Assessment of the HIV Surveillance System

Complete Study Report

Acronyms

NCDCPH	(L. Sakvarelidze) National Center for Disease Control and Public Health
STI	Sexually Transmitted Infections
M&E	Monitoring and Evaluation
BSS	Behavioral Surveillance Surveys with Biomarker Component
MOLHSA	Ministry of Labour, Health and Social Affairs of Georgia
PHF	Primary Healthcare Facility
PHC	Public Health Center

Executive Summary

1 Methodology

The assessment of the HIV/AIDS surveillance system in Georgia was conducted under the project financed by the Global Fund - "Establishment of evidence-base for national HIV/AIDS program by strengthening the HIV/AIDS surveillance system in the country," as a preparatory stage for developing the HIV/AIDS national strategic plan.

A review of the literature, and qualitative and quantitative research methods were used for conducting the study.

2 Main Findings

2.1 International Requirements for HIV Surveillance

The main international requirements for HIV surveillance system are standardized and tailored to the status of the HIV epidemic:

- Major indicators (biological, behavioral, and socio-demographic) of HIV surveillance are defined
- Desegregation variables are defined: age, gender, geographic area, place of residence (urban/rural), subpopulation groups and risk-factors
- Regardless of their HIV surveillance system specific, countries have the obligation to send information in a standard format regularly to the respective international organizations/bodies to keep EuroHIV, ENAADS and EHIDS databases up-to-date.

2.2 Priorities of the National Policy

Public policy documents reflect the vision of the state in developing HIV surveillance –HIV surveillance is recognized as one of the four strategies to halt and begin to reverse the spread of HIV/AIDS by 2015.

2.3 Regulatory Environment

1. Responsibilities and powers for implementing the surveillance of HIV/AIDS cases are not defined in the normative environment.
2. The normative environment doesn't provide for regulating the relationship between two or more parties in the field of HIV surveillance, save the unilateral obligation of medical facilities to report medical statistics.

2.4 Organizational and Functional Design

Involved Party	Responsibilities by Individual Function				
	HIV Testing	Behavioral Surveys	Disease Register	Data Analysis	Information Usage
Central Level					
Country Coordination					X

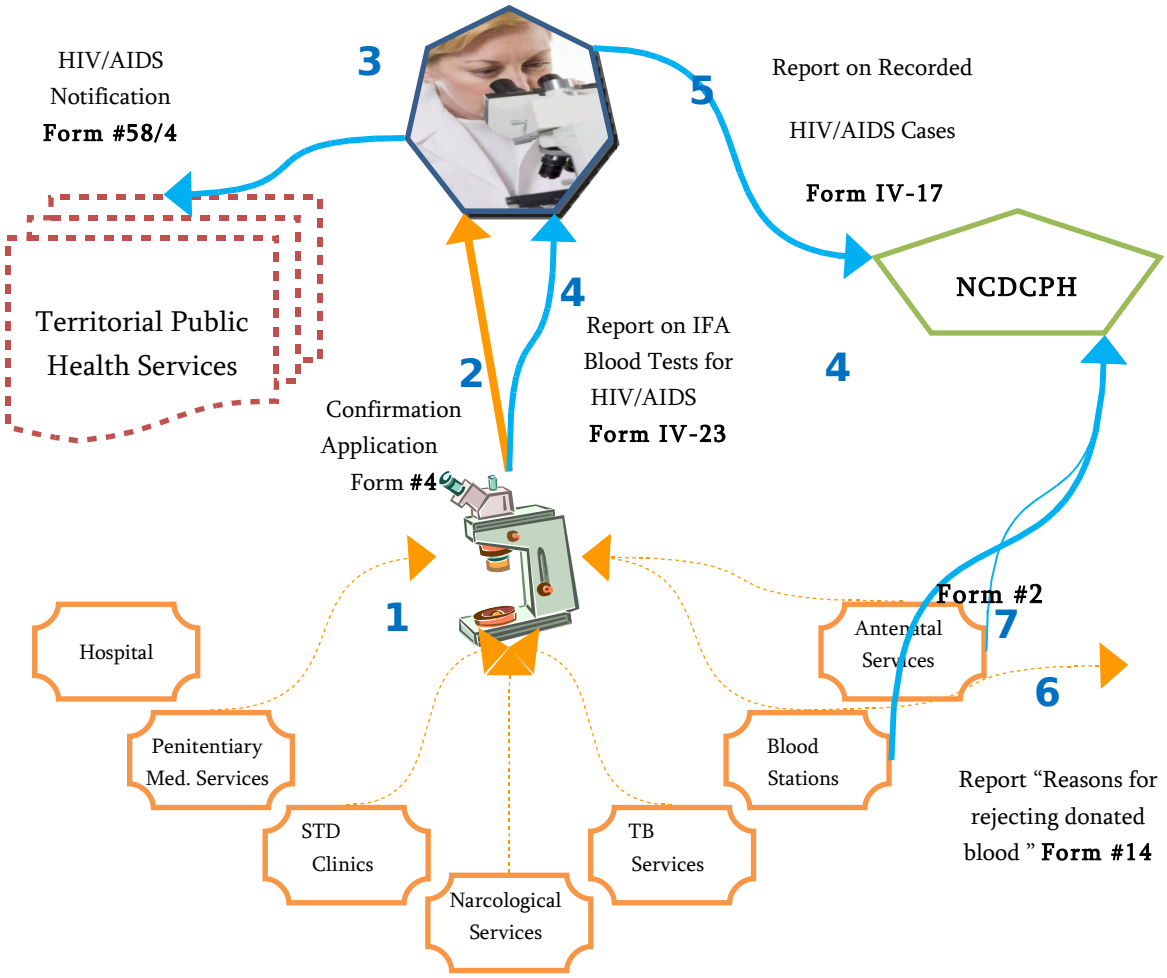
Involved Party	Responsibilities by Individual Function				
	HIV Testing	Behavioral Surveys	Disease Register	Data Analysis	Information Usage
Central Level					
Mechanism					
Ministry of Labour, Health and Social Affairs of Georgia					X
Infectious Diseases, AIDS and Clinical Immunology Research Center (With Central Reference Laboratory)	X		X	X	X
NCDCPH (Statistics Service, the HIV/AIDS Surveillance Department)				X	?
Central Blood Bank	X				
Lung and Tuberculosis Research Institute	X			X	
Narcology Research Institute (Central)	X				
STD Institute (Central)	X				
Medical Service of the Penitentiary System (Aldagi-BCI)	X				
Nongovernmental Organizations	X	X		X	X
Local Level					
Regional / District Public Health Services					
Regional Laboratories (Subdivisions of AIDS Center Laboratory)	X				
Regional Blood Transfusion Stations	X				
STD Clinics (Regional)	X				
Private Laboratories	X				
Antenatal Services	X				
Hospitals	X				

1. The majority of the HIV surveillance functions are not procedurally formalized and based on standard technical manuals / guidelines (and tools).
2. The function (and the methodology) of determining the number/size of high-risk groups is not defined and is left "orphaned".
3. Risk Behavior Subpopulation (the second generation) Surveys (BSS) are not institutionalized and are carried out by non-governmental organizations, which use a standard methodology and have experienced professionals at their disposal.

4. A standard format and a framework of data analysis have not been put into practice.

2.5 Information Flows

1. At the primary level the data collection is not standardized.
2. Data is transferred in an aggregate form (from the bottom to the top).
3. In the majority of cases information / test results are not communicated back to the referring facility.



2.6 Stakeholders

The stakeholders of the HIV/AIDS surveillance system, their roles, demands, expectations, and incentives are described in the table below:

Stakeholder	Role	Demands	Expectations	Incentives
Medical facilities	Detecting, recording, and reporting AIDS cases	Simplicity, clear directions	Accessible standard forms, guidelines	Predominantly professional
Laboratories	HIV Testing	Biological Safety	Quality assurance system	Predominantly professional
Public health centers	Reporting, data	Integrated system	Quality data	Professional and

Stakeholder	Role	Demands	Expectations	Incentives
	analysis			financial
The Ministry, ministerial structures	Policy and strategy development	Compliance with international standards	Information for Decision-Making	Predominantly Professional
Nongovernmental organizations	Studies exploring risk behaviors	Regularity, geographic coverage	State funding	Professional and financial
GFTAM funded project	Financial support of national response to HIV epidemic in accordance with a country request	Ensuring the possibility of assessing intermediate and final results of influencing the epidemic and its causing factors	Regular reports reliably describing the epidemiological situation	Proper reporting (showing results) to the donor organization
Donors	Supporting the functions of epidemiological surveillance, which hasn't yet been provided by the state itself.	Providing for and implementing international practice (experience) and standards	Institutionalizing the functions endorsed by them	Fulfilling international commitments (at the global level)

2.7 Material and Technical Capacities

1. The Material and technical base of local level facilities is rather poor. Specifically, curative-preventive facilities, laboratories, and blood stations virtually lack computer equipment, intranet, and the Internet.

2. From this perspective the situation is much better in central level institutions. The NCDCPH possesses enough material and technical facilities to perform analysis, but those means aren't sufficient to implement a state-of-the-art management information system.

2.8 Human Resources

1. The heads of the facilities participating in the surveillance system consider the basic computer knowledge and skills of the human resources employed there as being satisfactory.

2. As for the knowledge and skills for computer data processing/analysis, the assessment is unsatisfactory here, which is more apparent at the local level facilities.

3. Key technical staff turnover is not a serious issue at the central as well as the local level institutions participating in the epidemiological surveillance.

4. The key technical staff employed at these institutions is motivated to perform the work envisaged by the HIV/AIDS surveillance; however their professional motivation is more than simply financial. They recognize the specific benefits associated with the implementation of a cutting-edge information system and are not afraid of introducing innovations.

3 Evaluation and Conclusions

The results of analyzing the needs and the factors can be grouped in four categories using the SWOT analysis methodology: (see Figure 6 below).

	Positive	Negative
Internal	**Strengths**	**Weaknesses**
	The function of analyzing and reporting on HIV epidemic has been entrusted to the specialized public entity having adequate expertise and material and technical resources The experience and the technical resources are available in the country to conduct biological and behavioral surveillance surveys. The turnover of the key technical staff is low. The involved parties are interested and motivated in the system updating	There is no conceptual integrated framework for HIV surveillance. The system of vertical subordination or accountability between the central and local government bodies (services) participating in the HIV surveillance is virtually absent Information flows, all the way from initial recording to analysis, are not standardized The rules and forms currently used to collect and report information are technically defective and virtually useless to perform a full-blown analysis. Primary healthcare facilities are short of adequate resources and incentives to collect and submit quality data needed for epidemiological surveillance The element of informing is not used appropriately for advising and implementing other activities of epidemiological surveillance in the future.

External

Opportunities	Threats
International commitments of the country as a prerequisite of actually reflecting HIV surveillance in the national policy priorities Bringing NCDCPH regional structures into operation makes it possible to concentrate on the key functions of HIV surveillance at the sub national level The integration of HIV surveillance into the system of surveillance of other communicable diseases (the creation of an integrated surveillance system) Support from international partners and the utilization of accumulated international experience in standardizing the current surveillance methodology, tailoring it to the country and implementing it there.	Health care deregulation and limited capacities for implementing standardized case registration and reporting in the health market (the scarcity of "tools" at the government's disposal) Endless changes in the health care management system (organizational and functional rearrangements) Improper legislative practices featuring the absence, collision, or inappropriateness of essential legal norms. The lack of evidence-based decision-making practices in public policy and, consequently low demand for arguments / information There is a possibility for increasing HIV testing and expanding information flows / sources in case of decentralizing the confirmation – all of these are to be implemented without using up-to-date information and communication systems

3.1 Conclusions

Nowadays the HIV surveillance system meets the internal demands of the country and partially the requirements resulting from international commitments, but it by no means implies that the system doesn't need updating/improving:

The parties involved in the system's operation are not satisfied with the existing situation and want to ameliorate it.

The demand for HIV surveillance is expected to rise in the near future (for internal consumption).

The international commitments are not met in full.

Qualitative updating in the HIV/AIDS surveillance system is mainly needed for:

The management and analysis of information flows

The mechanisms of epidemiological investigation and consultancy

All of these major or less important qualitative updates should serve the following purposes (all main requirements for a revised epidemiological surveillance system):

Actual observance of the confidentiality principle, and the generation of reliable and technically sound information (evidence) for decision-making

The highest priority interventions include:

The development of a conceptual framework for the country's HIV surveillance system with participation of all stakeholders – all the key questions left open should be answered and the basis should be created, which will define the major characteristics of the system itself and the plan for its implementation and operation.

The functional and organizational arrangement of the HIV surveillance system on the basis of conceptual considerations, reflecting the system in the legal environment.

The standardization of all surveillance functions/activities through developing a methodology tailored to the capacities of the country, training technical staff, and exercising continuous control over the observance of the standards.

Only after implementing these two interventions is it possible to introduce a modern informational-analytical system, which will help all the involved parties and the major user – NCDCPH – to better perform the functions envisaged by the HIV epidemiological surveillance.

3.2 Recommendations

com 1. **Notwithstanding the fact that Georgia belongs to the set of countries with a low prevalence of HIV, it is desirable that the HIV surveillance system be developed considering the requirements set for the countries with a "concentrated epidemic" status, implying:**

1.1) monitoring changes in behavioral factors and the HIV prevalence rate among high–risk population groups

1.2) drawing connections between behavioral risk-factors detected in high-risk subpopulation groups and the general population in parallel with identifying these factors in high-risk population groups

com 2. **Before defining technical and methodological characteristics of the HIV/AIDS surveillance system, it is necessary that the system be conceptually understood by all stakeholders taking into consideration the gained experience and the drawbacks revealed by the study. The conceptual framework should:**

1.1) Answer several questions concerning the quality control of laboratory testing, the organization of voluntary counseling, and the management of information flows when a large number of entities are participating in the liberal healthcare market and deregulation with decentralization is taking place.

1.2) Explain the appropriateness and the possibility (feasibility) of an actual integration of the HIV/AIDS surveillance system with the surveillance system of the other communicable diseases or separation of the former from the latter one.

1.3) Set clearly the guiding principles and approaches, according to which choices will be made among the various options of organizational and functional arrangement of the system.

1.4) Define the rules (norms) based on which the legislation will be revised.

com 3. It is necessary to consider the appropriateness and the feasibility of uniting the functions of informing, counseling, and implementing epidemiological surveillance "under one ceiling", especially at the peripheral level. After "accommodating" the mentioned functions under one ceiling it's desirable to examine the issue of decentralizing the case confirmation and make decisions:

1.5) In any case the updated epidemiological surveillance system should fit with the multiplicity of participating actors (including the facilities providing confirmation services) in the unregulated healthcare market.

1.6) It is desirable that informing on confirmation results, providing post-test counseling, and conducting epidemiological investigation be performed by the same medical entity; it will facilitate maintaining the confidentiality and establishing trust between the HIV infected person and the surveillance system.

com 4. While revising normative acts after conceptual consideration, it is necessary that:

1.7) The issues of HIV/AIDS surveillance be clearly pointed out in every place, where the combination / integration of these issues with the epidemiological surveillance of other diseases is not appropriate (pursuant to the conceptual framework)

1.8) In each place where the obligation of one party (entity) is defined, the administration mechanism be clearly defined (i.e. what the entity ought to expect if it doesn't fulfill the obligation, in what form the reporting or fulfillment of the obligation is assessed, what the reciprocal obligation of the other party is and so on.)

com 5. While planning the technical characteristics and the management of information flows, it is desirable that:

1.9) the format and the content (the matrix of quantitative characteristics for internal and external usage with the disaggregation variables) of the analytical product be clearly defined in the first place and only then the guidelines and the tools for primary recording and transmitting data be developed

1.10) pursuant to the manual for the development of major indicators (UNAIDS, 2007), the reporting of the data from the lower level to the upper one be performed in the same non-aggregate form as data is collected at the lower level.

com 6. While planning information flows, it is preferable that the workload be minimized at the primary levels since there are no means of motivating them, controlling the quality of performed work, or mechanisms for administrative management there. In technical terms, it implies:

1.11) performing data collection in the most simplified format (minimizing the variables to be recorded and then reported by these facilities) using a paper medium.

1.12) centralizing the interface of entering the data into the electronic database (i.e. the information available on paper medium should be gathered at one place) initially and carrying out decentralization of this function only after considering arguments of cost-effectiveness and quality.

1.13) calculating the detection rate only for certain subpopulations at the initial stage (e.g. pregnant women, TB patients, prisoners in the penitentiary institutions), inasmuch as it is unrealistic to obtain complete data on each initial testing in a non-aggregate form from other medical facilities; in the future it will always be possible to add the data on each testing performed in other subpopulations to the main stream of information flow.

Introduction

The assessment of the HIV/AIDS surveillance system in Georgia was conducted under the project financed by the Global Fund - "Establishment of evidence-base for national HIV/AIDS program by strengthening HIV/AIDS surveillance system in the country" as a preparatory stage for developing the HIV/AIDS national strategic plan.

This report consists of several chapters:

The first chapter – "Methodology" – describes the methods used for evaluating the HIV/AIDS surveillance system.

The next chapter – "Study Results" is the descriptive part of the report: various aspects of the HIV surveillance system, such as International Requirements for HIV Surveillance and Common Approaches, Priorities of the National Policy, Regulatory Environment, Organizational and Functional Design, Information Flows, Stakeholders, Material and Technical Capacities, Human Resources are described one by one. As a rule, subchapters devoted to each subject / issue include an overview, a summary, and a list of main findings.

The chapter - "Institutional Assessment" - is devoted to the analysis of main findings. Two issues are highlighted in the discussion: the needs of improving the HIV surveillance system and the results of the so called SWOT analysis, summarizing strengths and weaknesses of the system as well as opportunities and threats to it.

The last chapter - "Conclusions and Recommendations" – is a logical continuation of the previous chapter and articulates conclusions and respective recommendations (to develop the national plan for the HIV surveillance).

Documents on study methodology (the so-called tools) are included, as well as quantitative data (statistical tables) and a list of reviewed literature is presented in the annexes.

The research team expresses gratitude to all the parties involved in the study having devoted their time and contributed to the effort at various stages of the research from the data analysis all the way to the articulation of the conclusions.

I. Methodology

II. A literature review and both qualitative and quantitative assessment methods have been used in conducting the study.

The requirements for the HIV surveillance system, international approaches, priorities of the national policy, and the legal environment were explored by field experts through reviewing the literature. The other issues were studied through extensive research using the methods detailed below.

The quantitative as well as the qualitative research methods summarized in the table below were used to achieve the objectives of the study:

Table 1:The methods used in the study

Component of the assessment	Assessment Method		
	Reviewing Records / Inventory Taking / Surveying	In-depth Interview	Focus Group
Organizational and Functional Design		X	
Stakeholders		X	
Information Flows	X		
Material and Technical Capacities	X		
Human Resources (Skills and Incentives)	X		X

1 In-depth Interviews

To fulfill the first and the second objectives of the study – i.e. to assess the organizational and functional design of the existing surveillance system and to perform the stakeholder assessment – in-depth interviews were taken with the respondents representing the following organizations / institutions:

Table 2:Respondents to the in-depth interview

Agency	Respondent
Global Fund Project in Georgia	1
Country Coordinating Mechanism	1
Ministry of Labour, Health and Social Affairs	1
Infectious Diseases, AIDS and Clinical Immunology Research Center	1
The Laboratory of Infectious Diseases, AIDS and Clinical Immunology Research Center	1
National Center for Disease Control and Public Health (Departments of Epidemiological Surveillance and Statistics)	2
Republican Blood Transfusion Station	1
WHO Georgia Country Office	1
United Nation Development Program (UNDP)	1
Foundation "Save the Children", Georgia Country Office	1
Non-Governmental Organizations (Bemoni, Tanadgoma)	1

A special questionnaire was used to conduct the in-depth interview (9, p. 87). The assessment of the functional design provided for considering the functions included/implemented in the international practice of the HIV/AIDS surveillance. Emphasis was placed on the shortcomings / problems existing in the country nowadays in terms of implementing these functions. Regarding the organizational design, the

information was collected concerning who the major parties involved in the system are and how the main functions of the HIV/AIDS surveillance and the respective responsibilities are distributed among them. The stakeholder analysis provided for identifying who the parties interested in the HIV/AIDS surveillance system are, what roles they have in the system functioning, and what their demands, expectations, and incentives are with regard to the HIV/AIDS surveillance system.

The in-depth interview also provided for determining how satisfied the respondents were in the end with the existing HIV/AIDS surveillance system and what their recommendations were for changing / improving the current system.

In addition, the respondents talked about the results of the national policy on HIV/AIDS at the end of the interview.

2 Record Review, Inventory, Survey

Information flows, material and technical capacities, and human resources were assessed in selected facilities of both the central and the local levels. Information flows were evaluated on the basis of reviewing respective records (registration, notification, reporting, and analysis) available in these facilities. Material and technical capacities were assessed using the inventory method. Data on human resources, particularly on their professional skills were collected through a survey by means of direct interview. All the three tools were developed in four varieties, one for each type of facility– central level institutions, public health centers, laboratories / blood stations and healthcare facilities (primary healthcare facility, hospital, STI clinic, women's consultation) (9 p. 92, p. 101, p. 112, p. 120).

2.1 Selection of Facilities

The following facilities were selected for reviewing records, taking an inventory, and surveying:

Central Level Institutions

Infectious Diseases, AIDS and Clinical Immunology Research Center

Reference Laboratory of Infectious Diseases, AIDS and Clinical Immunology Research Center

National Center for Disease Control and Public Health

Republican Blood Transfusion Station

Medical Service of the Penitentiary System

Skin and Venereal Diseases Research Institute

TB National Program

Narcology Research Institute

Local Level Facilities

Local facilities were selected in Tbilisi, Adjara, and Samegrelo on the basis of the following two considerations: a) exactly these three regions account for the major part of the recorded HIV/AIDS cases ;

and b) according to the plan of project actions, the updated model of epidemiological surveillance has to be introduced in the two pilot regions – in Tbilisi and in Batumi.

The sample size, i.e. the number of facilities by the type and location of a facility was defined as follows

Table 3:Distribution of the selected facilities by various characteristics

Type of facility	Region	District	#	Facility
Laboratory	Samegrelo	Zugdidi	1.	Zugdidi Reference Laboratory
		Senaki	2.	AIDS Laboratory and Blood Transfusion Room of Senaki District Hospital
	Achara	Batumi	3.	AIDS Center Laboratory of Batumi Hospital of Infectious Diseases
		Kobuleti	4.	Laboratory of Kobuleti Hospital
	Tbilisi		5.	Tbilisi Laboratory "Testi"
		Total	**5**	
Blood Transfusion Station	Samegrelo	Zugdidi	6.	Zugdidi Department of Blood Transfusion
	Achara	Batumi	7.	AIDS Laboratory of Batumi Blood Transfusion Station
	Tbilisi		8.	Tbilisi Blood Transfusion Station
		Total	3	
Public Health Center	Samegrelo	Zugdidi	9.	Samegrelo (Zugdidi) Regional PHC
		Khobi	10.	Khobi District PHC
	Achara	Batumi	11.	Achara (Batumi) Regional PHC
		Kobuleti	12.	Kobuleti District PHC
	Tbilisi		13.	Tbilisi Municipal PHC
			14.	Vake-Saburtalo District PHC
		Total	**6**	
Polyclinic	Samegrelo	Zugdidi	15.	Zugdidi Ambulatory-Polyclinic Amalgamation
		Khobi	16.	Khobi District Polyclinic
	Achara	Batumi	17.	Batumi #2 Polyclinic
		Kobuleti	18.	Kobuleti District Polyclinic (Family Medicine Center)
	Tbilisi		19.	Tbilisi #26 Polyclinic
		Total	**5**	
Women's Consultation	Samegrelo	Zugdidi	20.	Zugdidi Women's Consultation
	Achara	Batumi	21.	Women's Consultation of Batumi Maternity Hospital
	Tbilisi		22.	Women's Consultation of Acad. K. Chachava Perinatal Medicine and Obstetrics and Gynecology Research Institute
		Total	**3**	

Type of facility	Region	District	#	Facility
STD Clinic	Samegrelo	Zugdidi	23.	Zugdidi STD Clinic
	Achara	Batumi	24.	Batumi STD Clinic
	Tbilisi		25.	Tbilisi STD Clinic
		Total	**3**	
Hospital	Samegrelo	Zugdidi	26.	Zugdidi Multifield Hospital "Respublika"
	Achara	Batumi	27.	Batumi Republican Hospital
	Tbilisi		28.	Acad. O. Gudushauri National Medical Center
		Total	**3**	
Central Level Facilities	Tbilisi		29.	AIDS Center
			30.	Reference Laboratory of AIDS Centre
			31.	NCDCPH
			32.	Republican Center of Blood Preparations
			33.	Skin and Venereal Diseases Research Institute
			34.	National Program for Tuberculosis
			35.	Narcology Research Institute
	Total		**7**	

The following approach was used to select a specific medical facility: in each region, in the presence of several facilities with an appropriate profile, particular facilities were picked out randomly (random numbers were named by a nearby person who was unaware of what purpose this procedure served) from a list of facilities available at local public health services.

2.2 Respondents

The so-called "best informant", i.e. a person who was most familiar with the issues relevant to the assessment, was chosen as a respondent in each selected facilities. If necessary, several people would participate in the survey in case a particular issue was falling outside the scope of one respondent's competencies and the involvement of other personnel was required.

2.3 Data Analysis

Quantitative data were entered and analyzed by means of SPSS v13.0. The analysis was mainly descriptive.

3 Focus Group Discussion

The incentives for human resources to better implement the main functions of HIV/AIDS surveillance (as well as drawbacks / problems in the knowledge and skills of professional staff with regard to fulfilling the main functions of HIV/AIDS surveillance) were studied by means of group discussions. Ad-hoc guidelines were developed and used for leading group discussions. (see , p. 128).

