.13.	Carry out assessment of care and support services	# studies conducted			-	1	25,000	25,000			-	**25,000**	CCM / MoLHSA	Research institutions, NGOs	TBI-will be conducted if sufficient funding is secured
4.14.	Evaluate effectiveness of existing Behavior Change Communication interventions targeting MARPs in Georgia	# studies			-	1	25,000	25,000			-	**25,000**	CCM / MoLHSA	Research institutions, NGOs	TBI-will be conducted if sufficient funding is secured
5	**Communication and Advocacy**				**17,946**			**15,446**			**15,446**	**48,837.65**			
5.1.	Set up and maintain HIV web page at NCDCPH	web page maintenance	1.0	14,705	**14,705**	1.0	**14,705**	**14,705**	1.0	**14,706**	**14,706**	**44,118**	NCDCPH	NGOs, AIDs center, Research institutions, International organizations	State budget
5.2.	Print and disseminate the M&E framework and operational plan	# publications printed and disseminated	500	5.0	2,500			-			-	**2,500**	CCM/MoLHSA /NCDCPH	International organizations	State budget UNAIDS TGF
5.3.	Organize M&E data dissemination workshops	workshops attended by 25 participants in Tbilisi	4	185.0	**740**	4	185	740	4	185	740	**2,220**	CCM/MoLHSA /NCDCPH	NGOs, AIDs center, Research institutions, International organizations	UNAIDS TGF
TOTAL					**634,282**			**499,835**			**512,862**	**1,646,978**			