Each session of the focus group discussions lasted 1,5 hours on average. Discussions were conducted in the following four groups:

Table 4:District Laboratory / Blood Transfusion Station

Region	District	#	Facility	Position	Number

Achara	Batumi	1.	LTD Achara Blood Transfusion Republican Station	Manager	**1**
				Laboratorian	**1**
		2.	LTD Batumi Hospital of Infectious Diseases	Manager	**1**
	Kobuleti	3.	Blood Transfusion Department	Laboratorian	**1**
Samegrelo	Zugdidi	4.	Association "Ksenoni" Laboratory	Manager	**1**
				Laboratorian	**1**
		5.	Zugdidi Multifield Clinical Hospital "Respublika"	Manager	**1**
	Senaki	6.	JSC Senaki District Hospital	Laboratorian	**1**
				Total	**8**

Table 5:Regional and District PHCs

Region	District	#	Facility	Position	Number
Achara	Batumi	1.	Achara Department of Public Health	Epidemiologist	**2**
	Kobuleti	2.	Kobuleti Division of Achara Department of Public Health		
	Khelvachauri	3.	Khelvachauri Division of Public Health	Director	**2**
	Keda	4.	Keda Division of Public Health		
Samegrelo	Senaki	5.	Senaki PHC	Director	**4**
	Tsalenjikha	6.	Tsalenjikha PHC		
	Zugdidi	7.	Zugdidi PHC		
	Khobi	8.	Khobi PHC		
				Total	**8**

Table 6: Health Care Providers - Outpatient Clinic / Hospital / STD Clinic / Women's Consultation

Region	District	#	Facility	Position	Number
Achara	Batumi	1.	Batumi Family Medical Center	Deputy Director	**1**
		2.	Batumi Republican Clinical Hospital	Epidemiologist	**1**
		3.	LTD Achara Regional Center for Skin and Venereal Diseases	Director	**1**
		4.	Batumi Maternity Hospital, Women's Consultation	Epidemiologist	**1**
Samegrelo	Zugdidi	5.	Zugdidi Adult Polyclinic	Deputy Director	**1**
		6.	Zugdidi Medical Center, Department of Obstetrics and Gynecology	Director	**1**
		7.	Zugdidi Skin and STD Clinic	Director	**1**
		8.	Zugdidi Women's Consultation	Director	**1**
				Total	**8**

Table 7:Focus Group Composition – Tuberculosis National Program, Inst. of Venereal Diseases, Inst. of Narcology, Medical Service of the Penitentiary System

District	#	Facility	Position	Number
Tbilisi	1.	JSC Narcology Research Institute	Director	1
			Physician	1
	2.	Skin and Venereal Diseases Research Institute	Director	1
			Physician	1
	3.	National Center for Tuberculosis	Data Handling Manager	1
	4.	Aldagi – Prisons' Project	Assistant Manager	1
	5.	Penitentiary Department	Physician Expert	1
			Total	**7**

Each group discussion was conducted by two experts: a moderator – who led the discussion and a facilitator, who was in charge of recording personal characteristics of respondents, solving logistical issues, and taking notes of the discussion. All the four discussions were conducted in Georgian. All group participants consented to participating in the discussion as well as to having the discussion recorded on audiotape.

All the group discussions were recorded on audiotape, based on which transcripts were later made. A standard methodology was used to develop the code scheme for organizing the data (such as the data on the incentives of human resources, the factors causing the gaps in the knowledge and skills of the human resources with regard to implementing the main functions of the epidemiological surveillance and so on).

Study Results

4 International Requirements and Common Approaches to the HIV Surveillance

4.1 Overview

In general, a HIV surveillance system serves the purpose of reducing the epidemic in the country: the surveillance system should detect new HIV/AIDS cases and systematically collect complete and reliable information on the trends of HIV distribution and spread. On the basis of this information, response actions and the monitoring of programs for preventing and controlling the HIV infection should be planned and implemented[1].

The routine system of the HIV surveillance records only the HIV cases and is not sensitive in terms of forecasting expected spread of the infection. The latest system, i.e. the second generation surveillance system, informs the healthcare system about the prospective spread of the epidemic in advance through collecting information about the risk factors.

4.1.1 Requirements for HIV Surveillance System

It is important that the following issues be in focus right at the initial stage of designing the HIV/AIDS surveillance system: a) what should be measured (which biological and behavioral indicators should be used), b) which methods should be used for data collection, c) which subpopulations should be selected for the study, d) where the measurements should take place (in which geographic area), e) how frequently the measurements should be performed (the frequency of data collection), f) how the measurements should be implemented; g) how the data should be analyzed.

In general, the following requirements are established for the HIV/AIDS surveillance system:

Collecting data on HIV prevalence in the country as well as the information on new sources of infection and, based on these data, estimating the size and the expected trend of the epidemic spread in the country.

Detecting high-risk subpopulation groups and the geographical areas where planning and the implementation of anti-epidemic interventions are necessary

Studying behavioral factors in the high-risk subpopulation groups and tracking changes in these factors over time.

Collecting the information based on which it is possible to plan healthcare services as well as the anti-epidemic measures to be implemented by the public health authorities.

Evaluating the results of implementing specific anti-epidemic interventions

Forecasting the expected spread of the HIV infection for the next 5 years

[1] CDC definition of public health surveillance, 1988

Countries in the European region are required to report national data to the WHO and UNAIDS European collaboration center with the defined frequency. Namely, the data on HIV/AIDS cases are reported to the European Center for the Epidemiological Monitoring of AIDS (EuroHIV) every 6 months.

Anonymous information for each individual AIDS case is integrated into the European non-aggregate AIDS data set. Individual data on anonymous AIDS cases are integrated into the European Non-Aggregate Aids Data Set (ENAADS). Anonymous non-aggregate information on HIV cases is integrated into the European HIV Infection Data Set (EHIDS)[2]. Therefore, the country's epidemiological surveillance system should also meet the requirements of international organizations.

HIV prevalence data is updated annually in the European HIV prevalence data set, which contains aggregate data on HIV prevalence in a high-risk subpopulation (blood donors, pregnant women, etc.)

4.1.2 Requirements for the Surveillance System in Countries with different HIV Epidemic Status

Under the WHO and UNAIDS classification, countries are divided into three groups according to the status of the HIV epidemic, as countries with 1) low prevalence, 2) concentrated epidemic and 3) generalized epidemic of HIV.

Such classification of countries is based on the HIV prevalence data among various subpopulation groups. Over time, due to a change in the prevalence of HIV infection, a country may move from one group to another. The requirements for epidemiological surveillance system differ in countries with different status of the HIV epidemic.

In low prevalence countries the prevalence of the HIV infection is less than 5% in any population group. Therefore, the surveillance system should focus on collecting HIV prevalence and behavioral data among high-risk population groups and keep track of those changes in behavioral factors over time, which may cause an increase of the HIV prevalence in the country.

In countries with concentrated HIV epidemic the prevalence of the HIV infection is more than 5% among high-risk population groups and less than 1% among pregnant women in urban areas. The surveillance system should monitor the changes in the behavioral factors and prevalence of the HIV infection among the high-risk population groups, detecting not only behavioral risk-factors among the high-risk subpopulation groups but also connections between these subpopulation groups and the general population.

In countries with a generalized HIV epidemic, HIV prevalence is more than 1% among pregnant women. The surveillance system should focus on monitoring the prevalence of HIV infection and high-risk behavioral factors in the general population.

For the time being, Georgia is a low prevalence country. Accordingly, the HIV surveillance system should meet the requirements set for such countries. Nevertheless, the surveillance system in the country should be organized in such a way that the system could be easily modified along a change in the epidemic status to meet the requirements set for the countries with the concentrated HIV epidemic.

4.1.3 Major indicators used in the HIV Surveillance

Standard indicators have been developed for the HIV surveillance to be used for drawing comparisons over time and between geographic areas. The majority of these indicators should be reported by age and sex and

[2] WHO Regional Office for Europe; Methods for Second Generation HIV Surveillance Implementation For Countries of Central and Eastern Europe (CEE) and The Baltic States

several of them - by other variables, such as a risk-group[3]. The indicators are subdivided into three groups: 1) biological indicators, 2) behavioral indicators and 3) socio-demographic indicators. The list of the major indicators is given below.

Figure 1: Standard Indicators used in HIV Surveillance

Biological Indicators	1. HIV prevalence 2. STI prevalence 3. TB prevalence 4. Number of AIDS cases in the age-group of under 18 years 5. Number of AIDS cases in the age-group of 18 to 25 years 6. Number of AIDS cases in the age-group of over 25 years
Behavioral indicators	1. Percentage of persons having had at least one non-regular sex partner in the last 12 months 2. Percentage of persons having used a condom the last time they had sex with non-regular sex partner 3. In youth: age at first sexual intercourse (sexual debut) 4. Percentage of drug injectors having used a sterile syringe the last time they injected a drug 5. Percentage of drug injectors having used unclean shared syringes and vessels. 6. Percentage of drug injectors having used a condom the last time they had sex. 7. Among commercial sex workers: number of clients in the last week 8. Among commercial sex workers: percentage of female and male commercial sex workers having used a condom the last time they had sex 9. Percentage of males having used a condom the last time they had anal sex with male
Socio-demographic indicators	1. Socio-economic and educational status 2. An indicator of residency or migration status 3. Marital status 4. Parity (for antenatal sites)

4.1.4 Methods and Sources of Data Collection

There are several methods of data collection and sources of information for HIV/AIDS surveillance: 1) biological surveillance, which implies collecting the HIV prevalence data among different population groups, 2) behavioral surveillance, which implies collecting the behavioral data among subpopulation groups. 3) Routine surveillance of HIV/AIDS cases and 4) the other sources of information[4].

4.1.4.1 Biological surveillance:

Sentinel surveillance in defined sub-populations

The aim of sentinel surveillance (with sentinel sites) is to monitor the HIV prevalence rate in a defined sub-population. Existing medical facilities, where representatives of the general population seek medical assistance – e.g. STI clinics and TB clinics - are often used as sentinel sites. It has to be

[3] UNAIDS/WHO; Guidelines for Second Generation HIV Surveillance, 2000
[4] UNAIDS/WHO; Guidelines for Second Generation HIV Surveillance; 2000

noted that sentinel surveillance should be performed in those population groups for which no routine HIV screening is provided in the country.

Regular HIV screening of pregnant women

Countries, regardless of their epidemic status, are advised to collect HIV prevalence data not only among high-risk population groups but also in groups, which more or less represent the general population (e.g. pregnant women). Pregnant women serve not only as a good proxy indicator of the general population but also they are readily available for conducting serosurveys[5]

Regular HIV screening of professional cohorts

Since HIV surveillance in pregnant women doesn't provide us with the HIV prevalence data in males, countries are advised to collect data in other population groups (conscripts, migrants) to acquire a more comprehensive picture of HIV infection spreading trends.

Regular HIV screening of blood donors

The findings of routine HIV screening among blood donors are one of the HIV prevalence indicators in the general population.

Serosurveys of high-risk population groups (Drug injectors, CSW, MSM)

4.1.4.2 Behavioral surveillance:

Repeated behavioral surveillance surveys conducted on a regular basis in defined sub-population groups.

4.1.4.3 Routine surveillance of HIV/AIDS cases

HIV and AIDS case reporting by age, sex, geographic location, and risk-group

HIV and AIDS case reporting by routes of transmission

Annual reporting of the number of cases tested for the HIV infection by age, sex, patient group, and sentinel site.

The system of HIV and AIDS case reporting signals about the presence of HIV infection in a given population and can detect those sub-population groups that need further follow-up.

4.1.4.4 Other sources of information

Vital statistics

STI surveillance

TB surveillance

Second generation surveillance system does not utilize any different method of data collection. It uses data collected through two different methods (biological and behavioral) of surveillance for cross-checking and combines them in ways that the results acquire the property of a more solid evidence base. Second generation surveillance system should be suited to the state of epidemic in the country and address the specific needs of the country.

[5] UNAIDS/CDC/WHO, Guidelines for Conducting HIV Sentinel Serosurveys among Pregnant Women and Other Groups; 2003ddd

In low prevalence countries, to which Georgia currently belongs, the primary objective of the second generation surveillance system is to identify high-risk population groups and keep track of changes in HIV prevalence and behavioral factors in these groups. The second generation surveillance system should be dynamic- implying that along with a change in the country's epidemic status the system should shift its focus and adapt accordingly to the new needs of the country. The second generation surveillance data should be used for planning preventive interventions and assessing the impact of the implemented ones.

4.1.5 Data Flow and Analysis

Socio-demographic data and results of HIV/AIDS testing should be conveyed from the lower level to the regional/national level for entering, analyzing, and storing the data in the database. The data set should contain information coming from both the routine surveillance system and sero-prevalence surveys. It has to be noted that reporting of the data from the lower level to the national one should occur in the same non-aggregate form as the data is collected at the lower level. The data should be reported to the global level[6] in the same non-aggregate manner.

An HIV/AIDS registry exist at the national level is the the main and most important tool, based on which the execution of various necessary analyses will be possible.

To analyze **the HIV infection** data, to present them, and to prepare reports, it is recommended:

To analyze HIV prevalence rate by age, sex, geographic area, urban / rural location, subpopulation group, and risk factor.

To analyze trends of HIV prevalence rate over time by age, sex, geographic area, urban / rural location, subpopulation group, and risk factor.

Graphs and tables: prevalence rate and confidence intervals by year, age, sex, sentinel site, subpopulation group, geographic area ,and urban/rural location

Maps: Prevalence rate at each sentinel site.

To analyze **the AIDS** data, to present them, and to prepare reports, it is recommended:

Graphs and tables: number of cases by age, sex, geographic area and mode of transmission

Maps: number of cases by geographic area[7].

4.2 Summary

The main international requirements for HIV surveillance system are standardized and tailored to the status of the HIV epidemic:

- Major indicators (biological, behavioral, and socio-demographic) of HIV surveillance are defined
- Disaggregation variables are defined: age, sex, geographic area, urban/rural, subpopulation groups, and risk-factors

[6] UNAIDS, Monitoring the Declaration of Commitment on HIV/AIDS; Guidelines on Construction of Core Indicators, March, 2007

[7] WHO Recommended Surveillance Standards WHO/CDC/CSR/ISR/99.2

- Regardless of the specificities of their HIV surveillance systems, countries have the obligation to send the information regularly in a standard form to the respective international agencies/bodies to keep EuroHIV, ENAADS and EHIDS data sets up-to-date.

Notwithstanding the fact that Georgia belongs to the group of countries with low HIV prevalence , it is possible to develop the HIV surveillance system to meet the requirements for countries with a concentrated HIV epidemic status, including:

- monitoring changes in behavioral factors and the HIV prevalence data among high–risk population groups
- drawing connections between behavioral risk-factors detected in high-risk subpopulation groups and the general population in parallel with identifying these factors in high-risk population groups

Pursuant to the manual for development of major indicators (UNAIDS, 2007), the reporting of data from the lower level to the upper one should be performed in the same non-aggregate manner as the data is collected at the lower level.

5 Institutional Description

5.1 Priorities of the National Policy

What is the vision of the state in fighting against HIV/AIDS spread?

Which policy documents define the priorities (objectives and approaches) of the state?

What outcomes does the state policy envisage to attain?

How successful has progress been in achieving these outcomes?

What factors exist that may impede or facilitate the attainment of these outcomes?

5.1.1 Overview

The state policy on fighting against HIV/AIDS spread is reflected in the following documents:

The National Health Policy Document (2000-2009), 1999

The Strategic Plan for Health Sector Development in Georgia (2000-2009), 1999

The Main Directions of the State Policy in Health Care Sector in Georgia, 2007

The National Program for Economic Development and Poverty Reduction, 2003

2006-2010 National Strategic plan to fight HIV/AIDS, 2007

The National Strategic Plan to Fight Tuberculosis and HIV Infection (2007-2011), 2007

2008 State Healthcare Programs:

- The State Program for Ensuring Epidemiological Security
- The State Program for Disease Prevention

- The State Program for Early Detection and Treatment of HIV/AIDS cases
- The Obstetrics State Program

Municipal Programs

The Millennium Development Declaration, 2000

The UN Declaration of Commitment on HIV/AIDS adopted at the Special Session on HIV/AIDS of the General Assembly, 2001

Dublin Declaration on "Overcoming Barriers - Partnership to fight HIV/AIDS in Europe and Central Asia" adopted at the Ministerial Conference, 2004

The Regional Program for Urgent Response to the HIV/AIDS in the Commonwealth of Independent States, 2002

Washington Consultation Built on the "Three Ones" Principle, 2004

National Health Policy Document (2000-2009), 1999

The National Health Policy Document was developed in 1999. It was the basic strategic document defining the goals and objectives for maintaining and improving the population health for the next ten-year period. It should be noted that due to the implemented and ongoing reforms in the country in the fields of healthcare finance, regulation, hospital sector, and public health, as addition the institutional changes, the document has lost its topicality. However, at the present time, it has not yet been updated.

The policy document defines HIV/AIDS control and prevention as a priority. In chapters 2.5, "Reduction of Communicable and Socially Dangerous Diseases" and 2.7, "Promotion of Health and Healthy Lifestyle," the prevention of STIs and AIDS is formulated as one of the objectives to be achieved through a) improving the effectiveness of methods used for active detection and b) raising public awareness about the methods of individual self-protection.

The policy document defines:

The Involved parties and their responsibilities:

- Public Health Department – program planning and management
- National Center for Disease Control, AIDS Center and its Regional Branches, Blood Transfusion Stations – program implementation

Vertical Programs

Strategic Plan for Health Sector Development in Georgia (2000-2009), 1999

The strategic plan for health sector development in Georgia is the plan of implementing and monitoring the National Health Policy. It defines the sources and mechanisms of funding. Just like the policy document, it hasn't been updated to reflect the changes that have occurred since 1999.

The strategic plan stipulates that targeted programs for HIV prevention (such as AIDS prevention and Safe Blood programs) are financed by central budget transfers administered by the public health department. Pursuant to the document, the department has been entrusted with such responsibilites as analyzing and managing the epidemiological situation and supervising the health information system.

Main Directions of the State Policy in Health Care Sector in Georgia, 2007

This document was developed in 2007. It describes the healthcare reforms envisaged by the Governemnt of Georgia in the fields of health service organization, financing, and regulation.

The document on the main directions of the state policy is not as extensive and detailed as the policy document of 1999, consequently it doesn't say anything particular about HIV/AIDS. The document defines the main goal of the healthcare system as "improving the health condition of the population, which implies increasing life expectancy and enhancing the quality of life of the population, reducing the burden of non-communicable and communicable diseases, increasing immunization rates, and lowering maternal and child mortality rates."

This document has not been officially adopted for the time being and is available as a draft on the web-site of the Ministry of Labour, Health and Social Affairs of Georgia[8].

National Program for Economic Development and Poverty Reduction, 2003

One of the goals of the National Program for Economic Development and Poverty Reduction is the development of human capital. The program provides that health condition is a fundamental determinant of human capital and recognizes HIV/AIDS as a threat. The program also details that HIV/AIDS data in the country are not reliable.

In the document the goals of economic development and poverty reduction are linked with the Millennium Development Goals, including the goal on HIV/AIDS - to halt and begin to reverse the spread of the HIV/AIDS by 2015.

2006-2010 National Strategic plan to fight HIV/AIDS[9]

The first national strategic plan to fight HIV/AIDS was developed in 2002 under the lead of the then-government commission and with the international technical assistance, and it covered the period of 2003-2007.

The plan was updated in 2006 on the basis of the UNGASS report and the recommendations adopted as a result of national consultation conducted at the outset of 2006. Recent updates to the document were made at the beginning of 2007 in accordance with the ongoning reforms in the country[10].

In the document, economic development and poverty reduction goals are linked with the Millennium Development Goals, including the goal on HIV/AIDS - to halt and begin to reverse the spread of the HIV/AIDS by 2015.

8 http://www.moh.gov.ge/page.php?2
9 The paper is available only in English
10 The report considers the document updated in January 2007

The plan aims at decreasing the risk of HIV infection, reducing vulnerability to the epidemic and its impact in Georgia. The plan defines the basic outcomes of its 5-year-long (2006-2010) implementation:

The HIV prevalence rate is kept below 5% by 2010 (1% among drug injectors in 2004, 1.3% among CSWs in 2004, 4.3% among MSMs, in 2005)

The HIV prevalence rate is kept below 1% among pregnant women by 2010 (0.06% in 2005)

The HIV prevalence rate is kept below 5% among the 15-24 years old by 2010 (0.67% in 2005)

The survival rate of adults and children after 12 months of being on antiretroviral therapy is more than 90% by 2010 (88% in 2005)

The number of children orphaned and made vulnerable by HIV/AIDS each year is kept below 100 (103 children and adolescents cumulatively in 2005)

The number of AIDS death cases is kept below 1000 by 2010 (189 cases in 2004).

The Monitoring & Evaluation system and the data set comply with the "Three Ones"[11] strategy principles and the recommendations of UNAIDS on standard indicators for low prevalence countries.

The HIV prevalence rate is kept below 5% among TB patients by 2010 (2,3% in 2006)

The plan defines four strategic areas: 1) HIV/AIDS surveillance, 2) Prevention, 3) Treatment, Assistance, and Support, 4) National Commitments

Expected results with respective indicators and targets (outcome) are given for each strategic area. The plan also provides the working schedules of implementing strategic directions, identifying leading and partner organizations, sources of financing, budget, and the status of funding.

Strategic area - **1) HIV/AIDS surveillance**

The document gives a brief background of the surveillance system, stating the following: "Since 2007 the HIV/AIDS surveillance has been incorporated into the integrated program for surveillance of all notifiable diseases being administered by the NCDCPH[12] and it might be linked with STI and Hepatitis B and C surveillance nation-wide. Data is being collected and analyzed by the NCDCPH on a monthly basis and reported to the MoLHSA. However, there are no capacities for implementing behavioral surveillance at any level of the surveillance system".

The paper describes the main obstacles for the surveillance system:

There is no integrated national monitoring and evaluation and surveillance system implemented and functional

The capacities of the national stakeholders are inadequate in terms of implementing monitoring and evaluation and surveillance.

There is no second generation surveillance system implemented to monitor risk behaviors at the national level and the capacities of the evidence-based framework are limited.

[11] Three Ones strategy

[12] National Center for Disease Control and Public Health

Accessibility to voluntary consultation and testing services are overly limited, particularly at the sub-national level.

Target (outcome) of the direction:

The evidence-based framework focusing on high-risk population groups that determine the epidemic is implemented for the HIV/AIDS strategic programming.

Second generation HIV/AIDS surveillance is introduced and sustainable.

The expected results of the direction:

Second generation HIV/AIDS surveillance (sentinel and behavioral surveillance surveys with a biomarker component) is implemented in 4 regons. Behavioral and biomarker data are available for the following groups: intravenous drug users, commercial sex-workers, men having sex with men, prisoners, patients with TB, STI, and Hepatitis B and C, pregnant women.

The HIV/AIDS management information system is implemented nationwide, including case reporting and registers.

Access to voluntary counseling and testing services at the sub-national level is improved by 30-40%.

Main Actions:

HIV sentinel sites will be identified in all the 10 regions and monitoring will take place. The sentinel sites will include: STI clinics, TB clinics, medical facilities serving patients with Hepatitis B and C, women's consultations, facilities of the penitentiary system.

Periodic surveys with behavioral and biomarker components will be carried out in certain sub-population groups, such as: IDUs, CSWs, MSMs, IDPs, prisoners, migrants, the military. The surveys will be conducted once in two years.

(deals with voluntary counseling and testing services).

A nationwide HIV/AIDS management information system will be developed to strengthen the monitoring and evaluation capacities in all the components of the response to HIV/AIDS. The information system will be connected to every site in the country where HIV/AIDS related services are delivered.

Foreign technical assistance will be used for finalizing the development of the monitoring and evaluation system and the surveillance system by the topical group of UN agencies.

In addition, other capacity building activities such as: staff training, strengthening the regional and district HIV diagnostic and referral laboratories, assisting with IT equipment, etc. - will be carried out.

Notwithstanding the fact that the strategic plan was updated in 2007, the draft plan contains some inaccuracies in terms of the implementation time frame and the implementing agencies. For example: the development of the second generation HIV/AIDS surveillance system is planned for 2006 and the Department of Public Health and the AIDS center are indicated as the leading institutions. It should be noted that the existing version of the paper contains questions and comments, a fact which doesn't allow the document to be regarded as final.

Strategic Direction - 4) National Commitments

The background overview states that out of the "Three Ones" strategy the country has developed: one HIV/AIDS action plan (1) and one National HIV/AIDS coordinating body[13] (2). An integrated and coordinated National Monitoring and Evaluation System (3) hasn't so far been developed.

For each of the three components the targets (outcomes), the expected results, and the main actions are provided. The following are defined for the third component:

The Target (Outcome):

- The M&E is introduced and sustainable by 2007

The Expected Results:

- One integrated M&E system is introduced by 2006 and fully functional by 2007
- The staff involved in the M&E sytem has the technical ability to operate the system
- The M&E staff is prepared to use the integrated M&E data set
- The M&E sytem and the data set complies with the "Three Ones" strategy principle as well as the recommendations of the UNAIDS on standard indicators for low HIV prevelance countries.
- The data obtained by the M&E sytem is broadly disseminated among interested parties.

Main Actions:

- Establishement of the M&E division at the national level institution – the public health department, the AIDS center, the beneficiary institution of the Global Fund Project
- Provision of technical assistance (IT technologies) for the M&E division
- Training of national partners on the issues of M&E using Foreign Technical Assistance
- Employment of technical assistance to develop the M&E National Plan at the institutional and community level (administrative statistical system, program indicators, BSS[14] surveys)
- Publication of the M&E system annual reports on the web-sites and periodicals of medical statistics.

It's worth noting that the strategic plan has not been adopted by means of a decree of Parliament of Georgia or a decree of the Government of Georgia or an edict of the President. The plan was discussed and approved only by the Country Coordinating Council in 2007 and is not a normative act.

National Strategic Plan to Fight Tuberculosis and HIV Infection (2007-2011), 2007

This strategic plan was developed in the beginning of 2007 as an annex to the Strategic Plan to Fight HIV/AIDS. The document contains the SWOT analysis of the TB and HIV/AIDS programs; in the

[13] Coordinating Council
[14] Behavioral studies with a biomarker component

analysis the lack of the TB/HIV surveillance plan is recognized as one of the drawbacks of the programs.

The plan defines the impact, the outcome, and the results of the actions to be carried out and their budgets.

The impact

- Reduction of TB incidence among HIV infected people
- Reduction of TB related death rate among HIV infected people.

The outcome:

- Effective coordination of collaborative TB/HIV activities
- Improved accessibility to HIV services for TB/HIV patients
- Improved accessibility to TB services for TB/HIV patients

The results of the HIV program:

- B.1 Collaborative TB/HIV activities are incorporated in the Annual National HIV/AIDS Plan
- B.2 TB case-detection among HIV patients is improved
- B.3 Universal access to TB treatment is increased for HIV patients.
- B.4 Routine preventive treatment with Co-trimoxazole is provided for TB/HIV patients

Integrated results of the TB and the HIV programs:

- C.1 The TB/HIV national strategic plan is incorporated into the TB national strategic plan and the HIV/AIDS national strategic plan
- C.2 Effective functioning of the national TB/HIV working group is ensured
- C.3 The TB/HIV guidelines are developed and introduced.
- C. 4 The TB/HIV M&E plan is included in the M&E systems of the two programs.
- C.5 TB/HIV activities in the penitentiary system are implemented in a coordinated way
- C. 6 Infection control in TB and HIV facilities is improved.

State Healthcare Programs

The first state program aiming at HIV/AIDS prevention and control was introduced in 1994.

Until 2006, HIV/AIDS surveillance was a part of the state program[15] being administered by the Deparment of Public Health and implemented by the Infectious Diseases, AIDS and Clinical Immunology Research Center.

[15] E.g. in 2005 – Program for Promotion of Healthy Lifestyle, Disease Prevention and Prophylaxis of Socially Dangerous Diseases; in 2006 – Program for Disease Prevention

As a result of the reforms implemented in the beginning of 2007, the Public Health Deparment merged with the NCDC and the function of elaborating/administering its programs was entrusted to the MoLHSA.

In 2007, none of the state programs contained the component of HIV/AIDS surveillance.

The 2008 state programs dealing with HIV/AIDS prevention and control are described below. Table 8 (p. 23) presents a summary of some activities along with their implementing agencies and the sources of funding.

State Program for Ensuring Epidemiological Security, 2008[16]

The program covers a set of activities, the implementation of which ensures the prevention of communicable diseases through measures of epidemiological surveillance and control of diseases.

Chapter 1.2 gives the HIV statistical data, emphasizing the fact that the official statistics on the HIV don't reflect the actual picture in the country, thus making the objective of improving the HIV surveillance as an urgent issue.

One of the objectives of the program is: to improve the timely detection of communicable diseases through ensuring proper operation of the epidemiological surveillance system, including laboratory-based services. Epidemiological surveillance should be implemented at the regional and municipal centers to meet this objective and monitoring should be carried out to ensure the quality of the surveillance (the regional centers will monitor the municipal centers, and the municipal centers – the medical facilities).

Chapter 1.3 "The context of the epidemiological security in the country" describes the commitments assumed by the country with regard to communicable diseases, including the Millennium Development Goal[17]. It is also explained here that the achievement of these goals requires an integrated approach to be used with regard to public health as well as to primary healthcare and hospital sector. The program is accompanied with an annex presenting, among the other priority diseases, a list of actions and mechanisms of ensuring the measures to be implemented for HIV/AIDS prevention and control. It is also specified here that the HIV surveillance will be fulfilled by the NCDCPH and public health centers by themselves under this program[18], while epidemiological investigation of cases will be carried out by public health centers under municipal programs. The program provides that NCDCPH implements the suveillance for all communicable diseases at the national level and gets involved in epidemiological investigation of cases as needed.

The program will enter into force in March 2008. The program will be funded by the state budget, administered by the NCDCPH and its activities will be carried out by the municipal public health centers.

State Program for Disease Prevention [19], 2008

Under the safe blood component of the state program for disease prevention, the HIV/AIDS testing of donated blood is performed using the rapid test and the immunoenzyme test methods.

[16] A draft program was used for assessment; the program hasn't been approved by a normative act by the day of preparing the report.

[17] Halt and begin to reverse the spread of HIV by 2015.

[18] Currently, at the time of writing this document no such (specific) program that would provide for implementing HIV surveillance exists any more.

[19] The program hasn't been approved by a normative act at the time of preparing the report.

The program fixes the price of testing. It will be funded by the state budget. The terms and conditions of the tender and the contract will be defined by the Health and Social Programs Agency in coordination with the MoLHSA.

State Program for Early Detection and Treatment of HIV/AIDS cases[20]

The following activities are carried out under the program:

HIV counseling and testing high-risk group individuals (such as persons engaged in HIV-related risky behavior as well as babies born to HIV infected mothers), using the screening and confirmative methods.

Providing HIV/AIDS patients with outpatient services (instrumental diagnostics, treatment and prevention of opportunistic infections, laboratory monitoring, visits / counselling)

Providing HIV/AIDS patients with inpatient services (laboratory and instrumental diagnostics and treatment of diseases indicative of AIDS, laboratory and instrumental diagnostics and treatment of diseases related to HIV/AIDS (e.g. hepatic insufficiency and so on),).

The program fixes the prices of couselling and testing.

The program will be financed by the state budget. It will be implemented by the licenced medical facilities in Georgia having the appropriate licence for providing HIV/AIDS treatment.

The contract terms and conditions will be defined by the Health and Social Programs Agency in coordination with the MoLHSA.

Obstetrics State Program[21], 2008

The component of antenatal care of the program defines the volume of service to be delivered to a pregnant woman during an antenatal visit. At the first visit to be performed on the 13th week of gestation all pregnant women's blood serum should be tested for HIV antibodies (antigens) (using rapid / simple test method). It has to be noted that the benefit package doesn't provide for the voluntary counseling of pregnant women.

The program will be financed by the state budget. The contract terms and conditions will be defined by the Health and Social Programs Agency in coordination with the MoLHSA.

Municipal Programs

At the local level the functions of public healthcare are implemented through agencies (centers) established by local governance bodies. There are different sources of funding for carrying out the functions to be implemented: targeted transfers from the state budget (for delegated powers), the contract with the NCDCPH under the program for ensuring epidemiological security and local budgets (for exclusive powers).

The law "On Public Health" defines the powers delagated to local self-governing bodies, while the state budget for 2008 – the targeted trasfers for their implementation[22]. To exercise the delegated and exclusive powers, public health agencies should prepare municipal programs and submit them to the local self-governments for adoption.

[20] The program hasn't been approved by a normative act at the time of preparing the report.

[21] The program hasn't been approved by a normative act at the time of preparing the report.

[22] The local competencies are those obligations defined by the law "on public health" as well as by two other laws – "on conscription and military service" and "on military reserve service" .

The recommendation letter of the Minister of Labour, Health and Social Affairs of Georgia as of 09.02.2008 to the local self-governance bodies describes in details the advised staff list of the public health entities and functions to be carried out, according to the sources of funding. The epidemiological investigation of cases is among the functions to be fulfilled using budgetary transfers, while the recording of data collected by the surveillance system (urgent notification, sentinel and routine surveillance), the assessment of its quality, the verification of the data, and the reporting in compliance with the defined rules are to be carried out under the contractual arrangements with the NCDCPH. The letter also gives explanatory notes on transfer money provided for by the state budget, however it doesn't mention HIV infection separately.

It should be noted that the recommendation letter doesn't give advice on the organizational status of a local agency – the issue, which is defined neither in the law on public health nor in other normative acts. It's also worth noticing that the allotments dedicated specifically to implementing public health responsibilities are not separated out of the targeted transfers envisaged by the law on the state budget. Despite the fact that the recommendation letter specifies the estimated amount of expenditures on epidemiological case investigation within the epidemiological surveillance, this function might not be fully financed because the share of public health expenditures in the total amount of the targeted transfer is unknown.

Table 8:Certain HIV/AIDS activities by implementing organizations and sources of funding

Activity	Implementing Organization	Source of Funding
Testing of Donors' Blood using HIV Rapid/Simple and Immunoenzyme Tests	Contracted Laboratories[23]	Program for Disease Prevention (Safe Blood Component)
Epidemiological Surveillance	Public Health Service	Program for Epidemiological Security
Epidemiological Surveillance at the National Level	NCDCPH	Budget of the NCDCPH
Epidemiological Investigation	Public Health Service	Municipal Program
Testing of Pregnant Women using HIV Rapid / Simple test	Antenatal Clinics	Obstetrics Program
Voluntary counseling and testing of High Risk Group Individuals	Facilities licenced for HIV/ AIDS treatment	Program for Early HIV/AIDS Detection and Treatment
Testing of Non-High Risk Individuals with Screening, Immunoenzyme, PCR methods	Laboratories[24]	An Individual's Out-of-pocket Expenses
Confirmation with Immunoblotting Method	Facilities licenced for HIV/ AIDS treatment	Program for Early HIV/AIDS Detection and Treatment
Outpatient and Inpatient Treatment	Facilities licenced for HIV/ AIDS treatment	Program for Early HIV/AIDS Detection and Treatment; Global Fund Project

Millenium Development Declaration

By signing the Millennium Declaration in September 2000, Georgia assumed the responsibility to set and attain the 8 Millennium Development Goals based on the specific needs of the country. The 6th goal provides for combating HIV/AIDS, malaria, and other diseases and, to attain this goal, the country has set the following objective: *to halt and begin to reverse the spread of HIV/AIDS by 2015*. The first progress report on implementation of the MGDs (2004)[25] emphasizes the importance of developing an information base in order to compare and analyze the baseline and follow-up data. The same report evaluates the capacities for monitoring and reporting on the progress in achieving

[23] As indicated in the program; however, the blood transfusion stations themselves having the capability of HIV testing might be implied there.

[24] The laboratories capable of performing HIV testing using Rapid / Simple and Immunoenzyme methods are not registered

[25] Millennium Development Goals in Georgia, Tbilisi 2004

the goals. Quantitative and qualitative data, statistical analysis, information usage for policy-making and dissemination / reporting of information is evaluated as weak for the purposes of the sixth goal.

UN Declaration of Commitment on HIV/AIDS adopted at the Special Session on HIV/AIDS of the General Assembly[26], 2001

By adopting the Declaration on the special session of the UN General Assembly, Georgia became a party to the global consensus among 189 Member States concerning the action framework elaborated to achieve the Millennium Development Goals. To demonstrate the progress in fulfilling the commitments resulting from the declaration, countries are obligated to prepare yearly reports using the provided indicators and submit those reports to the UNAIDS.

The country has prepared and submitted two reports. The first one covers the period from 2003 to 2005, while the other deals with 2006[27]. One of the sections - "Challenges and Needed Actions" - of the later report emphasizes the problematic areas, such as: the lack of a national monitoring and evaluation system and the problems with the surveillance system. With regard to the latter the report goes as follows: "sentinel surveillance should be expanded to obtain reliable behavioral, epidemiological, and statistical data, which will help the government to develop an effective and goal-oriented policy. During the last years relevant epidemiological and programmatic data have been accumulated in the country, however, the data are fragmented and are not used for analysis and synthesis".

Regional Program for Urgent Response to the HIV/AIDS in the Commonwealth of Independent States[28].

The CIS countries developed a regional program for urgent response to the HIV/AIDS to fulfill the commitments resulting from the declaration; the program was signed by the leaders of the countries in 2002.

Dublin Declaration on "Overcoming Barriers - Partnership to fight HIV/AIDS in Europe and Central Asia" adopted at the Ministerial Conference[29], 2004

The Dublin Declaration specifies 33 actions to implement the assumed commitments, the 17th of which deals with the surveillance system: "Fund, improve, and harmonise surveillance systems in line with international standards, to track and monitor the epidemic, risk behaviors, and the vulnerability to the HIV/AIDS".

Washington Consultation Built on the "Three Ones" Key Principle[30], 2004

To allign the actions for fighting HIV/AIDS at the national level the countries are advised to follow the following key principles:

---

26 The Declaration of Commitment from UN General Assembly Special Sessions on HIV/AIDS (2001);

27 Monitoring and Declaration of Commitment on HIV/AIDS. Georgia Country report, reporting period January 1 – December 33, 2006. http://www.globalfund.ge. Submitted in January 2008 along with the CRIS file.

28 The Regional program of urgent response to the HIV/AIDS Epidemic Commonwealth of Independent States (May 2002);

29 The Dublin declaration adopted at the Ministerial Conference "breaking the barriers - partnership to fight HIV/AIDS in Europe & Central Asia" (November 2004);

30 "Three Ones" key principles. "Coordination of National Responses to HIV/AIDS" Guiding principles for national authorities and their partners. Washington Consultation, UNAIDS (25 April, 2004);

- One agreed upon HIV/AIDS Action Framework that drives alignment of all partners.
- One national AIDS authority, with a broad-based multi-sectoral mandate.
- One agreed upon country-level monitoring and evaluation system.

These principles are acknowledged by Georgia in the National Strategic Plan to fight the HIV infection (2006-2010).

5.1.2 Summary

The state policy aims at achieving the following main result: "to halt and begin to reverse the spread of the HIV infection by 2015".

To achieve the above mentioned result, the state policy is directed towards reducing the risk of the HIV infection, the vulnerability to the epidemic, and the impact of the latter. Four major strategic areas are defined:

- HIV surveillance
- Prevention of HIV spread
- Treatment, assistance, and support
- National commitments (under "Three Ones" key principles)

Notwithstanding the fact that the "National Strategic Plan to fight the HIV/AIDS, 2006-2010" is not a normative act, it declares most clearly the vision of the state on fighting the HIV infection and, particularly, on the development of the surveillance system.

The state policy on the HIV surveillance system is based on realizing / recognizing the following impeding factors:

- A lack of the integrated national M&E and surveillance system
- Low capacities (presumably of the system)
- A lack of the second generation surveillance system
- Low access to voluntary counseling, especially in the outlying districts

The state policy on the HIV surveillance is implemented by means of the specific state programs, such as:

- The 2008 State Program for Ensuring Epidemiological Security
- The State Program for Early Detection and Treatment of HIV/AIDS cases
- Municipal Public Health Programs
- Obstetrics State Program
- The Safe Blood Component of the State Program for Disease Prevention

5.1.3 Main Findings

The public policy documents reflect the vision of the state in developing HIV surveillance –HIV suveillance is recognized as one of the four strategies for achieving the goal of halting and beginning the reversal the HIV spread by 2015.

5.2 Regulatory Environment

This chapter discusses the HIV/AIDS legal framework in Georgia and describes each normative act in play in this field.

Descriptions of laws as well as directive acts are given only from the perspective of HIV/AIDS. Each normative act is reviewed considering specifically the articles being, to a certain extent, related with the subject of the research.

The final section discusses the examples of Sweden and Finland. This analysis is based on the norms provided in the legislative acts of respective countries as well as the information obtained from the web-sites of public agencies operating in the field of healthcare. A review of these examples is interesting to draw comparisons between Georgia and the best-practice countries.

5.2.1 Overview

Law of Georgia "On the Prevention of HIV Infection (AIDS)" (N 683, March 21, 1995)

The Law of Georgia "on the prevention of the HIV infection (AIDS)" is a basic law regulating the principles of fighting the HIV/AIDS. The law is rather general, defining the issues of HIV/AIDS as testing, treatment, and preventive follow-up of patients.

The law stipulates that there is the state's policy to fight HIV/AIDS as well as specific bodies implementing various activities. The existence of a government commission and the National Program for Fighting and Preventing HIV/AIDS is also worth noting. The government AIDS commission (which is formed by President) leads and coordinates activities of different state bodies in the field of fighting HIV/AIDS. This act states that President approves the National Program for Fighting and Preventing HIV/AIDS, which is based on the WHO recommendations and is implemented by the MoLHSA and other public institutions. The law also details that the MoLHSA has a specialized service under its authority to fight HIV/AIDS, implementing healthcare activities in the field; as for protection of human rights of AIDS patients – it is entrusted to the legal department of the Ombudsman Office.

The 3rd chapter of the law defines the issues of testing persons residing in Georgia for HIV/AIDS and sets the major principles in this area. HIV/AIDS testing is voluntary in Georgia and the protection of anonymity is guaranteed by law. In some cases (for Georgian citizens and foreigners legally residing in Georgia) HIV/AIDS testing is provided by state program funding.

The 4th chapter deals with testing, treatment, and preventive follow-up of the HIV/AIDS patients. Each individual being diagnosed with the disease is subject to preventive follow-up. It is one of the measures for preventing the spread of HIV/AIDS.

The 5th chapter determines the rights and the obligations and the responsibilities of HIV/AIDS patients and ensures their social protection. The act provides diseased persons with various social

benefits, treatment, and supervision within the scope of the state program. The confidentiality of such persons is also protected by the law. Obligations and legal liability with regard to spreading the disease are also defined for the HIV patients and their violations are punishable under the Georgian legislation.

The final 6th chapter regulates the rights and the obligations, the liability, and the relationships associated with social protection of medical personnel. Only medical facilities belonging to the specialized service of fighting the HIV/AIDS are authorized to issue certificates confirming that a person underwent the HIV/AIDS testing. The law also defines the liability for not fulfilling the measures of countering the spread of the HIV/AIDS while carrying out medical or other kinds of interventions.

Law of Georgia "On Health Care" (N1139, December 10, 1997)

Only one article of the law "on Health Care" refers to the issues of the HIV/AIDS. The article 83 defines that HIV/AIDS regulations are established in a special law. This article makes reference to the above-discussed law "on the Prevention of the HIV infection (AIDS)". Hence, the law "on Health Care" doesn't regulate in detail the legal regime for the HIV/AIDS. Only the general article 82 is worth noting- it states that: "The Ministry of Health of Georgia shall direct the activities needed for preventing and controlling sexually transmitted infections in compliance with the up-to-date standards considering the epidemiological situation by raising public awareness and providing relevant information to the society. The state shall define its policy on prostitution and implement necessary measures in accordance with the situation developing in the country".

Law of Georgia "On Public Health" (N5069, June 27, 2007)

The law "on Public Health" aims at promoting the health of the Georgian population and the practice of a healthy life-style as well as preventing communicable and non-communicable diseases.

The article 15 establishing prevention and control of specific infections is worth mentioning for the purposes of this research. HIV/AIDS is referred to as one of the specific infections for which the Ministry of Labour, Health and Social Affairs of Georgia ensures the development of an integrated state strategy for preventing and controlling the disease and organize its implementation. Sub-paragraph 2 of this article makes reference to the special law and determines that: "the ministry defines the regulations for controlling blood donations and transfusions, ensuring safety and quality of blood and its components as well as producing, storing, and using blood and its components and protecting donors' health and rights by means of special legislation."

The responsibilities of the Ministry in the field of preventing communicable diseases are defined in Article 7. The list of responsibilities mentions the obligation of the Ministry concerning epidemiological suveillance of communicable diseases. The law specifies that a list of occupations associated with high risk of the spread of communicable diseases as well as a list of appropriate preventive measures is defined by a legal act of the Minister of Labour, Health and Social Affairs of Georgia.

Law of Georgia "On Donation of Blood and Its Components" (N 687, March 21, 1995)

The law aims at ensuring the development of blood donorship and its components, as well as protecting donors' rights in Georgia through social, economic, legal and medical arrangements.

Only several articles are noteworthy with regard to communicable diseases. The law defines that a person must not have an infectious disease in order to become a donor. The act imposes the responsibility on a donor to inform medical staff about all his or her past illnesses during a medical examination. The citizen who deliberately conceals or falsifies the information about his or her illnesses will be held responsible pursuant to the Georgian legislation.

Order of the Minister of Labour, Health and Social Affairs of Georgia (N 241/n, December 5, 2000) "On Defining the Contraindications for Donating Blood and Its Components"

Only a few directives are worth noting with regard to HIV/AIDS in this normative act. It is laid down that while registering an active donor with a blood transfusion facility, a special form adopted by the Ministry of Health is filled in, where the donor confirms by signing that he or she is not a carrier of HIV or other diseases.

In the article on the contraindications for donorship it is defined that these contraindication are subdivided into 2 groups: a) absolute contraindications and b) relative or temporary contraindications. The absolute contraindications for donorship are: the AIDS, HIV carriage, and being in a high risk group for HIV/AIDS (homosexuality, drug addiction, prostitution, alcoholism, tattooing, needlestick injury)

Order of the Minister of Labour, Health and Social Affairs of Georgia (N 299/n August 16, 2001) "About the Adoption of the Sanitary-Hygienic and Epidemiological Requirements for Industrial Transfusiology Facilities".

One of the chapters of this normative act sets the requirements for donor selection and blood preparation. The only paragraph of the order worth mentioning for the purposes of this research is the one which establishes that while selecting a donor (a whole blood donor) it is necessary to collect various data; an AIDS/HIV carrier is permanently excluded from donorship.

Penal Code of Georgia (N 2287, July 22, 1999)

The penal code of Georgia establishes a liability for intentionally passing highly dangerous infectious diseases. In particular, the following are recognized as punishable acts: deliberately creating a threat of passing a highly dangerous infectious disease to another person or infecting a person with such a disease. The same being done to two or more individuals or, knowingly to a pregnant woman, is considered to be an aggravating circumstance and, thus, is punished more severely.

Code of Administrative Infringements of Georgia (December 15, 1984)

Administrative infringements in the field of labour, health, and social protection are provided in chapter 5 of the code. However, no article has anything to do with HIV infection or highly dangerous infectious diseases. It only establishes a liability for concealing a source of venereal disease and such contacts of patients that pose a threat of the spread of the disease. In its contents, this article doesn't apply to HIV/AIDS at all.

Law of Georgia "On Statistics" (N 1071, November 12, 1997)

All public institutions and services are bound to report to the State Statistics Department and its territorial branch offices reliable and complete statistical data provided for by the state statistical

work program free of charge within the limits of the law and observing the dates defined by this law. According to this statute, provided data are confidential if they allow identification of a subject of observation.

This act doesn't specify the kind of medical statistics and HIV/AIDS data collection and analysis. However, the order of the Minister of Labour, Health and Social Affairs "on the rule of producing and reporting medical statistical data" issued on the basis that this act has to be noticed in this regard.

Order of the Minister of Labour, Health and Social Affairs of Georgia (N 101/n, April 5, 2005) "On the rule of producing and reporting medical statistical data"

This order adopts the reporting and notification forms to be used for the surveillance and control of communicable diseases in Georgia and sets the rules for their maintenance and analysis as well as the dates of their submission.

Regional Departments of the MoLHSA, municipal, district, and regional public health centers, medical research institutions and healthcare facilities located in Georgia[31] ensure collection and reporting respective data to the legal entitiy of public law, namely – L.Sakvarelidze NCDCPH. Medical facilities are charged with the responsibility of submitting various medical statistical data, including monthly reports on sexually transmitted infections. The obligation of medical facilities in relation to detecting infectious diseases includes the recording of all cases of communicable diseases in the target area regardless of whether a patient seeks medical assistance with a private practitioner or at a medical facility. The obligation also implies informing the population on the importance of immediate notification of cases of infectious diseases as well as expected risks and potential advantages of treatment.

The ministerial order prescribes a standard log book for infectious diseases where all identified cases of infectious diseases should be recorded by a curative-preventive facility; all cases of communicable diseases / conditions identified in the coverage area are recorded by the local public health center in the log book for infectious diseases.

The normative act defines that in the case of HIV/AIDS detection, the confirming facility is obligated to report the test result in the form of a special notification in 72 hours past the final confirmation to the public health authority operating in the area where the individual actually resides. A regional / district PHC performs epidemiological investigations of HIV/AIDS cases being only commissioned (through special assignments) under the state program pursuant to the legislation in force.

In the general provisions of the order, it is indicated that "the effectiveness of managing communicable diseases is dependent on the functioning of a surveillance system. The surveillance system consists of: identification, registration, investigation, and confirmation of cases / outbreaks, data reporting, response and preparedness activities, feedback and communicaiton."

Order of the Minister of Labour, Health and Social Affairs of Georgia (N 40/n, February 7, 2007) "On Approval of 2007 State Health Programs"

This order sets forth that the number of cases of infections such as HIV/AIDS and other STIs is increasing in Georgia. To fight these infections, high-risk population groups, including people detained in penitentiary institutions, are being tested for the diseases above all others. Latent forms,

[31] After abrogating the licencing of medical facilities, it is unclear from a legal point of view how a "medical facility" is defined.

posing more danger in epidemiological terms to the popoulation than manifested forms of the disease, are being detected frequently during such investigations. This program provides for performing STI tests in penitentiary institutions and focus-groups.

Among the expected results, the noramtive act describes the timely identification of HIV infected people by means of voluntary free investigation of high risk group individuals (incl.: drug addicts, homosexuals, CSWs and others) and increasing their knowledge about HIV/AIDS.

The infectious disease component (Chapter 8) of the state program approved by the order covers HIV/AIDS inpatient services, including diagnostic investigations and treatment; as for the HIV/AIDS prevention subcomponent – it consists of 16 activities.

Edict of the President of Georgia (N 587, October 8, 1998) "On Strengthening the Measures to Fight and Prevent the HIV/AIDS"

The recent changes in this edict were made in 2002. The act describes in general the measures and the strategy to be implemented in the country, prescribing different public bodies to carry out appropriate measures for HIV/AIDS prevention. The edict approves the composition of the HIV/AIDS government commission (on the basis of the statute "on the prevention of the HIV/AIDS"), which coordinates the efforts of different bodies to fight the HIV/AIDS.

It can be said that this normative act is outdated and doesn't reflect the current reality. For example, the edict states in the introductory part that international experts consider Georgia a high-risk area for the HIV/AIDS. Therefore, this act is not relevant for reviewing the current legal environment.

Charter of the legal entity of public law – L. Sakvarelidze National Center for Disease Control and Public Health (Order N 107 /n, March 28, 2007)

This center is a legal entitiy of public law under the Ministry of Labour, Health and Social Affairs of Georgia. It carries out its activities through its central office and territorial units. It has a number of functions and powers in terms of operating in the field of public health care. The powers of the center are: **the identification of communicable diseases and risk-factors** on scientific grounds, **the operation of an information system, control and prevention of diseases**. It also carries out the function of ensuring the **operation of the integrated surveillance system for communicable diseases** and implementing appropriate measures within its competencies defined in the charter. The center also collects and maintains medical statistics.

The NCDCPH also performs laboratory activities. Its competencies include organizing and operating the national referral laboratory, dealing with particularly dangerous infectious diseases, and ensuring the biological safety of the laboratories. In addition, one of the functions of the center is to cooperate with international organizations and report data to them.

Note:

In 2001 "The Republican Center for AIDS and Clinical Immunology" merged with "The Center for Infectious Diseases" establishing "JSC Infectious Diseases, AIDS and Clinical Immunology Research-Practical Center". This center is responsible for prevention, epidemiological surveillance, diagnostics, treatment and scientific research of the HIV/AIDS and other infectious diseases in the country.[32]

[32] http://aidscenter.ge/

Infectious Diseases, AIDS and Clinical Immunology Research-Practical Center is a legal entitiy of private law and operates within the legal framework governing business activities.

Order of the Minister of Labour, Health and Social Affairs of Georgia (N 144/o May 1, 2007) "On Establishing the State Integrated Coordinating Council for Global Fund Project to Fight AIDS, Tuberculosis and Malaria in Georgia and Other Programs Targeting AIDS and Tuberculosis in the Country"

Under the authority of this order, **the state** integrated **a coordinating council** for the Global Fund project to fight AIDS, Tuberculosis and Malaria in Georgia and other programs targeting AIDS and Tuberculosis in the country was established. The council was founded to coordinate, make recommendations, and monitor the implementation of the contract signed between the Global Fund and the Georgian Health and Social Projects Implementation Center and other programs. Representatives of various non-governmental and governmental organizations may take part in the work of the council due to its specific nature.

The coordinating council implements multisectoral activities involving different stakeholders to fight the AIDS, TB and Malaria. It coordinates cooperation between the GF and other healthcare projects and ensures advancing and discussing AIDS-related issues at the governmental level.

Apart from GF projects, the council also supports and evaluates the work of various private organizations dealing with AIDS-related issues. The council creates the appropriate environment and gives advice to organizations implementing AIDS-related projects.

The authority of the council includes evaluating the level of reaching the objectives defined for fighting AIDS, TB and malaria in the country and elaborating recommendations, submitting proposals to the GF and other donor organizations on funding AIDS projects, and requesting program reports from other HIV/AIDS related projects.

The experience and comparative review of the best-practice countries – Sweden and Finland

It's interesting for comparison to discuss the cases of Finland and Sweden in terms of their implemention of epidemiological surveillance and fighting HIV/AIDS in the presence of appropriate legislation. Both countries have laws on communicable diseases. It is worth noticing that Georgia, unlike Sweden and Finland, has adopted a separate special law on HIV/AIDS. It's noteworthy that both countries have a state action plan and a clear strategy on fighting communicable diseases and this strategy is being followed by all competent bodies in very close cooperation with one another.

In Finland the advisory body/ committtee on communicable diseases is the the body in charge of fighting against infectious diseases and its activities are regulated by government decree. Here the analogy is apparent with the AIDS government committee established by the decision of the Government of Georgia on the basis of the law "on HIV/AIDS prevention". The National Public Health Institute (in fighting against communicable diseases) is the expert institution in the field. Normative acts of the Minister of Health adopted on the basis of the law on communicable disaeases are in force in the country.

In Finland the entire system of the Ministry of Social Affairs and Health plays the major role in fighting infectious diseases. In its normative acts, the ministry gives a list of communicable diseases

and the principles to fight them as well as organizational issues. A similar normative list and nomenclature of diseases is also in force in Georgia.

The Ministry of Health of Finland has local units – regional state authorities –in charge of monitoring communicable diseases in the areas of operation (similar to the public health units in Georgia), planning and managing activities to combat these diseases as well as supervising the observance of the respective regulations enacted in the field. The local units submit proposals to the Ministry of Health about certain decisive measures to be implemented to eliminate infectious diseases. In contrast to Georgia, the by-law prescribes in Finland that district hospitals / health centers (districts are divided according to the areas of operation of hospitals) are also involved in combating infectious diseases, ensuring the accessibility of specialized services in the areas of their operation for treating infectious diseases, the organization of necessary trainings, and the dissemination of information on existing communicable diseases at various levels (e.g. at the regional level).

The Department of Infectious Disease Epidemiology and Control of the Finnish National Public Health Institute plays an important role in collecting data and making recommendations. It cooperates with the local units and gives them directions; it also cooperates with regional and central health authorities. Physician notification on the HIV case is sent directly to the National Public Health Institute for subsequent response (sending the results, while protecting personal data, to a health center physician and a hospital physician working on infectious diseases). Laboratories working on dangerous pathogens are also charged with the responsibility of notification.

The Finnish Public Health Institute possesses a specialized AIDS laboratory (a referral laboratory) and an AIDS unit. The insitute maintains the National Infection Disease Register prescribed by the law. This organization implements the so-called passive and active surveillance of the AIDS and plays the role of a major expert in policy decisions on fighting AIDS. Similar to Georgia, this institution is also subordinated to the Ministry of Health, however it plays quite a powerful role in preventing infectious diseases.

The Swedish Law on Aims of Public Health (2003) has strengthened the role of the existing Swedish National Institute of Public Health, particularly the AIDS board of this organization. The institute leads the implementation of the national action plan for preventing AIDS and STIs adopted at the government level.

The Swedish Communicable Diseases Act aims at creating a better balance between the population's need for protection and an infected person's rights. Like in Georgia, testing for communicable diseases is also voluntary in Sweden. The National Board of Health and Welfare is responsible for undertaking surveillance of communicable diseases and regulating and coordinating activities in this field all over the country.

Public health work is divided among 21 community boards and 290 local self-governances. The National Institute of Public Health manages the statistics for the local units. Since 1992 the institute has been working on the implementation of preventive measures of fighting AIDS under the targeted project “measures against AIDS and sexually transmitted infections”. The institute also cooperates closely with the non-governmental sector, like the coordinating council operating in Georgia. Additionally, there is an Institute for Infectious Disease Control operating in Sweden- also a government authority. Its mission is to monitor the epidemiology of infectious diseases among Swedish citizens and promote control and prevention of these illnesses. The main function of this

institute is to undertake the surveillance of communicable diseases in particular and analyse current epidemiological situation both in the country and internationally. The surveillance is implemented in close cooperation with "health workers of community communicable disease control".

Unlike Georgia, (where the public health authority is subordinated to the Ministry) the Swedish National Institute of Public Health is an independent authority established on the basis of the Government Decree. In Scandinavia, the statistics on communicable diseases are maintained by the public health authorities themselves, independent of the Ministries.

As for the norms of criminal law, knowingly infecting other people with a particularly dangerous disease leads to criminal liability in almost all European countries as well as in Georgia.

5.2.2 Summary

"The rules of the game" in relation to HIV/AIDS surveillance are mainly defined by the Law of Georgia "On Statistics" and the order of the Minister of Labour, Health and Social Affairs of Georgia (N 101 /n, April 5, 2005).

- Duties of involved parties are defined pursuant to the above mentioned order:
  - Medical facilities are responsible for collecting and reporting data for HIV epidemiological surveillance (using statistical forms)
  - In case of HIV/AIDS detection, the confirming facility is obligated to send a notification to the respective (territorial) public health authority within 72 hours
- It is not clear what will happen if any of the above mentioned obligation is not fulfilled (or is fulfilled inadequately).

The Law of Georgia "on Public Health" defines only in general the responsibilities of the state with regard to epidemiological surveillance of communicable disease.

The Law of Gerogia "on the prevention of HIV infection (AIDS) " mainly defines the rights and the responsibilities of parties involved in HIV testing and prevention (anonymity, confidentiality and so on)

The function and respective powers for implementing HIV surveillance are not clearly defined in the normative environment and, presumably, are implied in the charter of the legal entity of public law being under state control (within the integrated surveillance of communicable diseases).

Pursuant to the legislation, ensuring the operation of the integrated surveillance system for communicable diseases is a function of **L. Sakvarelidze National Center for Disease Control and Public Health**. The domain of its authority includes:

- Identification of communicable diseases and their risk-factors
- Running the information system
- Disease control and prevention

5.2.3 Main Findings

Responsibilites and powers for implementing epidemiological surveillance of HIV/AIDS cases are not defined in the normative environment.

The normative environment doesn't provide for regulating the relationship between two or more parties involved in the field of HIV surveillance, save the unilateral obligation of medical facilities to report medical statistics.

5.3 Organizational and Functional Arrangement

5.3.1 Overview

5.3.1.1 Organizational Arrangement

Until April 2007 the HIV/AIDS surveillance administered by the Public Health Department within the scope of "the state program for HIV/AIDS surveillance" was implemented by the JSC Infectious Diseases, AIDS and Clinical Immunology Research-Practical Center (hereafter AIDS center) along with 11 regional and 56 district laboratories and regional public health center epidemiologists. One of the several epidemiologists working at the regional public health centers was assigned to HIV/AIDS surveillance (however they were not formally bound to do so). In the view of respondents, it was a "***well-organized system of epidemiological surveillance***".

Since April 2007, HIV/AIDS surveillance has become a part of the integrated surveillance of communicable diesases with the latter formally being the responsibility of the National Center for Disease Control and Public Health (hereafter, the NCDCPH). An HIV/AIDS surveillance unit was specially established within the NCDCPH with only two epidemiologists employed there. The transfer of the HIV/AIDS surveillance function to the NCDCPH wasn't based on a ministerial order - ***"the state program for HIV/AIDS surveillance simply was not included in the list of state programs and in the new budget law". Hence "the abolishment of this program doesn't even have a specific author".*** The representative of MoLHSA pointed out that the NCDCPH was charged with the responsibility of implementing the HIV/AIDS surveillance under its charter prescribing the surveillance of communicable diseases in general, without specifying the functions: ***"the charter prescribes that NCDCPH shall implement epidemiological surveillance by a specially assigned staff"***.

5.3.1.2 Functions

The major functions of HIV/AIDS surveillance (HIV testing / serosurveillance, notification / reporting, risk behavior surveys in subpopulation groups, disease register and cohort follow-up, data analysis, dissemination, and usage of information) accepted in the international practice are not defined/prescribed formally in the appropriate normative documents (e.g. Minister's Order or manuals / guidelines) in methodological or organizational terms.

HIV testing / Serosurveillance

At the moment, HIV testing of high-risk group individuals is implemented by the AIDS center laboratory (in Tbilisi) and 8 regional laboratories located in big cities (Batumi, Zugdidi, Kutaisi, Telavi, Akhaltsikhe, Poti, Rustavi, Gori), under the state program for early detection and treatment of HIV/AIDS cases. When a suspicious case (a positive rapid test result) is detected, the individual's blood / serum is sent to the AIDS center for confirmation along with referral form #4.

The central blood transfusion station, together with 16 regional and district blood transfusion stations, implements "the safe blood component of the state program for disease prevention", under which these stations are obligated to screen donors for 4 infections, including HIV. In each suspicious case of a positive test result, the individual's biological specimen is sent to the AIDS center for confirmation along with referral form #4.

HIV testing is also provided at the Lung and TB National Center under the GF program. Blood sampling is performed at TB clinics and blood / serum is sent to the AIDS center for testing.

HIV testing of pregnant women is performed at women's consultations and polyclinics providing antenatal services to the population under the Obstetrics State Program. When a suspicious case (a positive rapid test result) is detected, the pregnant woman's blood / serum is sent to the AIDS center for confirmation along with referral form #4.

The medical service of the penitentiary system performs the HIV testing of high risk prisoners (drug addicts). The procedure is mandatory and blood is sent to the AIDS center for testing. In addition, according to the representative of the penitentiary system, they identify the contacts of the already infected patients and send this information to the AIDS center for further response:

„... everything is all-right here, we have the information, however not all prisoners are tested for HIV. We know whom we need to test....". The respondent noted that these functions are carried out under the official duties.

Not long ago, the implementation of medical service functions of the penitentiary system has been transferred to Aldagi/BCI, whose representatives stated that they were going to perform the HIV screening of all new prisoners confined in the penitentiary system within their function in order to establish full control over the situation with regard to this diesase:

„...next to nothing is being undertaken in the penitentiary system for the moment, what is being done is only a rather small piece of work. We are going to perform screening of all prisoners for HIV and if a prisoner is transferred to another jail facility / site, he or she will enter the new location with the already determined HIV status . . ."

As the representatives of the Institute of Skin and Veneral Deseases have pointed out, patients of STI clinics are tested for the HIV rather inconsistently. The state program doesn't provide for testing STI patients at all.

Under the USAID-funded "STIs and HIV prevention project" implemented by the "Save the Children" foundation, health offices have been opened at Kutaisi STI Clinic and Batumi Mother and Children Republican Center, providing anonymous counselling and testing for STIs and HIV infection (the service is free of charge and confidential).

It should be noted that there are medical facilities (e.g. hospitals), which buy test -kits with their own money and perform HIV testing of patients. In such cases the costs are borne by patients themselves. Its important to note that a complete list of laboratories providing HIV testing in the country doesn't exist.

Each suspicious case identified in blood transfusion stations, laboratories, and other facilities is referred to the AIDS center reference laboratory. Confirmation is carried out only in the AIDS center throughout the country.

Case Reporting

Laboratories participating in the implementation of the "state program for early HIV/AIDS detection and treatment" report to the AIDS Center every month using the form # 23, however it should be noted that the

statistical form #23, which is normatively approved by the Minister's Order # 101/n, is a yearly statistical form. The laboratories use this form for monthly reporting.

Blood transfusion stations participating in the "Safe Blood Component of the State Prorgram for Diesase Prevention" also report data on donors' HIV testing to the AIDS center every month using form #23. Blood transfusion stations also send reports to the Central Blood Transfusion Station using form #868 (invoice of work performed). These reports only contain information about the number of testing (rather than the number of suspicious cases) as well as financial data. Blood transfusion stations also report to the NCDCPH using the yearly statistical form #14 (approved by the Minister's Order # 101/n). In this form, the reason for totally rejecting donated blood is indicated. For its part, the Central Blood Transfusion Center sends monthly reports to the AIDS center using form #23.

It's worth mentioning that a unified database of blood donors exists in the country, containing a nominal list of donors along with their test results. Data entry is perfomed by each blood transfusion stations in this database. Consequently, if information on a rejected blood donor is entered in the database by one of the blood transfusion stations in the databases of the rest of the blood stations, the area across the donor's surname is highlighted with red colour, which indicates that the donor is not eligible to give blood.

Women's consultations do not report to the AIDS center. They report to the NCDCPH using the monthly report form IV-02. This statistical form is approved by the Order # 101/n of the Minister of Labour, Health and Social Affairs of Georgia as of 05.04.2005. In paragraph 7 of subchapter II "Antenatal Care" of this form the total number of HIV tested cases is indicated. Outpatient clinics, providing antenatal services do not use the form IV-02 (which are intended for women's consultations) for reporting notwithstanding the fact that they perform the HIV testing of pregnant women.

Women's consultations and outpatient clinics providing antenatal services to the population report the information about the number of performed testing to the Health and Social Programs Agency . They also report to the Vishnevskaia-Rostrapovich Fund using "the form for accounting consumption of medical goods for HIV and Hepatitis B testing", so far as the fund supplies women's consultations with the test-kits, which are needed to perform HIV testing.

The National Program for Tuberculosis reports to the GF and provides information on the total number of testing performed and the number of HIV infected people. In addition, the National Program for Tuberculosis reports to the WHO/EURO the data on the number of TB cases and HIV infection among TB patients in the region.

The AIDS center reports to the NCDCPH using the yearly form # 23 approved by the Minister's Order # 101/n (sectoral statistical reporting, "report on blood HIV/AIDS IFA testing results"), the form #17 (yearly agency-level statistical observation) approved by the Order # 101/n of the Minister of Labour, Health and Social Affairs of Georgia as of 05.04.2005, the Annex 1 "report on HIV-infected and AIDS patients registered during a calendaer year" (newly registered cases) and the Annex 2 "report on HIV-infected and AIDS patients" (overall statistics of cases by the end of a given year). These annexes are not approved as normative acts.

The reporting and notification forms used in the system, according to the existing regulations, are described in detail in the appendices which are annexed to this assessment report (see. , p. 132 and p. 133)

Risk behavior subpopulation surveys

As the NCDCPH staff members pointed out, conducting risk behavior subpopulaton surveys is currently the function of their institution, but they cannot implement these surveys due to the lack of state funding.

Risk behavior subpopulaton surveys are conducted in Georgia, however the role of the state in planning and implementing such surveys is negligible for the moment "due to the lack of the needed resources or simply the absence of the respective will". Therefore, in the view of the respondents, this is exactly the reason the institutionalization of such surveys hasn't occurred in the country.

The majority of risk behavior subpopulation surveys in the country have been conducted with the financial support of international donor organizations; namely, these surveys were carried out by non-governmental organizations "Bemoni" and "Tanadgoma" under the USAID funded "STIs and HIV Infection Prevention Project" being implemented by "Save the Children" foundation. Three surveys among IDUs and CSWs were conducted in Tbilisi, 2 - in Batumi and 1 – in Kutaisi during a six-year period under this project; and one survey was carried out in Tbilisi among MSM in 2007. As it was stated by the representative of "Save the Children" foundation, these surveys were implemented based on the international methodology being perfected during the years; survey protocols and instruments have been elaborated. However, it has to be noted that a unified catalogue for all of these surveys doesn't exist.

> *„Unfortunately, we didn't manage to conduct a survey among youth populations, being also a risk group (it was the donor's decision to place emphasis on very high risk population groups). The surveys are administered every two years. However, they can be conducted even less frequently i.e. every 3-4 years. In fact, it is impossible to track changes in behavior in such a short period of time".*

Determining the size of high risk population groups

As the representatives of the NCDCPH pointed out, determining the size of high risk population groups is their function, but it is not implemented.

All respondents say that the number of high risk population groups is not determined in the country. They indicate that the lack of needed financial resources and appropriate adapted methodology, as well as the deficit of local expertise, are the reasons for such a state of affairs. Under the project of "Save the Children" foundation, it is planned to conduct this survey among drug addicts. As a representative of the NGO "Bemoni" pointed out, it is decided to conduct a similar survey under the South Caucasus Action Program on Drugs (SCAD) implemented under the aegis of the UN Development Program, though the methodology to be employed by the study is unknown. In addition, it should be noted that the the experts in the field value the significance of implementing this function adequately, which, in their view, is highly important to determine the HIV prevalence among high risk population groups accurately and plan scientific studies properly.

> *„...there is a very big need for it in the country. IDUs are the highset risk group for the AIDS and no one can tell you precise numbers or epidemiological data on this group . . . "*

> *„... A suitable methodology for this is not available in the country..."*

> *„...the legal environment was, indeed, an impeding factor and therefore the law on drug addiction was liberalized under the GF project, since the success of the project was mainly contingent on this development ..."*

„...this function is not fulfilled, however I think that other countries also face this problem ...“

„...stigma is truly present and more involvemnet of social workers with this issue is needed...“

„...it was included in this year's plan of the project of "Save the Children" foundation for the IDUs. We found international consultants known worldwide, however we haven't managed to bring them here yet. I also know that this is planned under the SCAD program ...“

„...they are not conducted and the reason for it is the lack of respective will on the part of the state and the absence of appropriate funding needed for them...“

„...I think that determining the size of high-risk subpopulation groups is important in general and especially with regard to IDUs, since drug addiction is revealing the signs of a pandemic ...”

Disease Register and Cohort Follow-up

There is a register of HIV-infected and AIDS patients in the AIDS center. The cohort follow-up is performed not only because of epidemiological surveillance, but also for not overlooking the moment of treatment. All HIV infected individuals necessarily go to the AIDS center every four months and undergo a certain set of testing. Additionally, it should be noted that, as it was pointed out by a representative of the GF, the database was simplified under their project.

„...the database that the AIDS center had was very cumbersome. It was interesting for clinicians, but inflexible and hard to use in terms of comprehending the entire epidemiological situation in the country. The database that we have developed is also far from ideal since I think that it is tailored to the needs of our program for the most part rather than to those of the country in general ...“

The AIDS center performs the follow-up of the cohort of diseased individuals in accordance with the "special clinical guidelines".

"...we possess all kind of information about our patients. They are under our continuous observation. The follow-up performed in accordance with the special clinical guidelines enables us to determine the correct tactics of treatment ...”

Data Analysis

The respondents consider that data analysis is performed in the country nowadays, however no framework and specific methodologies of analysis exist. Additionally, the respondents pointed out that problems of data reporting don't allow for a complete and deeper analysis.

Analyzing data is currently a function of the NCDCPH. However, the AIDS center still performs it imperfectly due to its own inertia. As it was noted by a representative of this center, *"creative analysis*

of any kind, then its generalization and an elaboration of its conclusions on its basis weren't performed in the past and is not a case in these days either"

„...what is done for the moment is a simple analysis, not allowing to make generalizations".

Dissemination and Usage of Information

As the majority of respondents noted, dissemination of information takes place though the data is not used for policy-making.

Dissemination of information at various levels of the system is rather disorganized and, furthermore, there is no interest in using the results of the analysis in the country nowadays. *"The majority of reports rest on shelves."*

Some experts think that the strategic plan document for 2002-2007, which was prepared by the country and set the stage for receiving the first project from the GF on AIDS component, may be considered as an example of using information successfully in the country.

According to a representative of the GF, information is disseminated under the GF project inconsistently. Data is provided to the Ministry of Health by means of reports and to the public by means of presentations at various events. The GF uses these data to plan its future activities. The revision of ongoing and new projects as well as budget planning for the GF projects are performed based on this information. As for the state programs, decisions are made on unclear principles.

In the "Save the Children" foundation's project, the data received from surveys conducted under the project are used for developing its new strategies.

"For example, the study showed that the disease can spread among IDUs via shared vessels. After revealing this fact, the direction of the information campaign has changed."

The data obtained through second generation surveys, conducted under the "Save the Children" foundation's project at the national level, are used only to prepare UNGASS reports.

5.3.1.3 Problems / Flaws in Implementing the Functions

HIV testing / Serosurveillance

The lack of external quality control of respective laboratories was indicated to be the most improtant drawback in implementing the HIV testing / serosurveillance function. At the same time, respondents say that the qualifications of personnel needed to fulfill this function are quite high and respective laboratories have all the necessary equipment as well.

Problems with the transportation of laboratory samples from regions carried out predominantly by public transport were stated as the second important issue with regard to this function. Blood or serum is mainly carried to the AIDS center by a random person, (a patient's friend or relative, laboratorian's relative, acquaintance) due to the lack of needed financial resources.

Furthermore, field experts consider the reduction of state funding for HIV testing as a negative development.

Additionally, incongruity between specific characteristics of the HIV infection and the periodicity of donating blood by a donor under the safe blood program was mentioned as a serious flaw (the HIV

infection is characterized by a 3-month-long "window" period, whereas a donor is allowed to donate blood every 2 months).

„...Quality control is a general problem of laboratory diagnostics in Georgia. Leading laboratories, not only the AIDS center laboratory, try to introduce elements of internal control. The AIDS center laboratory itself has implemented internal quality control, however external quality control is not performed at all.....“

„...The state funding for HIV testing has been reduced substantially during the recent years...“

„...Blood manufacturers meet European standards. All tests needed for blood testing are performed, though I feel that the quality control of provided test-systems should be improved. In addition, HIV infection is characterized with a three-month-long "window" period, whereas donors are allowed to come here and donate blood every two months. This issue also needs to be resolved. The safe blood program should be defined as a priority program in the country ...”

„...The function of HIV testing and serosurveillance is, in truth, implemented successfully at the AIDS center laboratory. We receive test-systems produced in different countries; we recheck them here; moreover, we are not satisfied with only one test result and always perform rechecking with 2 or 3 different kinds of tests. We always check test-systems for how much sensitive they are when there is a low concentration of antibodies in blood; high concentrations may be accompanied by clinical signs as well ...”

„...In some cases test-systems are of low quality and cannot really detect whether there is the disease or not. This attribute is controlled at our center's level, but I don't know what is going on in the regions in this regard...“

„...HIV testing is well-organized. There is adequate equipment for it and medical personnel is also well-prepared. Staff members of regional AIDS centers frequently come to Tbilisi to participate in training sessions specially organized for them...”

"...The quality of provided tests are quite high. Apart from a few exceptions, virtually all suspected cases are confirmed in the AIDS center. However, despite this, I'm still not usually content with one test result and, to be on the safe side, I still recheck before sending a sample...”

"...Under the Safe Blood State Program, HIV testing is performed using registered test-systems, which are standardized for the AIDS center as well as for the regions, however control of test-systems still remains a problematic issue...”

„... All test systems are supplied with their own instructions and methodologies. They are supplemented by internal quality control. As for external control – it doesn't occur.."

„...Trasporting biological samples is a burning issue in the country. Blood or serum is mainly delivered by a random person due to the lack of resources needed for transportation..."

Reporting

In the view of the absolute majority of surveyed respondents, the function of HIV/AIDS case reporting needs a systematic reform in the country. The parties involved at different levels of the system emphasized various flaws in the implementation of this function based on specifics of their work.

According to field experts, the existing function of reporting is uncoordinated: respective responsibilities of reporting (who, where, and in what format) aren't clearly defined for all involved parties. Therefore, the respondents think it necessary to develop/streamline standard procedures and the format of reporting, which will ensure the improvement of data quality. In addition, the following problems were mentioned as the impeding factors for the successful implementation of this function:

The lack of a complete list of levels and facilities involved in the reporting system in the country (including the list of private medical facilities). There are many laboratories, where HIV testing is performed without any pre or post testing. They report neither to the AIDS center reference laboratory nor to the NCDCPH. *„...Nowadays all laboratories have been entitled to perform HIV testing. I'm totally unfamiliar with the list of all laboratories which should report data to me. Hence, some of them send information and some don't. There are many new private laboratories performing HIV testing. I don't remember them ever sending anything to us..."*

At the central level the NCDCPH has been deprived of the control function *„..The problem is that the medical statistics service was deprived of the control function. When control is removed, no one sends you information..."*

The data on patients who have underwent HIV testing beyond the program is unknown. *„...In the country there are many laboratories, which do not participate in any program. HIV testing is performed in theses laboratories, but these data aren'r gathered in the system..."*

It was noted that information doesn't flow in a timely manner either from the peripheral level to the AIDS center or from the AIDS center to the lower level. Data reporting has a more structured pattern under specific programs, where clear programmatic (rather than organizational) subordination exists, within which both the format and the recipient of reporting, as well as its periodicity, are defined.

Additionally, representatives of data recipient organizations put a particular emphasis on the problems of completeness and quality of the aggregated reporting format. Specifically, it was noted that the current format of reporting doesn't provide for those necessary parameters that are needed for the country to perform complete epidemiological analysis of the disease: e.g. the data on the total number of HIV tested people is not complete, since the current reporting forms don't contain such necessary variables as the age-group (e.g. form #23 and form #17), cause of death (form #17) and so on. Furthermore, it was noted that it is necessary to define a standard format of analysis in the first place and then bring the data elements and the structure presented in the reporting form into line with this analysis.

„... Laboratories send us a sectoral statistical monthly reporting form #23 along with the notification form that we have developed. Data on HIV tested individuals in the first form is devided by the group code and gender, but there is no breakdown by age. In our opinion, we supposedly developed a simple notification form, however its on-site usage turned out very difficult. The age breakdown is very important to the needs of epidemiological analysis, though..."

„...Only 8 laboratories that we retained from the old structure report to the AIDS center..."

„...HIV testing is voluntary and in some cases is registered anonymously, thus creating the risk of double recording..."

„... The cause of death is often not specified. It's important to indicate whether the AIDS is the cause of death or not in the reporting form..."

„...I receive aggregated data, whereas I need them to be in a disaggregated form to perform analysis; so I usually ask the AIDS center to provide me with disaggregated data and they do so..."

Consumption of Healthcare Services

Respondents noted that there is no adequate funding available for covering the population of the country with health care services, including the HIV/AIDS surveillance, while the provision of quality services is technically possible.

"...with regard to AIDS, Georgia differs from many developing countries with the ability to provide such services to an individual that many developed countries fail to; by that I mean the standard and the quality of laboratory testing and the intellectual support; however, the funding for universal coverage of the population with these services is insufficient ..."

Guidelines / Methodical Directions

According to the respondents, HIV/AIDS surveillance guidelines haven't been developed.

"...The guideline in English (UNAIDS, WHO) has been translated. However, it wasn't a formally approved guideline. The WHO workshop was held by that time and the above- mentioned guideline was for the participants"

"... There are some methodical recommendations, but not for surveillance. These directions are annexed to the program; they know which form is to be filled-in and when they send blood, the accompanying form is also provided. The methodical recommendations also specified how long it is possible to store a serum and how it must be sent".

The Level of Knowledge of Healthcare Providers

As the majority of respondents pointed out, the level of knowledge with regard to detecting cases of the disease is low among healthcare providers in medical facilities; it is unknown whether medical personnel are informed about the HIV/AIDS reporting procedure. Additionally, healthcare providers don't realize the importance of complete and timely reporting. It was also noted that healthcare providers' awareness of counseling patients is also low. Patient counseling is performed inadequately in state medical facilities. Healthcare providers don't have basic knowledge of epidemiology.

> *"...The level of knowledge is very low. In general, many of them who work on this issue misunderstand the term surveillance; they don't have basic knowledge of epidemiology".*

> *"...people who perform reporting should take training courses continuously".*

> *"...It's necessary to raise awareness of legal issues, what are the rights of a physician and those of a patient..."*

Educating the Public

It was noted that there are many flaws in raising public awareness on part of structures of the AIDS center and non-governmental organizations.

> *"...Apart from the fact that the public receives information in healthcare facilities, it is necessary to inform a broad audience of population in general; the role of mass-media comes forward here; organizations working in the field should encourage mass-media and involve it in their activities ..."*

> *"...The reproductive health survey and two major UNICEF surveys reflected the importance of public awareness for preventing the HIV infection. Unfortunately, it turned out that the level of knowledge was very low."*

Risk Behavior Subpopulation Surveys

Representatives of organizations implementing such surveys said that the participation of involved parties in the survey planning process was very low.

„despite sharing the documents with stakeholders and involved parties, either no or rare feedback is provided by them."

Furthermore, it was also noted that the standardization of the instrument in the country is hindered by the absence of a unified monitoring and evaluation system, with which the indicators of each individual program or survey should be brought into line later.

Additionally, it was also pointed out that only a few people have the necessary skills to perform this function in the country. Therefore, staff training and professional development were indicated as one of the important measures in order to perform scientific research of high standards.

„...It is quite an important function, however it is not implemented on a regular basis. The implementation of this function is not performed by the state; it has been a long time since non-govenmental organizations have assumed this function. However, I think that its fulfillment is quite uncoordinated. While planning such a survey, an epidemiologist should play a major role here..."

„... Carrying out such kind of surveys needs special methodological approaches that we are short of and, most importantly, surveys are not being institutionalized..."

„...Formerly, such kind of surveys were carried out by the AIDS center under grant funding from the USA, however they lacked scientific credibility..."

„..."Save the Children" foundation has been carrying out such kind of surveys since 2002. We apply international methodologies to the surveys performed under our project and use representative samples. Survey protocols have been developed and the methodology and the tools have been improved (already being used by the GF as well) under our projet. However, we haven't worked with youth as with a separate risk group. Only very high risk groups were surveyed according to the donor's requirement...".

"...An additional basic weakness of such surveys is that the questions are not those of interest for the UN and the country. The breakdown should be given by years, risk-groups, and cities. Moreover, in the MSM questionnaire the question on "condom use during the last sex" has been left out. Therefore, it is necessary that participation of the involved parties be very high when developing such a survey instrument..."

„...Such kind of surveys are mainly donor dependent and are implemented by non-governmental organizations. There is no unified register of surveys in the country and I regard it as a very serious matter..."

"„... Such surveys are carried out only in selected regions and cannot reflect a whole picture..."

"...Such surveys have been carried out, however a unified database doesn't exist. Previously, there was a unified database at the National Health Institute, which was liquidated. Furthermore, there are only 3-4 people from different organizations who can perform such surveys..."

"...While performing such surveys, we use the indicators (being gradually brought into line with the international indicators) that we are interested in. If the country develops an integrated monitoring and evaluation system, we will adapt it as well..."

Epidemiological Investigation

The lack of the needed standard tool / format for conducting an epidemiological investigation has been named as the basic problem in this field. In addition, it was also noted that the special emphasis put on the rights of HIV infected people in the law creates serious obstacles for administering epidemiological survey (*"one might not be able to fill-in even a half of the questionnaire…*")

Furthermore, a one-year long "failure period" was named as an important issue in this area (the AIDS center performs it inadequately, while the NCDCPH hasn't started to perform it yet) and the respondents think that it will adversely affect the overall epidemiological situation in the country later.

In addition, the inclusion of the "third person" in the process relating to transferring the epidemiological surveillance function to the NCDCPH was indicated as a serious hindrance. There are shortcomings in conducting epidemiologidal investigations as well as in the knowledge and skills of the personnel.

> *"…When you first tell a person that he or she is HIV infected and at the same time explain to him or her that this information will be kept entirely confidential and all of a sudden say "now go to another place and tell other people about your condition", will he or she go? many of them will refuse to go…"*
>
> *"..The AIDS center carries out epidemiological investigations even today under its own inertia, though not to the same extent as in the past. At the same time, we don't report to anyone any more, since we are not responsible for fulfilling this function any longer…"*
>
> *"…It is necessary to develop a standard format of case reporting and epidemiological investigation…"*
>
> *"…There is an important obstacle here: such a big emphasis is put on the rights of an infected individual that you don't know what to do after you detect a case… everything becomes dependent on the will of an infected person after this and what is your function then?*
>
> *"…Epidemiological investigation was carried out by the AIDS center with the assistance of regional PHC epidemiologists, though they didn't have this function assigned officially…"*
>
> *"…The NCDCPH has been charged with the responsibility to carry out this function, however it has neither adequate human capacities nor financial resources for today…"*
>
> *"…All the knowledge we have is practice-based … training is necessary to perform epidemiological investigation… I can assign less than an average score to my staff in this regard …"*
>
> *"… Workshops are necessary… only two persons can perform epidemiological investigation at my center, the rest can't do it…"*

Data Analysis

The absence of a standard framework and format of analysis of HIV/AIDS data in the country was named as an important issue in this regard. According to the respondents, incompleteness of data and the absence of methodological support are the impeding factors for performing a comprehensive data analysis. – ***"obtained data allows to perform only a superficial analysis, it's desirable that computerized databases and analytical programs be available"***. Inadequate understanding of the role of analysis by the personnel working at the lower levels (providers of data) is a serious problem as well.

> ***"...Data analysis is performed by the AIDS center under its own inertia, though without financial support of any kind..."***
>
> ***"...Analysing data is our (the medical statistics department of the NCDCPH) function. The personnel at the lower levels of the system don't understand the importance of data analysis and it is reflected in incomplete reporting on their part..."***
>
> ***"...Nowadays it is impossible to determine HIV prevalence among the HIV tested population, since the data on the overall number of HIV tested individuals is unavailable..."***
>
> ***"...the scarce information that we (NCDCPH) receive allows us to perform only a superficial analysis. It is desirable that computerized databases and analytical programs be available..."***
>
> ***"...Data analysis is performed under our ("Save the Children" Foundation) program providing for measurement of program indicators. Quite interesting information has been accumulated under the program during the years..."***
>
> ***"...Certain capacities as well as experience in analyzing data are available. In 1998 the stage was set for preparing annual national health reports in Georgia being done by the National Health Institute. A certain team was working on this issue and there was a methodology being continuously improved..."***
>
> ***"... Human resources are available and I feel that the state should assume responsibility with regard to them. As for supplying computers, there is no problem with it..."***
>
> ***"...Monthly reports submitted by the 8 regional laboratories to the AIDS center do not contain a breakdown of data by age groups being very important for the analysis..."***
>
> ***"We (AIDS center) didn't carry out creative analysis of any kind that would allow us to make some generalizations..."***

5.3.1.4 General Assessment of the Existing HIV/SIDS Surveillance System

The main reasons for the respondent's dissatisfaction are a virtual absence / inadequacy of the system and a legal"vacuum" with regard to the system. For the time being the system is disorganized from the

organizational and functional perspectives, the functions and the responsibilities of the parties involved in the system's functioning aren't established and specified clearly.

> *"...The old system doesn't work any more and a new one hasn't been established yet. The system needs improvementin its current state . Conditions have changed, but the system is still imperfect, the major problem is establishing the structure ..."*

> *"... There is no epidemiological surveillance system any more, it is not detailed, there is a legal vacuum..."*

> *„...It is unknown who does what, under which program, and with whose financial support..."*

> *"...There is no unity and coordination along with the absence of a unified system for monitoring. What is performed is scattered and fragmented..."*

The respondents are also dissatisfied with the fact that state funding for HIV testing has been substantially reduced and, on the contrary, the share of donors' funding has increased during the last 2-3 years.

> *"...One of the major components of the strategic plan is the financial component, where the analysis is given of what funding is needed, how much money is available, and what is the deficit..."*

> *„One of the risks is that 70% of the strategic plan is funded by donors and as soon as the country moves from the below-average to the above-average level of development according to its macroeconomic indicators (there is such a chance, since the country experiences economic development), the donors' funding will decrease drastically. E.g.: the GF has its own criteria to which countries it gives grant funding. Therefore, the state should be prepared for such a development..."*

5.3.1.5 The Results of the National Policy

According to the repondents, there is a progress in HIV testing of pregnant women (coverage rate is 80%), as for HIV testing of TB patients and the Safe Blood Program the coverage reaches almost 100%.

In terms of creating a unified coordinated monitoring and evaluation system, progress has been manifested in establishing a national working group to develop this system with the UNAIDS support.

The most prominent achievement has been that the demand for treatment is covered by 100%. There is no progress in terms of prevention, unfortunately being dependent on financing.

5.3.1.6 Recommendations of the Respondents

The respondents' recommendations with regard to improving the HIV surveillance system can be summarized and formulated as follows:

- *"It is necessary that the rule on collecting and transporting laboratory samples and maintaining a cold chain be elevated to the legislative or the normative level".*

- *"HIV testing of groups being at risk should be expanded at the expense of the state; it will facilitate early detection of HIV/AIDS cases and prevent the spread of infection".*
- *"Training of all kinds of physicians should be improved to avoid delayed diagnosis".*
- *"A structure and program funding must be established to perform better on contact investigation in each detected case"*
- *"It's necessary to establish an organized second generation surveillance system for HIV risk-groups for the country to have real data on HIV prevalence among different risk groups."*
- *"For epidemiological surveillance to be timely and of high quality, its necessary that standards be set, functions be specified among involved parties and those functions be detailed"*
- *"VTC programs should be thoroughly evaluated and recorded".*
- *"The personnel maintaining reporting should undergo regular training"*
- *"Particular attention should be paid to establishing a well-functioning service of blood banks. Blood transfusion service should be put to order with regard to legal/organizational, technical, and staffing issues"*
- *"Educating people should be enhanced to eliminate HIV/AIDS related stigma "*
- *"The mechanism for establishing a new horizontal HIV/AIDS surveillance system should be considered in the context of arranging public health service on the whole. Strategically, this system should be integrated into the general system of epidemiological surveillance, though the latter should have appropriate, adequate, and well-organized public health and epidemiological services throughout the country."*
- *"Several registeres should be established: fist of all, the birth register, the cancer register, the myocardial infarction register and many more. It is practiced in developed countries. If this program initiates the creation of a real AIDS register with all its components, it will be an outstanding achievement.When it is developed conceptually, the state should support setting up 2-3 registers "*
- *"The NCDCPH should be strengthened to take on the function of HIV/AIDS surveillance. A well coordinated system with strictly defined functions should be established in the nearest future".*

- *"To carry out risk behavior surveys, it is necessary that at least the basic questions be standardized to make it possible to compare data by years and regions "*

- *"The organizations working in this area should involve mass media in their activities to inform broad masses of population. Coordination is needed to avoid functional overlapping, save resources (human and financial) and increase awareness"*

- *"The country has found a powerful donor represented by the GF, however it doesn't mean that the donor's support will never end; sooner or later the country will have to take on this responsibility step by step without leaving gaps in its implementation".*

5.3.1.7 The Parties Involved in the System

5.3.1.7.1 Responsibilities

The major participants in the HIV/AIDS surveillance system and their responsibilities by particular funcitons are described in the below Table 9:

Table 9: Involved parties and their responsibilities

Participant	Responsibilities by a Particular Function				
	HIV Testing	Behavioral Surveys	Disease Register	Data Analysis	Information Usage
Central Level					
Country Coordinating Mechanism					X
Ministry of Labour, Health and Social Affairs of Georgia					X
Infectious Diseases, AIDS and Clinical Immunology Research Center (With Central Reference Laboratory)	X		X	X	X
NCDCPH (Statistics Service and HIV/AIDS Surveillance Department)				X	?
Central Blood Bank	X				
Lung and Tuberculosis Research Institute	X			X	
Narcology Research Institute (Central)	X				
STI Institute (Central)	X				
Medical Service of the Penitentiary System (Aldagi-BCI)	X				
Non-Governmental	X	X		X	X

Participant	Responsibilities by a Particular Function				
	HIV Testing	Behavioral Surveys	Disease Register	Data Analysis	Information Usage
Central Level					
Organizations					
Local Level					
Regional / District Public Health Services					
Regional Laboratories (Subdivisions of the AIDS Center Laboratory)	X				
Regional Blood Transfusion Stations	X				
STI Clinics (Regional)	X				
Private Laboratories	X				
Antenatal Services	X				
Hospitals	X				

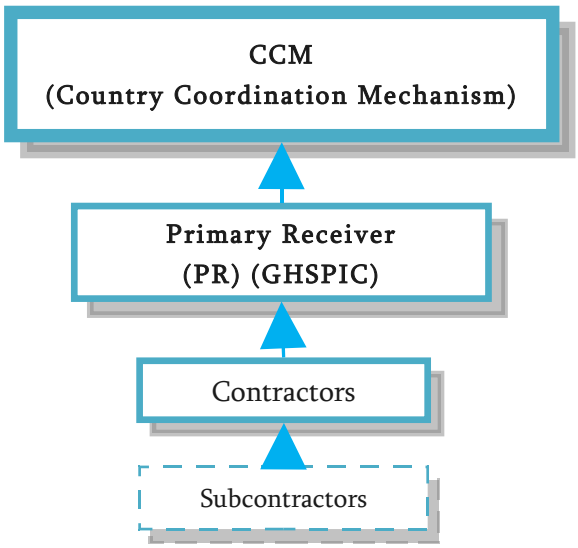
The functions of the participants at the central level are predominantly data analysis and use of information, while the functions of the participants at the local level are limited only to HIV testing.

5.3.1.7.2 Program-related/ informational accountability of the involved parties

A great majority of parties involved in the HIV/AIDS surveillance system are independent structures in organizational terms and there is no subordination between them. Subordination takes place under certain programs.

Batumi and Zugdidi AIDS centers are accountable to the AIDS center only under the GF program: ***"... when this program ends, they won't be accountable to us in any way. They are independent legal entities...".***

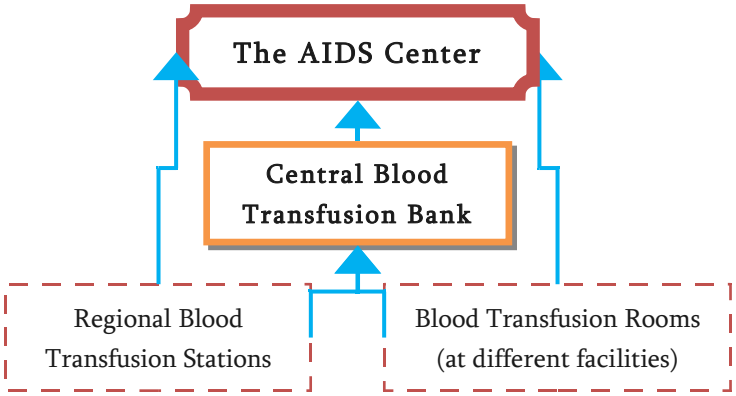
The Central Blood Transfusion Station has contracted several regional blood transfusion stations under "the safe blood component of the state program for disease prevention": "***From blood transfusion stations I receive information on the nominal list of donors and the amount of produced blood. In addition, I get financial data. They aren't accoutable to me in any way except for the program...***"



Consequently, it is impossible to work out a general pattern of subordination for all parties involved in the system. The figures given below present subordination arrangements under specific programs:

The GF program

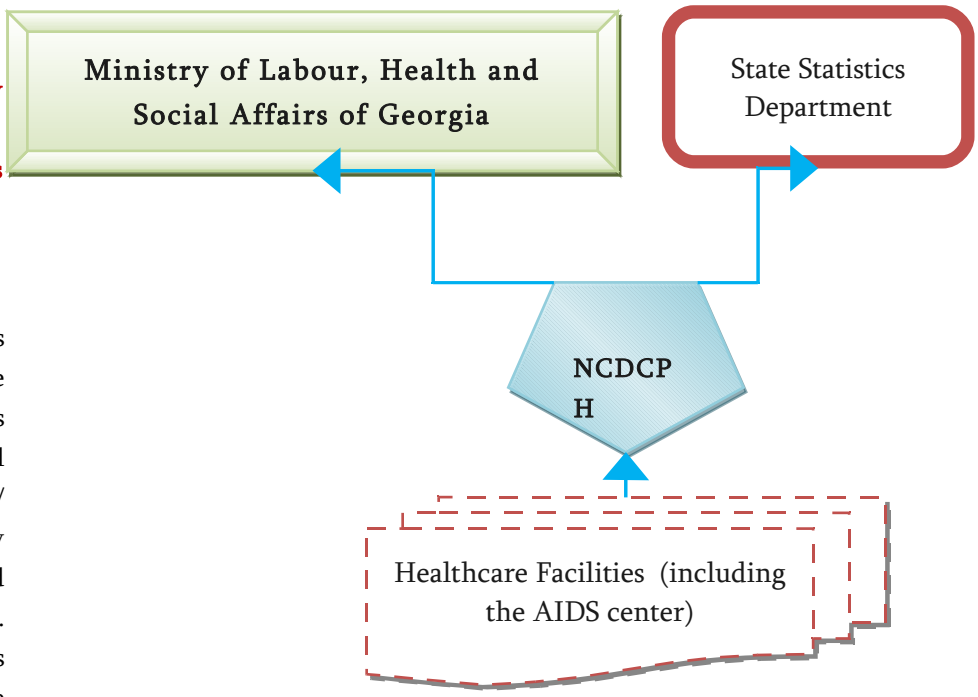
The subordination arrangement is very simple under the GF program. Subcontractors send monthly program reports to the contractor organization of the GF (financial reimbursement is made dependent upon this). The contractors, on their part, send monthly reports to the primary receiver (PR) of the monies of the GF program. The latter is responsible for reporting on progress of the program to the CCM; the reports are submitted to the CCM in the form of presentations by each program component.



Safe Blood Component of the State Program for Disease Prevention

Regional blood transfusion stations report to the Central Blood Transfusion Station the data on donors (nominal and codified list of donors, the amount of blood produced during a month, the number of performed HIV testing and related financial account) under the Safe Blood State Program. As for the information on HIV tested donors, according to a representative of the Central Blood Bank, blood trasfusion stations report the data directly to the AIDS center in addition to the Central Blood Bank.

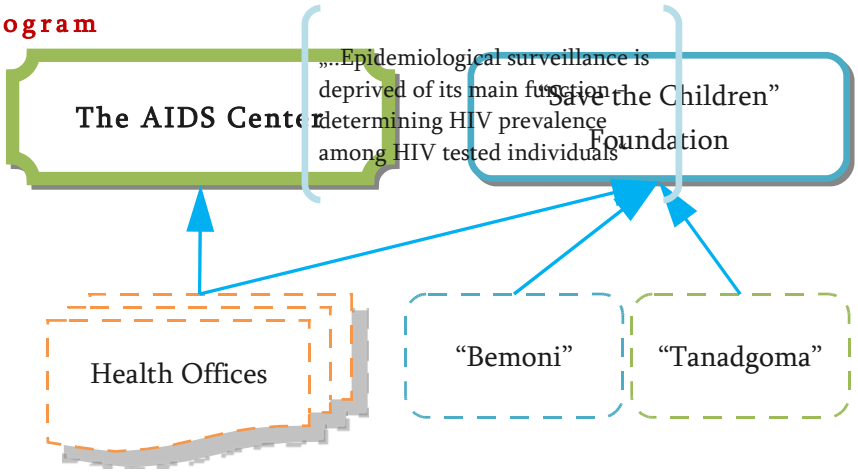
Informational accountability regulated by respective approved orders concerning statistical reporting forms



The Statistics Department of the NCDCPH receives reports from medical facilities (including HIV/ AIDS data) both by statistical forms approved by the Minister's order. The NCDCPH, for its part, reports to the MoLHSA under the organizational order of the Ministry (in July each year), and sends summary data excerpted from different statistical forms to the State Statistics Department.

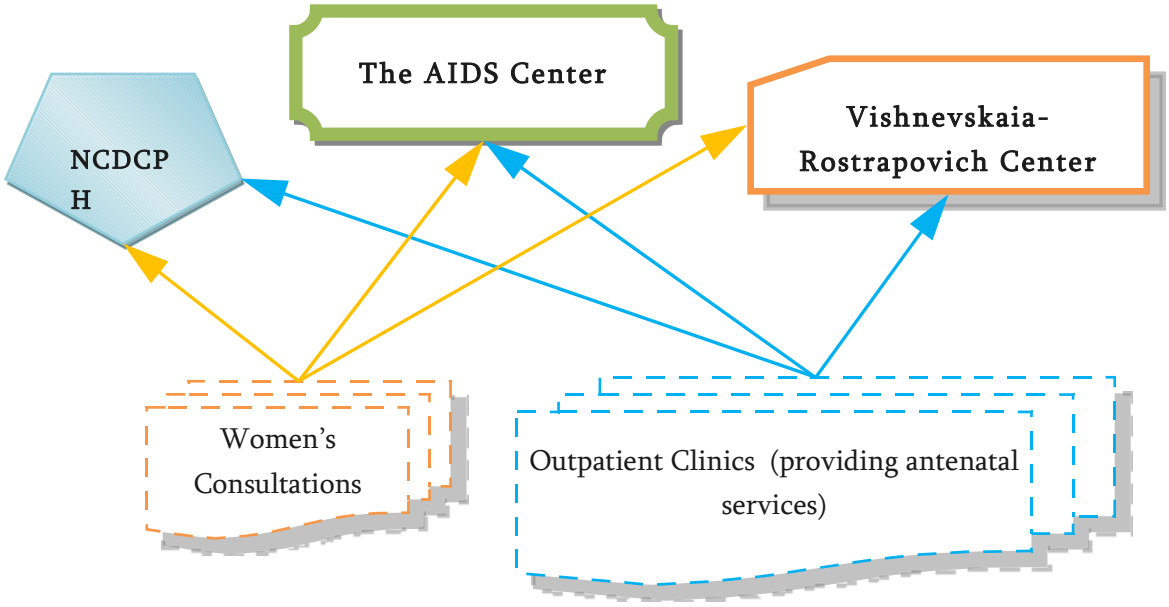
STI and HIV Prevention Program

Health offices opened under this program report program data to the "Save the Children" foundation. As for the information on suspected HIV cases, it is sent to the AIDS center for confirmatory testing.



Antenatal Care Component of the State Obstetrics Program

Women's consultations and those outpatient clinics providing antenatal services to the popoulation report to the Vishnevskaia-Rostrapovich Fund under the antenatal component of the State Obstetrics program (the financial reimbursement is made dependant on the reporting). In addition, these facilities report data directly to the statistics department of the NCDCPH on a monthly basis (the number of HIV tested individuals, including positive results and so on).



5.3.2 Summary

The existing epidemiological surveillance system is disorganized in terms of its organizational and functional arrangements.

Functions

Out of the major functions of HIV surveillance accepted internationally, the following are implemented under the existing HIV/AIDS surveillance system in Georgia to various extent and different levels of success:

- HIV testing / Serosurveillance
- Risk Behavior Subpopulaiton Surveys

- Disease Register and Cohort Follow-up
- Data analysis and
- Dissemination and use of information

Only some of the above-mentioned functions are formally defined/detailed in terms of methodology or organization (e.g. minister's orders, guidelines / methodical directions)

There are certain flaws / problems / obstacles in carrying out each of the existing functions. Particularly:

- Case reporting – individual cases aren't reported, there is no standard format for such reporting, in addition responsibilities of different facilities at different levels aren't defined with regard to reporting on AIDS cases.
- HIV testing / serosurveillance – there is no external system for controlling the quality of work of the laboratories performing HIV testing. Laboratory samples are predominantly transported by public transport, without observing the basic requirements of biosafety. For the time being, the function of confirming HIV/AIDS cases is fulfilled by one organization ("natural monopoly"), however, pursuant to the exsiting rules, this function can be carried out by two or more institutions.
- Risk behavior subpopulation surveys – the majority of such surveys have been conducted in the country with the financial support of international donor organizations. There is no unified catalogue for all these surveys, making it extremely difficult to judge how exhaustive and representative these surveys were. These surveys haven't been institutionalized in terms of allocating the state funding; furthermore, there is no coordinating mechanism for planning second generation surveys (BSS), adapting survey instruments and carrying out these surveys in the country.
- The total number of high-risk groups has not yet been determined in the country. The main problem here is the absence of necessary financial resources and respective adapted methodologies along with the deficit of local technical expertise.
- Disease registry and cohort follow-up – is implemented by the AIDS center maintaining a database of both AIDS-affected and HIV-infected people. The database structure and the cohort follow-up methodology need perfection, which will lead to substantial improvement of collecting the data on HIV/AIDS treatment and outcomes in the country.
- Epidemiological investigation – the need/necessity of performing epidemiological investigations has not been realized conceptually, considering the current epidmiological situation along with the human and financial resources available in Georgia. There is no standard instrument / format for HIV/AIDS epidemiological investigation. It is unclear who is responsible for epidemiological investigation at different levels, to what extent epidemiological investigation is supported financially and whether adequately trained human resources are available locally. The existing legal framework and regulations create a certain barrier to carrying out epidemiological investigation, concerning the issue of confidentiality in the first place.

- Data analysis – there is no standard analytical frame and format for HIV/AIDS data. To some extent it is linked with the scarcity of reported data and the flaws found in it. The absence of an integrated HIV/AIDS monitoring and evaluation system is a serious problem in the country, particularly the fact that a set of national indicators capable of serving as an important guide for data analysis has not been developed.
- Dissemination and use of information – resource allocation, program planning and implementation is particularly based on the available data and information.

In general, the main reasons for the respondents' dissatisfaction are a virtual absence / inadequacy of the system and a legal "vacuum" with regard to the system. For the moment the system is disorganized from the organizational and functional perspectives, the functions and the responsibilities of the parties involved in the system functioning aren't established and specified clearly.

Against this background, the survey has revealed several positive sides as well – particularly, there is progress in terms of HIV testing of pregnant women (coverage rate is 80%) as well as the HIV testing of TB patients and the expanison of the Safe Blood Program (coverage rate is 100%). Also the fact that working toward developing a unified system of monitoring and evaluation has begun in the country. .

The involved parties and distribution of functions

The main parties involved in the HIV/AIDS surveillance system and their responsibilieis by particular functions are described Table 9"above p: 49:

The transfer of epidemiological surveillance function to the NCDCPH in 2007 wasn't based on the minister's order:

- "the state program for HIV/AIDS epidemiological surveillance" disappeared
- the function was reflected in the charter of the NCDCPH (without specifying the details) in the implied form (under epidemiological surveillance of communicable diseases in general)
- ***„The NCDCPH doesn't have either sufficient financial or human resources to carry out this function.***

Before that the Infectious Diseases, AIDS and Clinical Immunology Research-Practical Center (the AIDS center) was responsible for carrying out the HIV epidemiological surveillance:

- Epidemiological investigations were fulfilled by the Center itself In Tbilisi and by the PHC epidemiologists (being unofficially "assigned" to the HIV infection) in the rest of the country without targeted funding.
- The operation of the AIDS center was financed through "the state program for HIV/AIDS epidemiological surveillance", which was developed and administered by the Public Health Department; the AIDS center used to "win" the tenders to be the implementing organization due to the absence of alternative providers.

For the moment, the AIDS center is responsible for treating HIV infected and AIDS patients, whereas the NCDCPH is charged with the duty to analyze epidemiological situation and carry out second generation surveillance.

In the past, HIV surveillance was carried out under the state program, though now it is to be fulfilled routinely by the NCDCPH regular staff using the center's own money without receiving any extra funds / additional money alloted for this purpose (through a program or in the budget of the institution)

Confirmatory testing of all suspicious positive cases as well as serosurveillance is performed by the laboratory of the Infectious Disease, AIDS and Clinical Immunology Research-Practical Center.

Non Govenmental Organizations (by foreign funding) carry out HIV testing of high risk groups (anonymously) in three major cities (Tbilisi, Kutaisi, Batumi) and conduct BSS surveys every two years under the "STI and HIV infection prevention project".

Before the function of medical service of the penitentiary system was transferred to ALDAGI/BCI, the medical service itself had been identifying high risk prisoners, taking blood samples from them regardless of their will and sending the samples to the AIDS center for testing. ALDAGI/BCI plans to continue implementing this funciton.

5.3.3 Main Findings

The majority of the HIV surveillance functions are not procedurally formalized and based on standard technical guidelines (and tools).

The function (and the methodology) of determining the number of high risk groups is not defined and is left "orphaned".

Risk behavior subpopulation surveys (BSS) are not institutionalized and are carried out by non-governmental organizations, which use a standard methodology and have experienced professionals at their disposal.

The standard format and the framework of data analysis are not put in practice.

5.4 Information Flows

5.4.1 Overview

5.4.1.1 Identifying / Recording Cases

Recorded Cases

Out of the 28 local level facilities, included in the study, HIV/AIDS (sporadic) cases were recorded only in 13 of them during the last 4 years. No cases were recorded in outpatient clinics and in 4 out 6 public health centers. (see. Table 11 „Case Recording", p. 136).

Standard forms / Procedures

The following couldn't be found in any of the local level faocilities:

A special standard log book for recording HIV/ADIS cases

A standard definition of an HIV/AIDS case

A guideline / methodical direction on HIV/AIDS surveillance

HIV/AIDS cases were recorded only at isolated facilities using non-standard log books developed by each of these facilities by hand. Certain facilities used a communicable disease log book 60/A due to the lack of a standard log book specially provided for this purpose.

Ensuring Confidentiality

The rules and conditions of storing non-standard log books used for HIV/AIDS case recording didn't rule out access to confidential information by non-authorized personnel. Specifically, these log books, generally record a patient's name, surname, age, and address and aren't stored in special rooms. They are usually stored in offices of persons responsible for dealing with this issue, on their desks, or in the drawers of their desks. In the majority of cases the doors of the offices and/or drawers can't be locked, however the staff of the facilities are sure that no one enters their room but that if anybody does, they know that no one will touch their articles or papers.

5.4.1.2 Lab Testing / Confirmation

HIV Testing

HIV testing is performed in the majority of the local level facilities using Rapid / Simple test methods; the only exception is outpatient clinics (however, some outpatient clinics have this capacity and, of course, they do have test-kits as well). Out of the studied public health centers, HIV testing (using a Rapid / Simple Method) is carried out only in the public health division of the Tbilisi municipality health service. This laboratory performs HIV testing on the basis of its internal standard, and, consequently, test-systems are also puchased on its basis. The PHC central laboratory performs HIV testing under the contract signed with one of the women's consultations. (see. Table 12 HIV testing, p. 136).

Testing Methods

Medical facilities, where HIV testing is performed use a rapid / simple test and 6 facilities (Tbilisi hospital, Tbilisi STI clinic, Tbilisi Blood Transfusion Station and laboratory, Zugdidi and Batumi laboratories) offer IFA testing as well. Furthermore, a representative of Tbilisi Blood Transfusion Station pointed out that they mainly carry out IFA testing.

Written Directions

Written directions on how biological samples have to be taken, stored, and transported for HIV testing / confirmation were found only in two local level facilities: in Tbilisi Blood Transfusion Station and in one of Tbilisi laboratories (the so-called "standard operational procedures"). As for the other studied facilities, one of the women's consultations noted that such information was included in the study materials handed out at one of the training courses, while the representatives of the other facilities indicated that there was no such kind of document at their facilities. (see Table 13 „Written Directions for Taking, Storing, and Transporting Lab Samples", p. 136).

Sending Biological Material

Taking and trasporting biological samples for HIV testing / confirmation isn't carried out only by outpatient clinics (when needed, outpatient clinics refer a patient himself or herself); other facilities save isolated exceptions send biological samples to other facilities for HIV testing / confirmation (as a rule, samples are sent to the AIDS center for confirmation). (see. Table 14 „Sending Biological Material, p. 137).

When a material is sent, it is usually blood or serum. In 4 out of 15 facilities samples aren't stored before being transported, since they are sent immediately to a laboratory for HIV testing. Seven facilities have

indicated that material in Ependorf tube is stored in a freezer; and in the other two facilities samples are stored in a refrigerator without being frozen.

Transportation of Samples

Only the representative of a Tbilisi hospital indicated that biological material is sent for HIV testing / confirmation by a special transport in an Ependorf tube placed in a plastic bag. Other medical facilities located in Tbilisi (STI clinic and women's consultation) send lab samples for HIV testing / conformation by a regular transport also in Ependorf tubes. As for regions, material is transported by hand (in a tube, in a capped syringe and so on) by a patient or his or her friend/relative.

Material from nearby facilities is sent to regional laboratories by hand, in some cases by any means of transport or a courier. One laboratory (Batumi AIDS laboratory) indicated that samples are transported from jail facilities (***"...mainly come from jails"***) using a cold box.

Local laboratories and blood transfusion stations indicated that they send samples to Tbilisi AIDS center for confirmation using special containers. A cold box and a reusable container are used for these purposes. In some cases materials are transported by train (being sent with an acquaintance) and on some occasions a sample is carried by a physician himself or herself.

Referral Form

Samples being sent from Tbilisi medical facilities to the AIDS center for confirmative testing are accompanied by a referral form #4 developed by the AIDS center though not approved by any order; while samples from regions are accompanied by non-standard referral forms all of them indicating a patient's name and surname. Age, gestational age (in one of the women's consultations), department name (in one of the hospitals), and the ID number of a patient record are also provided in the majority of cases. On one of the forms a patient's address was recorded along with other information.

Laboratories receive non-standard referral forms together with biological material; these forms usually contain a patient's surname, name, age, and gender. A code (standard group coding) is indicated only in some cases.

Receiving Test Results

A different picture was found with regard to the timeliness of receiving test results in almost all 14 observed local level facilities which carry out HIV testing. Some of the facilities (3 out of 14) don't receive test results at all and among those which receive, some get this information the same day and others in 1-4 days or 1 week later (by phone). One of the facilities mentioned that it is informed of a test result the same day that the testing is performed.

Informing a patient about the test result

As for informing a patient about the test result, outpatient clinics stated that they had never had a positive test result in their practice. Representatives of the hospital pointed out that they mainly detect the condition in terminally ill patients and clinical signs are the very reason to suspect the disease. In case of a positive test result, the patient is informed about it by the doctor in charge (one of the representatives of a hospital has indicated that they give information directly to a patient's relative / friend since ***"the patient himself of herself is frequently in a critical condition due to the severity of the disease"***). Representatives of women's consultations and STI clinics have indicated that they don't inform patients and refer them to the AIDS center to this end.

Different patterns are observed in various laboratories / blood transfusion stations in terms of informing patients. One of them indicated that they inform a patient about a negative test result, while a positive test result is communicated by the AIDS center only. A representative of one of the laboratories has pointed out that in case of an initial positive test result they tell the patient that he or she needs additional testing and explain to him or her where to go. Only the representatives of Batumi AIDS center have indicated that they offer pre- and post- testing counselling services to patients during which the test result is communicated.

5.4.1.3 Notification / Reporting

Notification

Pursuant to the regulations in force, laboratories carrying out confirmatory HIV testing send an urgent notification (form #58-4) to local PH authorities, however it should be noted that out of 6 studied PH centers no HIV/AIDS case notification form has been found in four of them whatsoever. It's also worth mentioning here that a question arises in general whether it is necessary that laboratories maintain urgent notification of PH centers when PH authorities don't provide for any urgent measures to be implemented as a response action.

Reporting

In all local level facilities included in the study, researchers specifically requested to be shown the recent standard aggregated reports sent during the last four years. Particular attention should be paid to the fact that such a report has been found in only one of the 28 studied local level facilities, namely in Zugdidi AIDS center (see. Table 15 „Reports from Local Facilities", p. 137).

Written Directions

Written directions for the lower levels in the hierarchy of the information system on where and how to report HIV/AIDS cases haven't been found or aren't available at the central level facilites. Consequently, such written directions on how to report HIV/AIDS cases do not exist in any of the assessed local level facilities.

Updated List of Facilities / Entities

An updated list of facilities reporting to a central level institution is available at the NCDCPH, the AIDS center, and the Narcology Research Institute. (see. Table 16 „Listing of Facilities at the Central Level", p. 137).

An updated list of facilities / laboratories located in the area of operation didn't exist in any of the assessed PH centers. (see. Table 17 "Listing of Facilities at the level of Public Health Centers", p. 138).

Confidentiality

There is a practice of storing reported information confidentially at cenral level institutions: e.g. NCDCPH's HIV/AIDS epidemiology division has an electronic database of HIV infected patients and this data set is provided by the AIDS center; this computer is not connected to the network; a code word to switch on the computer is known by only three employees of the division and if they leave the room, the doors are locked with the key.

The AIDS center stores the first and the last names of HIV infected patients in special binders placed in a bookcase, which is locked with a key and is accessible to only a limited number of individuals. In addition,

there is an electronic database and its password is accessible to only three epidemiologists employed by the facility. As for the archive, information is transferred to the archive in a sealed form after 5 years of storing.

Epidemiological Investigation

A filled-in HIV/AIDS epidemiological investigation card was found only in Kobuleti PHC and this investigation was carried out in 2005. None of the filled-in (of 2 or 3 years old or older) epidemiological investigation cards were found in the other 5 PH centers included in the study.

Analysis

Epidemiological analysis of HIV/AIDS data is performed only at the central level. Among the central level institutions, HIV/AIDS epidemiological data is analyzed by the AIDS center, the NCDCPH (HIV/AIDS epidemiology division) and the Tuberculosis National Program. Under this program a standard analysis is carried out, which provides for assessing HIV prevalence by geographic area and time. Therefore, a program technical report giving an epidemiological profile of HIV/AIDS is prepared based on the above mentioned analysis only under the Tuberculosis National Program and is the technical user of this report the GF.

It's worth noticing that only one (Batumi center) out of 6 PH centers analyzes HIV/AIDS data and prepares a technical report giving HIV/AIDS epidemiological profile based on this analysis. The local government is the user of this report.

Feedback

Virtually no feedback is provided in the HIV/AIDS surveillance system. Central level institutions communicate verbal information to interested entities / organizations at lower level upon the request of the latter.

5.4.2 Summary

There is no technical description and integrated picture of information flows:

- which would describe information sources, modes, the format, and the periodicity of data transmission as well as the functions of analyzing and reporting
- which would serve as a guide for the parties involved in the HIV epidemiological surveillance and for organizing the information management system

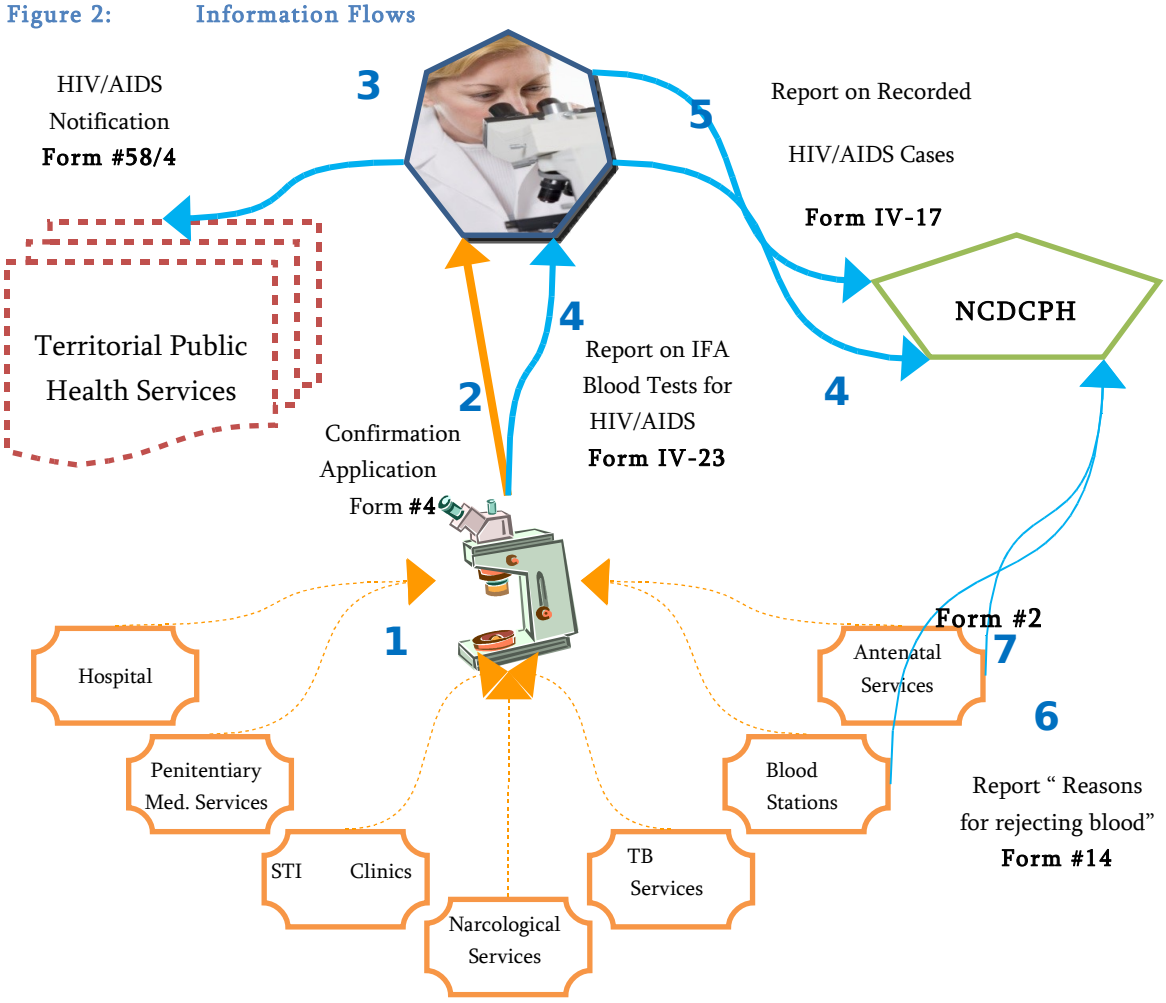
Reliable data on the number of HIV testing isn't available at the central level to perform an epidemiological analysis.

Collection and storage of HIV testing data (arrows #1 on the graph) aren't regulated and standardized at primary level facilities (medical facilities with their own laboratory capacities or stand-alone laboratories).

From the primary level:

- Reporting on IFA testing is performed through aggregate data using form #23 - reports are sent to the confirming facility (arrow #4), however this form should logically be sent to the NCDCPH (where all statistical forms are accumulated).
- If an IFA testing gives positive result, blood / serum (or a person) is sent for confirmation with the form #4 (arrow #2 on the graph). The form #4 contains personal data of a tested patient (last name, first name, father's name, age, nationality, and citizenship, place of residence) in an open form.

Figure 2: Information Flows



A confirming facility: sends a notification to local PH authorities using the form #58/4 (arrow #3) – the age data is aggregated, the gender field contains the box "unknown" (which indicates that initial data might be incomplete i.e. gender isn't specified); a record number assigned in the form 60/A is indicated instead of personal information.

The NCDCPH receives information from three sources – data are grouped in the following way:

- from a confirming facility in the form IV-17 (arrow #5) and the form IV-23 (arrow #4)
- from a blood transfusion station (arrow #6)
- from antenatal care facilities (except outpatient clinics) – the form #2 (arrow #7)

As it is shown on the graph, the medical facility or laboratory where the initial testing has been performed, doesn't get information back in any form.

5.4.3 Main Findings

1. Data collection isn't standardized on the primary level.
2. Data is transferred in a non-aggregate form (from the bottom to the top)
3. The test result / information is mainly not communicated back to the facility, which sends a sample for tesing

5.5 Stakeholders

The stakeholders of the HIV/AIDS surveillance system, their roles, demands, expectations, and incentives are described in the table below:

Table 10: Stakeholders

Stakeholder	Role	Demands	Expectations	Incentives
Medical facilities	Detecting, recording and reporting of AIDS cases	Simplicity, clear directions	Accessible standard forms, guidelines	Predominantly financial
Laboratories	HIV Testing	Biological Safety	Quality assurance system	Predominantly financial
Public health centers	Reporting, data analysis	Integrated system	Quality data	Professional and financial
The Ministry, ministerial structures	Policy and strategy development	Compliance with international standards	Information for Decision-Making	Predominantly Professional
Nongovernmental organizations	Studies exploring risk behaviors	Regularity, geographic coverage	State funding	Professional and financial
GFTAM funded project	Financial support of national response to HIV epidemic in accordance with a country request	Ensuring the possibility of assessing intermediate and final results of influencing epidemic and its causing factors	Regular reports reliably describing the epidemiological situation	Proper reporting (showing results) to the donor organization
Donors	Supporting the functions of epidemiological surveillance which hasn't been provided by the state itself yet.	Providing for and implementing international practice (experience) and standards	Institutionalizing the functions endorsed by them	Fulfilling international commitments (at the global level)

5.6 Material and Technical Capacities

5.6.1 Overview

5.6.1.1 Computer Equipment

Computer equipment used for epidemiological surveillance isn't available in 13 out of the 28 local level facilities. It's worth noticing that the computer equipment available in the studied facilities is mainly in a good working condition. (see Table 18; p. 138)

Internal (local) network is present at the following facilities:

1) Zugdidi Multifield Hospital "Respublika"
2) Batumi Republican Hospital
3) Tuberculosis National Program
4) Narcology Research Institute

5) The AIDS Center

6) The NCDCPH

The Internet is available at the following facilities

1) Tbilisi Municipal PHC

2) The Laboratory of AIDS Center of Batumi Infectious Diseases Hospital

3) Tbilisi Laboratory "Testi"

4) Zugdidi Reference Laboratory

5) The AIDS Laboratory of Batumi Blood Transfusion Station

6) Tbilisi Blood Transfusion Station

7) Zugdidi Department of Blood Transfusion

8) Tbilisi Hospital (Acad. O. Gudushauri National Medical Center)

9) Batumi Republican Hospital

10) Zugdidi Multifield Hospital "Respublika"

11) Women's Consultation of Batumi Maternity Hospital

12) Women's Consultation of Tbilisi Acad. K. Chachava Perinatal Medicine and Obstetrics and Gynecology Research Institute

13) Tuberculosis National Program

14) Narcology Research Institute

15) Skin and Venereal Diseases Research Institute

16) Reference Laboratory of the Infectious Disease, AIDS and Clinical Immunology Research-Practical Center

17) Infectious Disease, AIDS and Clinical Immunology Research-Practical Center

18) National Center for Disease Control and Public Health

5.6.2 Summary and Main Findings

Material technical base of local level facilities is very limited. Specifically, computer equimpent, intranet, and the Internet are virtually absent at curative-preventive facilities, laboratories, and blood transfusion stations.

In these terms, the situation is much better at central level institutions. There is enough technical capacity in the NCDCPH to perform analysis, however they are insufficient to introduce an up-to-date information management system.

5.7 Human Resources

5.7.1 Overview

5.7.1.1 Human Resources Involved in HIV/AIDS Surveillance

64,2% of staff employed at central level institutions working in HIV/AIDS epidemiological surveillance is under age 45 and 35,8% are between 45 and 65 years of age. The situation is different at local level facilities: 34.6% of staff is under age 45, 63.2% is between 45 to 65 years and a very small portion (2.1%) is over 65. About 74.9% of the individuals formally or practically dealing with fulfilling the function of epidemiololgical surveillance are females (79.2% at central level institutions and 73.6% at local level facilities). Almost all employees at the assessed facilities are full-time workers (save a few exceptions: in total 3 individuals – 1 laboratorian and 2 physicians work part-time). Besides, about 58.5% of staff engaged in epidemiological surveillance at central level institutions have worked for 10 and more years at a given position, while the same indicator at local level facilities amounts to 87.4% (see. Table 19 „Human Resources Involved in HIV/AIDS Surveillance by Facilities", p. 145).

5.7.1.2 Staff's Skill level, Motivation, and Openness to Innovations

Skill level, motivation, and openness to innovations of the staff engaged in fulfilling HIV/AIDS surveillance function were assessed by the heads of the facilities through answering 9 questions (3 on skill level, 3 on motivation, 3 on openness to innovations) using a 5-point scoring method (from 1 = completely disagree to 5 = completely agree). Data was analyzed by facility levels (local and central).

Table 20 „Evaluating the knowledge of the personnel by heads of facilities (1=completely disagree, 5= completely agree)" (p. 149) shows that computer skills of their employees were assessed by the heads of central level insitutions as relatively good in contrast to the assessments done by the heads of local level facilities.

Table 21 Assessment of employee turnover by facility heads (1=completely disagree 5=completely agree)(p. 149) shows that according to the assessment of heads of facilities, the employee turnover isn't a serious problem either at local or at central level facilities. The directors of the facilities disagree with the statement that it's extremely difficult to retain qualified staff at jobs for a long time. They also do not reckon that staff turnover interferes with fulfilling key functions related to the HIV/AIDS epidemiological surveillance.

On average, the heads of both the central and the local level facilities neither disagree nor agree with the statement that their employees involved in the implementation of surveillance functions are motivated to fulfill the responsibilities / tasks they are charged with. It should be noted that the heads of the facilities completely agree with the statement that the same employees recognize the specific benefits associated with the implementation of a cutting-edge information system and are not afraid of introducing innovations. (see. Table 22 "Assessment of staff motivation by facility heads (1=completely disagree 5= completely agree)", p. 150).

The results of quantitative data analysis is in compliance with the qualitative data obtained during focus group discussions. Specifically, in the opinion of the focus group respondents, there are some flaws with regard to financial motivation of the employees engaged in fulfilling the HIV/AIDS epidemiological surveillance function.

> ***"... we do have enthusiasm if there are financial incentives as well... financial motivation is necessary...",***

"...What I'd like to say is that employees need more motivation..."

"... Salaries are very low..."

"... Functions need programs and money. When my epidemiologist has a salary of 200 GEL, I can't tell him or her to go ahead and search for an AIDS patient's contacts. Even air isn't free of charge these days and how can the work with an AIDS affected person be free of charge ?..."

"... People should be given money. Previously, those who worked with TB and AIDS patients had employee bonuses...These people should have big salaries."

5.7.1.3 Training

Table 23 „Training of the personnel" (p. 150) shows that the employees (at least one in a facility) of only 3 (2 district laboratories and 1 district PHC) out of the 28 facilities included in the assessment have ever undergone training in HIV/AIDS epidemiological surveillance.

5.7.2 Summary and Main Findings

The heads of the facilities participating in the surveillance system consider basic computer knowledge and skills of their human resources as being satisfactory.

As for the knowledge and skills for computer data processing/analysis, the assessment is unsatisfactory, being more apparent at the local level facilities.

Key technical staff turnover is not a serious issue at the central nor at local level institutions participating in the epidemiological surveillance.

The key technical staff employed at these institutions are motivated to perform their work envisaged by the HIV/AIDS surveillance, however their professional motivation is higher than financial. They recognize the specific benefits associated with the implementation of a cutting-edge information system and are not afraid of introducing innovations.

Institutional Assessment

An institutional assessment consists of two parts:

From the perspective of analysis, the first part "Needs" is focused on the current situation and is looking for reasons in the present and in the past (where we are now and how we have gotten here).

The second part "SWOT Analysis" is future-oriented and devoted to an analysis of the current situation in order to make use of advantages and opportunities as much as possible, reduce weaknesses and take into account risks (avoid them if possible) while planning for the future

6 Needs

6.1 Understanding Needs

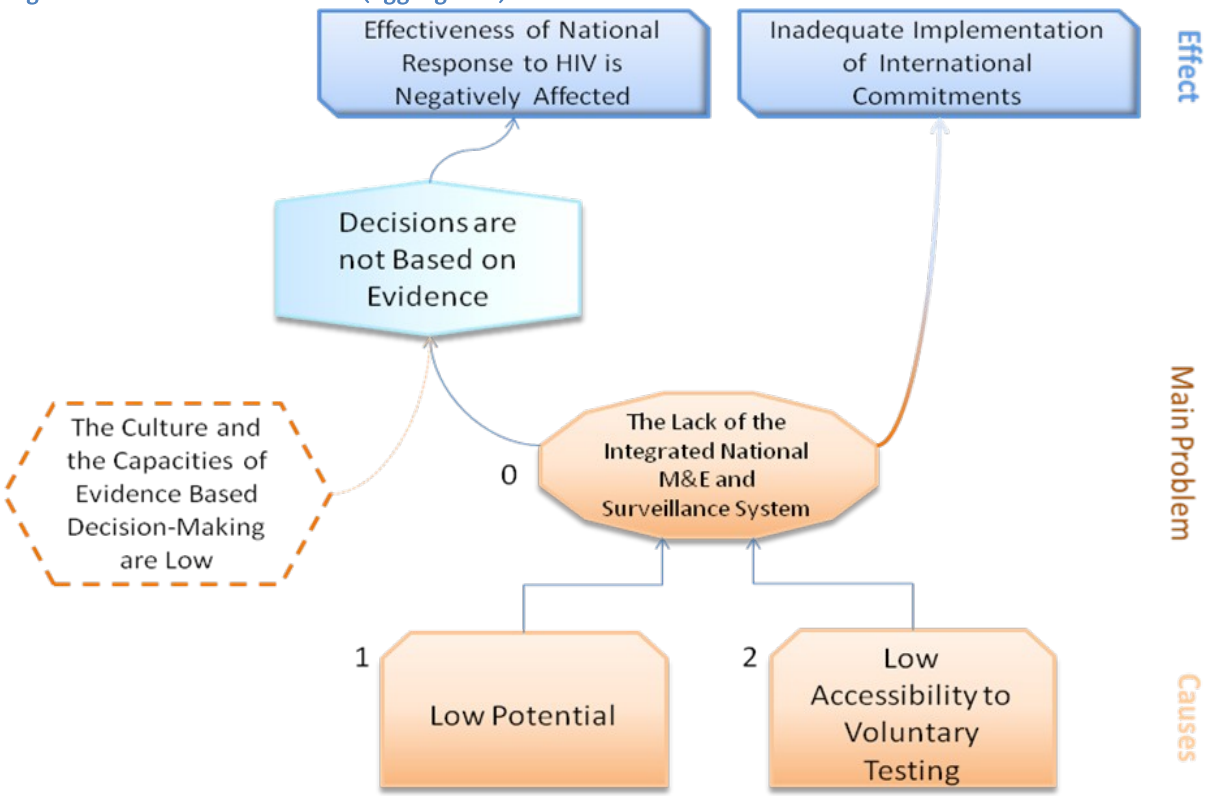
Main concepts, approaches and informational flows used for surveillance of communicable diseases aren't considered carefully enough nor tailored to the specifics of the HIV infection; this fact often leads to confusion when using commonly known terms. The usage of such terms as "identification", "notification", or "reporting" is more passively, although these words have other meanings.

The following cause and effect relationships are revealed by analyzing the priorities of the national policy and the regulatory environment for HIV surveillance and the requirements set for the system – see Figure 3, below.

The National Strategic Plan to Fight HIV/AIDS (2006-2010) declares that there is no unified national M&E and surveillance system (the "main problem" in the problem tree). The lack of the unified national M&E and surveillance system leads directly to the situation when the country doesn't fully comply with its international commitments in ("effects" in the problem tree). In addition, it doesn't supply decision-makers with sufficient evidence (to create demand and set the stage for evidence-based decision-making practice and capacities); eventually, the effectiveness of the national response (reaction) to the HIV infection is impaired ("effect" in the problem tree"). The lack of the unified national M&E and surveillance system constitutes a problem since it affects the effectiveness of the national response to HIV infection and a proper compliance with the international requirements.

As for the reasons causing the main problem, the National Strategic Plan to Fight HIV/AIDS (2006-2010) names two factors: "low potential of the interested parties" and "low accessibility to voluntary testing" ("causes" in the problem tree).

Figure 3: Problem Tree (aggregated)

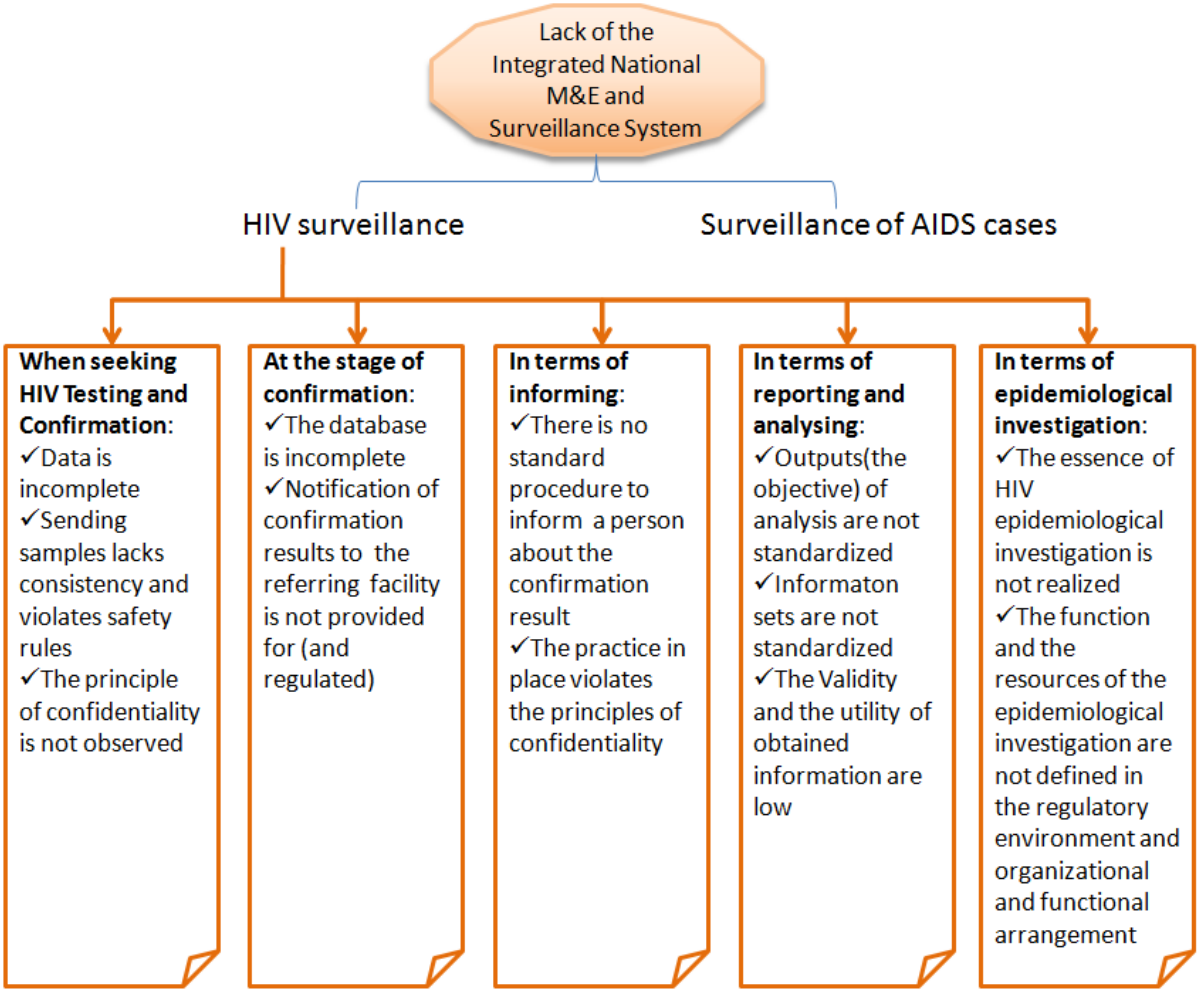


What does "…the lack of surveillance system" mean?

To answer this question, an initial analysis of the main findings reveals a picture depicting the current situation and showing what we are dissatisfied with (what concerns us). It won't be correct to say that there is no HIV/AIDS case surveillance system at all. It is functioning but with serious flaws. The shortcomings revealed by the study are grouped separately for HIV and for AIDS surveillance and presented below.

The revealed weaknesses of HIV surveillance can be categorized according to the system components as follows:

Figure 4: The Weaknesses of HIV Surveillance



1. With regard to seeking HIV testing and confirmation
   1.1. Data on HIV tested individuals is incomplete:
      1.1.1. There is no standard format for data recording
      1.1.2. (Standardized) rules for information storage and referral for confirmation are not defined
   1.2. Blood (serum) is transported without observance of any rule, which:

1.2.1. poses a threat to people

1.2.2. makes the accuracy of confirming questionable

1.3. Confidentiality is violated right at the beginning when an individual's contact / personal information is sent for confirmation according to the form #4

2. In terms of confirming:

2.1. Not all cases sent for confirmation are registered with the database in a non-aggregate manner, even based on the data reported through the form #4.

2.2. Only confirmed cases are registered with the electronic database.

2.3. Notification of a referring facility about confirmed cases isn't provided for at all; hence, respective rules and methodology aren't defined: in spite of this, pursuant to the rule concerning confirmed HIV / AIDS cases (order #101n), a notification is sent to territorial public health authorities, though for unclear purposes or any benefit in terms of the epidemiological surveillance.

3. In terms of informing:

3.1. There is no standard procedure for communicating a confirmation result to an individual (regardless of a confirmation result), recording the result of the confirmation at the referring facility and, in case of a positive result, carrying out patient counseling and epidemiological investigation.

3.2. The existing practice violates the principles of confidentiality, causes discomfort to HIV infected patients, and makes it difficult to carry out patient counseling, follow-up, and epidemiological investigation.

4. In terms of reporting and analyzing:

4.1. The objective of the analysis isn't defined and analytical products aren't standardized (for internal and external usage).

4.2. Data sets needed for analysis aren't systematized.

4.3. The validity or the utility of data received by means of the existing reporting practice (form IV-23, form IV-17) is very low to carry out a sound analysis.

5. In terms of epidemiological investigation:

5.1. The essence (the purpose) of epidemiological investigation isn't realized conceptually, and there are no specific requirements.

5.2. The function of carrying out HIV epidemiological investigation (regardless of its content) as well as the amount of money needed for its implementation isn't detailed either in the normative environment or under the organizational arranmgements

As for the surveillance of AIDS cases, a standard AIDS clinical case definition as well as a guideline for clinical identification of AIDS cases isn't used at the majority of medical facilities.

6.2 Analysis of the Factors

Returning to the (aggregated) problem tree (see. Figure 3, p. 65), the national strategy cites two causes of the main problem. What is the first one of these two – "low potential"?

I.e. what are the factors leading to the low ability ("inability") of the existing system to fulfil its function and meet the minimum requirements (to be used inside and outside the country)?

We can seek the answer to this question in four fields (directions):

External factors, e.g. declarative nature of the priorities of the national policy, imperfect normative (legislative) environment, the country's development policy (maximum deregulation) or system-wide reforms in the healthcare system (shifting to market relations without balancing the healthcare market, unending "rearrangement" in the sectoral management system)

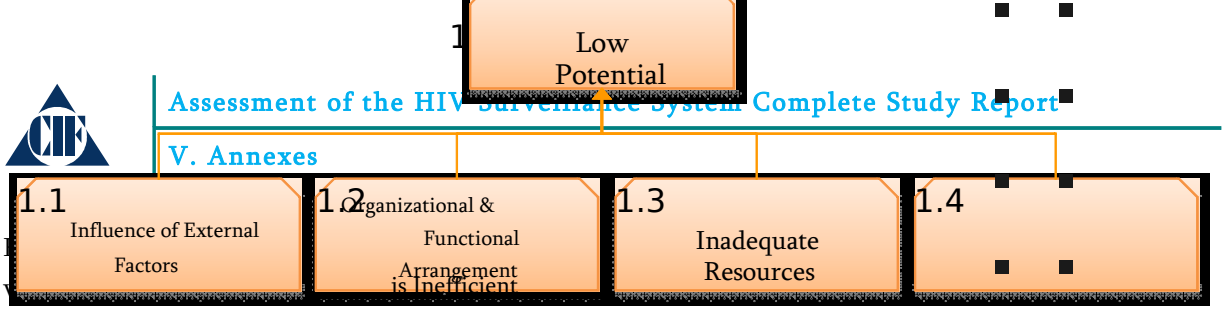
Internal factors of the system (1.2 – 1.4 on the figure below):

- Factors related to the organizational and functional arrangement of the system
- Resources: human resources, material and technical base, money to cover recurrent (operative) expenses
- Methodological and technical factors (concerning "how" or "which way" to do business)

Figure 5: Groups of Reasons Leading to Low Potential of HIV Surveillance

Weak Material &

gavskd
i
gogo
ni? S
IFA
thices
rrang
emen
t



grouped in the above-mentioned four areas only where it is worthwhile and helps in drawing conclusions.

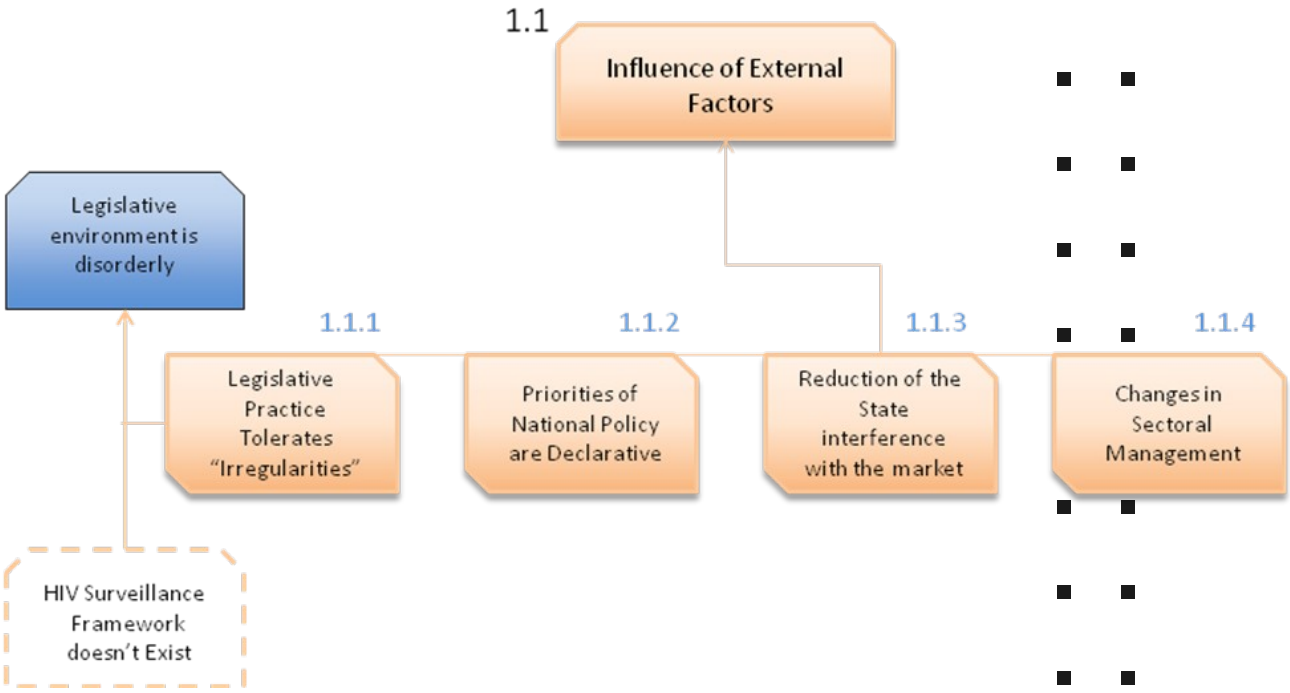
6.2.1 External Factors

Analyzing external factors is important as far as they:

impede or facilitate improving or enhancing the potential of the system

create or suppress incentives (or demand) to improve potential

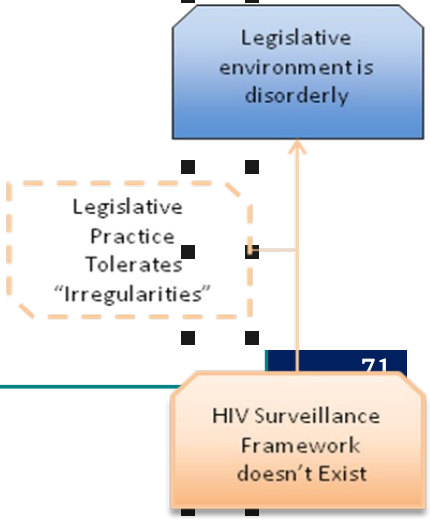
The analysis of external factors and their influence on the HIV surveillance system will be focused mainly on four issues:



Legal environment

The low capacity of the Surveillance system might better be considered as a cause of an unstable legal environment, rather than a result.

Research showed that a great deal of essential aspects needed for the system to function correctly either aren't defined or are unclear and conflict with other norms. **While surveying experts, an unstable legal environment is frequently cited as a major cause of the problems existing in the epidemiological surveillance system. This causal attribution is both debatable and dangerous, despite being a very common opinion. It is disputable, because the irregularity of the legal environment (which is not questionable!) might be considered as an implication of another (other) more basic causative factor(s) and dangerous since, if it is true and the**



basic causes won't be considered, we won't be able to enhance the epidemiological surveillance system and the quality (appropriateness) of the legal environment will essentially remain unchanged as well." In our specific case the concern (regarding external factors in relation to the legal environment) is that the legal environment tolerates such an irregular situation perfectly well instead of ensuring that legislative practice serves the so-called "protective role" – i.e. not allowing the existence of mutually exclusive or useless regulations and filling the vacuum in the shortest time possible and, thus, giving an impetus for putting the legal norms on HIV epidemiological surveillance in order.

Then what is the main cause of the current state of affairs in the legal environment concerning HIV epidemiological surveillance?

The main cause is the absence of a conceptual framework for HIV epidemiological surveillance- this is well understood and recognized by the interested parties. It simply follows from the questions, which are still open and, if left unanswered, the efforts being made on epidemiological surveillance will remain as fragmented as they are today.

It's possible to delve deeper into the reasons for the absence of this conceptual framework. A factor may be the lack of time to develop such a framework, due to the accelerated pace of the legal environment, compared to the public health system. The small number or absence of interested parties is also problematic, especially when a conceptual understanding of the issue isn't perceived by many to be necessary, and those who do perceive it necessary have little power to influence the situation). Another reason may be a general "monopolizing" of the issue- when public management of one of the public policy issues is implemented through the so-called "closed loop" and impedes .the participation of other stakeholders

Even without a deep analysis of causative factors, it is clear that if a conceptual framework of HIV surveillance is not developed for the country, it will be impossible not just to organize legal norms in the legislative environment, but also to achieve effectiveness in other efforts for designing, organizing, and making the system functional- areas of equal importance.

Priorities of the National Policy

The country has declared rather clearly its public policy goal against the spread of HIV infection- this is a very positive (stimulating) development on its own account. However, considering the fact that this public policy goal was set by the previous government (under the National Program for Economic Development and Poverty Reduction in 2003), it is questionable whether it will influence either short or long term decisions made by the current government. This public policy goal is repeated word-for-word in the National Strategic Plan to Fight HIV/AIDS (2006-2010), developed under the new government. Unfortunately, the plan is not an officially adopted state policy document, prescribing policy-makers at different levels to take it into account. It is valuable as a good technical document showing that HIV/AIDS surveillance is one of the four strategies of the national policy to be achieved. Furthermore, the document sets technical requirements (specifications) for the future HIV surveillance system and the needed actions to be undertaken (along with their outcomes).

It's not a surprise that HIV/AIDS surveillance is not included as a separate section in the public policy instruments (such as state health programs or budgetary acts) needed to implement the declared priorities. A detailed expert analysis of state programs and the budget law is necessary to determine that the state

doesn't disregard the issues of HIV surveillance. HIV surveillance "is hidden behind" the activities aimed at ensuring epidemiological safety and the general surveillance of infectious diseases (save the state program for HIV/AIDS early detection and treatment, financing and fulfilling the functions of epidemiological surveillance in part). It is not a negative development on its own. Quite the reverse, it would be welcomed if we had an integrated system of communicable disease surveillance, under which HIV / AIDS surveillance would be carried out (considering the specifics of the condition) along wih the surveillance of such diseases as viral hepatitis B or C, STIs, TB, and so on.

The county's international commitments (mainly resulting from the Millennium Declaration, The UN Declaration of Commitment on HIV/AIDS adopted at the Special Session on HIV/AIDS of the General Assembly (2001) and the Dublin Declaration (2004)) have larger potential for influencing public policy prioritization (to be reflected in allocating resources and fixing responsibilities for ultimate results). An affiliation with these so-called "soft" instruments of international law creates the necessary prerequisites for effective advocacy on the part of interested parties (if there are any), though it is insufficient to positively affect the declarative nature of the national policy priorities.

Effective advocacy (both inside and outside the healthcare system, in the area of public policy) is needed to use these opportunities for organizing and supporting the operation of modern HIV epidemiological surveillance.

HIV epidemiological surveillance isn't clearly declared as a priority of the national policy and where it is declared as such, it doesn't have enough weight to influence the decision making in the field of public policy.

Healthcare Reforms and the Country's Development Policies

Healthcare reforms and development policies of the country bear direct and indirect influences on the arrangement and operation of the HIV surveillance system. Among a great number of factors two of them are worth mentioning (in terms of their influence / significance):

minimal government intervention in the market (according to the best traditions / values of liberal democracy):

- maximum deregulation of almost all matters of public policy including healthcare and
- reducing government's role in production of medical services

Endless reforms in healthcare management system (organizational and functional rearrangements)

Exploring the suitability of these processes (factors) or appropriateness of technologies used for their implementation is not the subject of our analysis.

How does the reduction of government intervention in the healthcare influence the HIV surveillance system?

This issue, and more specifically the influence of this factor on the improvement and functioning of the health information system in general, is analyzed in a rather detailed way in the assessment of the health information system conducted under the aegis of Health Metrics Network in 2007-2008 and in the strategy

for health information system development[33]. According to this assessment, the first factor creates serious difficulties in recording data and generating / transmitting information for epidemiological surveillance: public bodies are short of administrative leverages to demand medical facilities to collect / report data to them let alone the quality control of these data.

Furthermore, the deregulation of the healthcare sector and the accessiblity of laboratory and diagnostic equipment all create prerequisites for virtually any entity to perform HIV testing (using a rapid / simple method or an indirect immunofluorescent (IFA) method). Today such entities aren't registered (and it's almost impossible to make a complete inventory of such entities) and they don't provide any supervision of testing quality. Notwithstanding the fact that only one entity carries out HIV confirmation today, it cannot be ruled out that other entities also have technical capacities for confirmation (using Western Blot or PCR). Ultimately, the necessity arises to fit the design of HIV surveillance system to a pluralistic and maximally deregulated environment. We may consider this factor (approaches or "rules of game" pertinent to the liberal market relations) as being given and, while conceptualizing the issue, try to find the answers to such questions as:

Should the quality control of confirmatory lab testing be performed and how will the quality control be implemented?

How will the flow of information needed for epidemiological surveillance be ensured in the presence of key player multiplicity (primary and confirmatory laboratories) and an unregulated healthcare market?

How will confidentiality be maintained in the presence of a multiplicity of entities carrying out HIV testing (e.g. teaching them the coding standard and maintaining the standard)?

It's difficult to clearly answer the question of whether reducing the government intervention in the HIV surveillance system in the healthcare market is a negative or a positive factor. In the following analysis we'll try to answer these questions at least partially and set out recommendations, which will help to find the ultimate answers during conceptualization.

As for endless organizational and functional changes in the system of healthcare management, this factor wields a negative influence on HIV surveillance in the following ways:

during frequent changes in players, the key functions "are lost along the way" or they are transferred mechanically (formally)

investing in one structure becomes risky if it is unkonwn how long it will last or how long it will be responsible for one or another function of epidemiological surveillance.

Ties between central and peripheral structures are reduced against the background of incomplete decentralization of the healthcare sector (as well as that of public administration); this is relevant to public health authorities in the first place. There are inadequate financial resources in the majority of administrative entities to enable local uthorities to fulfill their functions (within exclusive or delegated competencies) and transfers from the central budget become necessary. At the same time, the mechanisms at the central level are inefficient to make local authorities accountable and to perform supervision:

Local authorities are administratively subordinated to local governments and, despite receiving funds from the central budget, it is unclear to which of the central healthcare management bodies they are accountable for the activities performed using these funds and for the results of these activities.

[33] Curatio International Foundation: "Strategic plan for developing health information system in Georgia", 2008

Contractual arrangements under the state program (i.e. placing orders and demanding respectively) remain the primary tool used by the central public health body to involve local public health authorities in the HIV epidemiological suveillance and manage them.

Hence, the following question remains open for conceptualizing: is it reasonable for improving the surveillance of HIV and other infectious diseases to move certain functions from the central to the peripheral level,in effect, to deconcentrate them?

6.2.2 Internal Factors of the System

The key players, their expectations, capacities, or functions are detailed in the descriptive part and the summaries of the document.

To what extent the system is well-suited (or faulty) in terms of organizational and functional arrangement can by analysed from the perspective of supply and demand. Based on this approach, the organizational and functional arrangement of the epidemiological surveillance system is considered to be well-suited so far as it meets demands. If we take this assumption as a benchmark, then the first question to be answered will be:

What are the current demands (or will be the future demands) for the HIV surveillance system?

The demand for HIV surveillance depends on two factors in the country: the need for reporting under the international commitments (the so-called “external use”) and for evidence to make decisions and act on them under the national response to HIV epidemic. If evidence-based public policy decision-making (on HIV infection or other urgent healthcare issues) is “unpopular” in a country, demand is mainly driven by external use.

Unfortunately, currently this is the very situation in the country in terms of demand. To illustrate this, it is enough only to look at the 2008 state program for HIV/AIDS early detection and treatment, where there is not even one number (save the amount of budgetary money) characterizing the epidemiological situation, substantiating commensurability of the scope of envisaged activities or describing what measurable outcomes the state intends to achieve.

If we take into consideration the fact that the country manages, if not completely, then at least quite well, to cope with its international commitments (this can be illustrated by the 2006 Country Monitoring Report on the Implementation of the UN General Assembly Declaration of Commitments on HIV/AIDS), we can assume that the surveillance system meets the demands in terms of its organizational and functional arrangement regardless of the dissatisfaction of experts and insiders (so-called “cooks”).

It’s also noteworthy that the desire and the interest for improving HIV surveillance mainly come from the insiders of the system rather than its consumers (public policy decision-makers).

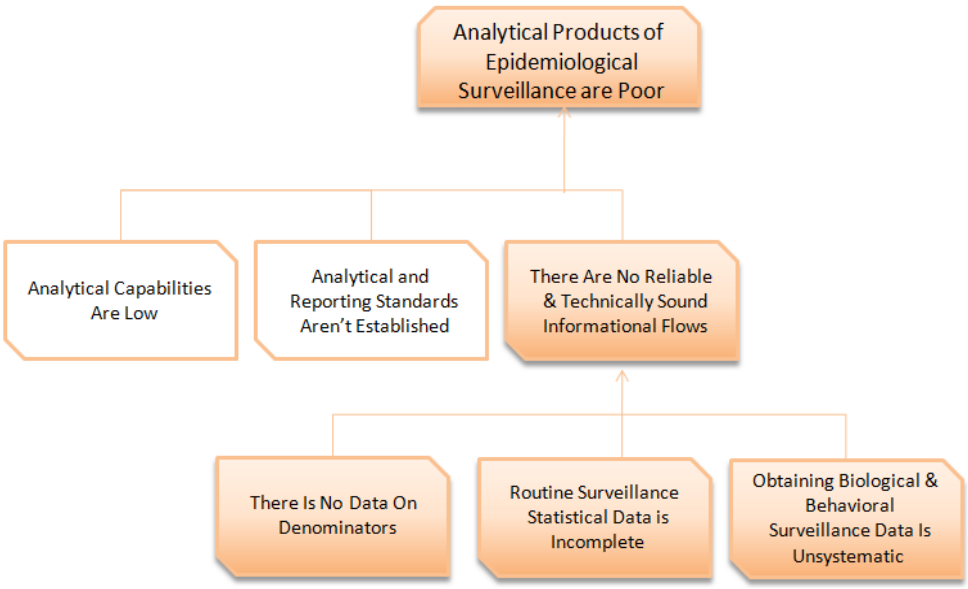
It turns out that it’s not necessary at all to analyze the drawbacks of the existing organizational and functional arrangement of the system, if the HIV surveillance system meets the demands.

It is not arguable that the above-mentioned “balance between supply and demand” will not last for a long time:

Sooner or later the practice of evidence-based decision-making will be established in public policy; when it happens and policy makers or implementators will look for arguments/data and it will turn out that the epidemiological surveillance system won’t be able to provide such information- it will be too late. Taking measures in advance today is required to organize a continuous supply of reliable data and evidence even after 5 years.

If the epidemic becomes more powerful and reaches the status of a concentrated epidemic, demands towards the epidemiological surveillance system will increase (in the field of public policy) qualitatively and volume loads will also grow.

Therefore, it's preferable that an analysis of the organizational and functional arrangement of the system be built on a hypothetical question: if there is a high demand for data used for evidence-based decision making on HIV epidemic and spread of AIDS, what can the existing organizational and functional arrangement of the system offer?



Let's start with the function of analyzing and reporting – it is now "settled" in the NCDCPH and this fact is quite reasonable, considering the role of this public entity. Is there anything that prevents the NCDCPH from implementing this function successfully? Let's assume that information flows about the epidemic are properly organized. The study has showed that the NCDCPH will have enough professional or material resources to perform analysis if a standard format of analysis and reporting is developed and additional training of the technical staff working on HIV related issues is performed.

The fact that the NCDCPH is unable to perform a complete analysis nowadays is, indeed, related to the absence of reliable and technically flawless information flows. Data supply can be analyzed in three directions:

The lack (or unreliability) of denominators needed for analysis

Flaws in the information generated by means of routine surveillance

The fragmented nature of biological and behavioral surveillance surveys and the quality of data

Even if all the participants fulfilled properly the duty of obtaining, collecting, and transmitting information, the reporting forms are so unsuitable in technical terms that it's impossible to retrieve non-aggregate variables and perform analysis (which contradicts international standards / requirements). Even data submitted in aggregate form is almost unusable so far as the categories used for grouping aren't mutually exclusive (namely, the "group code" in the form #23) leading to confusion while filling-in the reporting forms (i.e. forms #4, #23 or #17) and interpreting received data.

While the data on seropositive cases detected by rapid / simple or IFA HIV testing is more or less accumulated in one facility when referred for confirmation, (using the form #4), non-aggregate data on other testing (seronegative cases) isn't reported at all and isn't subject to analysis.

As for determining the number of high-risk groups and reporting data for analysis, this function has been left "orphaned". Furthermore, there is no standard methodology for determining the denominator.

Biological and behavioral surveillance is mainly carried out by non-governmental organizations with foreign funding. This method / source of data collection isn't institutionalized in the surveillance system of the country, however such a decision is articulated clearly in the strategic plan for 2006-2010. It's also noteworthy that the prepared technical staff already have gained significant experiences in conducting such surveys, and their methodology and practice are already in

No less interesting is the situation around the processes following HIV confirmation, which imply notifying a confirmation result, informing a patient, and carrying out an epidemiological investigation. According to the existing rule, if an HIV/AIDS case is confirmed, notification (form #58/4) is sent to the territorial public health authority (operating in the area of the actual place of residence of the HIV-infected patient). In principle, a public health authority is responsible for "recording a case" and using the data for "situational analysis". It's unclear why it is necessary to register a case in a territorial public health body, when it has already been recorded in the system of epidemiological surveillance at the

The importance and the process of informing an HIV-infected patient about his or her condition aren't conceptualized at all:

There is no procedure or standard defining who and how this person communicates a confirmation result (positive or

The moment of informing an individual about a positive result of a confirmatory testing is used insufficiently to carry out voluntary counseling and epidemiological investigation, i.e.

Here are the questions left open and, if remain unanswered, they won't allow to develop a well-suited system:

What purpose does HIV epidemiological investigation serve? Depending on the purpose, what is the optimal approach to be used?

Is it reasonable that AIDS epidemiological surveillance be based on identifying AIDS cases by clinical signs?

What mechanisms can be used to ensure that pirmary level facilities collect and report quality data?

Is it justified and feasible to "demonopolize" the function of HIV confirmation?

It applies to a lesser extent to self-referred cases, when an infividual goes directly to a confirming facility and gets the result of HIV testing in person. In all other cases (when blood is sent from regional / district facilities) information is communicated in different ways and confidentiality in such cases is usually completely disregarded.

As for HIV epidemiological investigation, it is not clear what purpose it serves and how reasonable (cost-effective) it is to carry out such an investigation. This function is formally present for now and its implementation is included in the competencies of public health authorities (in an implied form). If they truly decide to carry out an epidemiological investigation in each confirmed case, the notification form won't allow them to do so at all. The study has showed that a confirmed case notification form (#58/4) hasn't been found at the assessed public health centers.

It's obvious that the purpose of HIV epidemiological investigation needs careful consideration; it should be weighed whether it is reasonable to carry out such investigations in low-prevalence or concentrated epidemics, when the epidemic is mainly present in high-risk groups. It should be thought over whether it is possible to combine epidemiological investigation with the counseling function and to focus on preventing HIV transmission rather than identifying the source of infection (which is almost impossible in CSWs and IDUs).

Only after such conceptualizaiton will it be possible to discuss who and in what form can take on the functions of informing, counseling, and performing epidemiological investigation so that confidentiality is observed and the risk of stigmatization is considered.

While such a conceptual consideration it will also be necessary to discuss the issue of accessibility to HIV testing, especially to confirmatory testing. It may turn out to be much more convenient to "move" confirmation and related counseling and epidemiological investigation to the regional level (i.e. decentralization). Then it should be decided who may take on this function: territorial public health services, blood transfusion stations or other healthcare facilities (bearing in mind the risk of stigmatization). The existing practice of contacting a patient by a third person(or more) after confirming an HIV case and thus causing discomfort to the patient may be changed if the contact is limited to relationship between two persons only.

The study showed that (as it was expected) the situation was satisfactory at the central level in terms of technical capacities, whereas there was a lack of resources at the peripheral level.

Without making considerable investments (the appropriateness of which should be assessed by a separate estimation), it is impossible to record data at primary level facilities and transmit it using up-to-date information and communication technologies. Such advanced technologies wouldn't be necessary at all if it wasn't necessary to record and transmit data on each individual tested at primary level facilities. Most important is the fact that confirming institutions and the NCDCPH have enough technical capacities to transform data into electronic form and process and analyze it. If it becomes necessary to operationalize an online information system, additional investments will be needed.

Finally, the study showed that surveillance activities related to informational flows are virtually not financed directly from any source and the burden of actual expenses falls on the involved parties. This factor should be considered at the stage of designing an improved system - **if the burden of collecting and transfering data rises sharply for the involved parties, the need of financing expenses at least partially may become inevitable.**

The need in surveillance material and technical base and financial resources may rise substantially if the number of initial testing and presumably seropositive cases identified by rapid / simple HIV test needing confirmation increase. In such a case, the issue of retaining the function of HIV/AIDS confirmation at the central level or "moving" it to the regions (the matter discussed in the analysis of external factors) becomes topical once again.

7 SWOT Analysis

The results of analyzing the needs and the factors can be grouped in four categories using the SWOT analysis methodology: (see Figure 6 below).

It's not a surprise that the list in the right column (negative factors / aspects) is more extensive than that in the left one (positive aspects / strengths).

Figure 6: SWOT analysis of the HIV surveillance system

Internal

Positive	Negative
Strengths	**Weaknesses**
The function of analyzing and reporting on HIV epidemic has been entrusted to a specialized public entity having adequate expertise and material and technical resources The experience and the technical resources are available in the country to conduct biological and behavioral surveillance surveys. The turnover of key technical staff is low. The involved parties are interested and motivated in the system updating	There is no conceptual integrated framework for HIV surveillance. The system of vertical subordination or accountability between the central and local government bodies (authorities) participating in the HIV surveillance is virtually absent Information flows all the way from an initial recording to an analysis are not standardized The rules and forms currently used to collect and report information are technically defective and virtually useless to perform a comprehensive analysis. Primary healthcare facilities are short of adequate resources and incentives to collect and submit quality data needed for epidemiological surveillance The element of informing is not used appropriately for advising and implementing other activities of epidemiological surveillance in the future.

External

Opportunities	Threats
International commitments of the country as a prerequisite of actually reflecting HIV surveillance in the national policy priorities	Health care deregulation and limited capacities for implementing standardized case registration and reporting in the health market (the scarcity of "tools" at the government's disposal)
Bringing NCDCPH regional structures into operation makes it possible to concentrate the key functions of the HIV surveillance at the sub national level	Endless changes in the health care management system (organizational and functional rearrangements)
The integration of HIV surveillance into the system of surveillance of other communicable diseases (the creation of an integrated surveillance system)	An improper legislative practice featuring an absence, collision, or inappropriateness of essential legal norms.
The support of international partners and the accumulated international experience in standardizing the current surveillance methodology, tailoring it to a country and implementing it there.	The lack of evidence-based decision-making practice in public policy and consequently low demand for arguments / information
	There is a possibility for increasing HIV testing and expanding information flows / sources in case of decentralizing confirmation – all of these are hard to implement without using up-to-date information and communication systems

Conclusions and Recommendations

8 Conclusions

Today the HIV surveillance system meets internal demands of the country and partially the requirements resulting from international commitments, but it by no means implies that the system doesn't need updating/improving:

The parties involved in the system operation are not satisfied with the existing situation and want to ameliorate it.

The demand for HIV surveillance is expected to rise in the near future (for internal use).

International commitments have not been met in full.

Qualitative updating in the HIV/AIDS surveillance system is mainly needed for:

The management and the analysis of information flows

The mechanisms of epidemiological investigation and counseling

All of these major or less important qualitative updates should serve the purposes of (the main requirements for the revised epidemiological surveillance system):

Actual observance of the confidentiality principle

Generation of reliable and technically sound information (evidence) for decision-making

The highest priority interventions include:

The development of a conceptual framework for the country's HIV surveillance system with participation of all stakeholders – all the key questions left open should be answered and the basis should be created, which will define the major characteristics of the system itself and the plan for its implementation and operation.

The functional and organizational arrangement of the HIV surveillance system on the basis of conceptual consideration and reflection of the system in the legal environment.

The standardization of all surveillance functions/activities through developing a methodology tailored to the capacities of the country, training technical staff, and exercising continuous control over the observance of the standards.

Only after implementing these two interventions is it possible to introduce a modern informational-analytical system, which will help all the involved parties and the major user – the NCDCPH – to better perform the functions envisaged by the HIV epidemiological surveillance.

9 Recommendations

com 1. Notwithstanding the fact that Georgia belongs to the countries with low prevalence of HIV, it is desirable that the HIV surveillance system be developed considering the requirements set for the countries with the "concentrated epidemic" status, implying:

1.1) monitoring changes in behavioral factors and the HIV prevalence rate among high–risk population groups

1.2) drawing connections between behavioral risk-factors detected in high-risk subpopulation groups and the general population in parallel with identifying these factors in high-risk population groups

com 2. Before defining technical and methodological characteristics of the HIV/AIDS surveillance system, it is necessary that the system be conceptually understood by all stakeholders taking into consideration the gained experience and the drawbacks revealed by the study. The conceptual framework should:

1.1) Answer several questions concerning the quality control of laboratory testing, the organization of voluntary counseling, and the management of information flows when a large number of entities are participating in the liberal healthcare market and deregulation with decentralization is taking place.

1.2) Explain the appropriateness and the possibility (feasibility) of actual integration of the HIV/AIDS surveillance system with the surveillance system of the other communicable diseases or separation of the former from the latter one.

1.3) Set clear guiding principles and approaches, according to which choices will be made among the options of organizational and functional arrangement of the system.

1.4) Define the rules (norms) based on which the legislation will be revised.

com 3. It is necessary to consider the appropriateness and the feasibility of uniting the functions of informing, counseling, and implementing epidemiological surveillance "fewer than one ceiling", especially at the peripheral level. After "accommodating" the mentioned functions under one ceiling, it's desirable to examine the issue of decentralizing case confirmation and make decisions:

1.5) In all cases, the updated epidemiological surveillance system should fit with the multiplicity of participating actors (including the facilities providing confirmation services) in the unregulated healthcare market.

1.6) It is desirable that communication of confirmation results, post-test counseling, and epidemiological investigation be performed by the same medical entity; it will facilitate maintaining the confidentiality and establishing trust between the HIV infected person and the surveillance system.

com 4. While revising normative acts after conceptual consideration, it is necessary that:

1.7) The issues of HIV/AIDS surveillance be clearly pointed out in every place, where the combination / integration of these issues with the epidemiological surveillance of other diseases is not appropriate (pursuant to the conceptual framework)

1.8) In each place, where the obligation of one party (entity) is defined, the administration mechanism should be clearly defined (i.e. what the entity ought to expect if it doesn't fulfill the obligation, in what form the reporting or fulfillment of the obligation is assessed, what the reciprocal obligation of the other party is and so on.)

com 5. While planning the technical characteristics and the management of information flows, it is desirable that:

1.9) the format and the content (the matrix of quantitative characteristics for internal and external usage with the disaggregation variables) of the analytical product be clearly defined in the first place and only then the guidelines and the tools for primary recording and transmitting data can be developed

1.10) pursuant to the manual for the development of the major indicators (UNAIDS, 2007), the reporting of data from the lower level to the upper one be performed in the same non-aggregate form as the data is collected at the lower level.

com 6. While planning information flows, it is preferable that the workload be minimized at the primary levels since there are no means of motivating them, controlling the quality of performed work, or mechanisms for administrative management there. In technical terms, it implies:

1.11) performing data collection in the most simplified format (minimizing the variables to be recorded and then reported by these facilities) using a paper medium.

1.12) centralizing the interface of entering the data into the electronic database (i.e. the information available on paper medium be gathered at one place) initially and carrying out decentralization of this function only after considering arguments of cost-effectiveness and quality.

1.13) calculating the detection rate only for certain subpopulations at the initial stage (e.g. pregnant women, TB patients, prisoners in the penitentiary institutions), inasmuch as it is unrealistic to obtain complete data on each initial testing in a non-aggregate form from other medical facilities; in the future it will always be possible to add the data on each testing performed in other subpopulations to the main stream of information flow.

Annexes

Annex # 1. In-Depth Interview Questionnaire for the Main Informants

Introduction

My name is XXXXX.

You are participating in the assessment carried out by "Curatio" International Foundation under the program for strengthening HIV/AIDS suveillance financed by the Global Fund. The goal of this assessment is to help improve the HIV/AIDS surveillance system in Georgia. Today, during the next 30 minutes, I'd like to talk to you about what you think of the HIV/AIDS surveillance system, specifically how the system is arranged in organizational and functional terms, who the participants and stakeholders are, what the achievements in implementing the state policy on HIV/AIDS prevention and control are, and what improvements are needed in this area.

I remind you that its your right to participate voluntarily in this interview. The information shared during this interview is entirely confidential.

During the interview you can refuse to answer any unwanted question you feel uncomfortable with or cease to participate in the interview at any time.

For practical reasons the interview will be recorded on the audiotape based on which a transcript of recordings will be made. To ensure confidentiality, the audio recording will be erased in 6 months. Your name and other personal information will be removed from the transcript. The results of the study may be used for publications, however the information will be presented in such a way that the names of participants will not be identifiable.

I have several specific questions I'm going to ask in this interview; I'd like to start with the issue of organizational and functional arrangement;

Organizational and Functional Arrangement

1. First of all, please, describe which functions are defined (considered, formulated, described in detail) within the existing system of HIV/AIDS epidemiological surveillance. We are also interested in the programs (funded by the state or donors) under which these functions are carried out.

> **Ask specific questions** to ensure that the respondent is talking about all major functions fulfilled in the international practice. Clear answers should be obtained during the interview whether each of the following functions is specifically defined / prescribed and fulfilled and at what level (local, regional, central) and under which program the functions are implemented:

Functions:

Case Reporting

HIV testing / Serosurveillance

Risk Behavior Subpopoulation Surveys

Determining the Size of High-Risk Population Groups

Disease Register and Cohort Follow-up

Data analysis

Information Dissemination and Use

Functions can be defined / described in detail in:

Ministerial Orders

Guidelines / Methodical Directions

2. Now, please, let's talk about the flows / problems / obstacles in fulfilling each existing function.

Ask specific questions to ensure that the respondent is talking about each major function (question 1) implemented at different levels (local, regional, central) as well as under individual programs. Each of these functions should be discussed by individual components:

Case Reporting

- identification, recording (standard case definition)
- reporting
- utilization of health services
- providers' knowledge level
- public education

HIV testing / Serosurveillance

- laboratory testing methodologies
- infrastructure and other material resources
- human resources and their knowledge level
- quality assurance (internal and external)

Risk Behavior Subpopulation Surveys

- whether a survey catalogue (i. e. a full list of surveys conducted in the country along with their short descriptions) is available
- technical capacities of national institutes and human resources
- participation of national institutes
- institutionalization

Determining the Size of High-Risk Population Groups

- stigma, unfavorable legal environment
- technical / methodological difficulties

Disease Register and Cohort Follow-up

- geographic coverage
- drop-out from the follow-up

Data analysis

- technical capacities of institutions and human resources
- IT support

Information Dissemination and Use

- feedback
- policy development
- program planning and implementation

3. Who are the major parties involved in the HIV/AIDS suveillance system?

Ask specific questions to ensure that the respondent is talking about every potential participant at local, regional, and central levels. It's important to explore organizational arrangement and administrative subordination of each involved party (to better represent administrative subordination of the involved parties, draw simple graphical schemes; it may be preferable to draw separate schemes for different functions or programs):

Country Coordination Mechanism

Ministry of Health

The AIDS Center

AIDS Central Reference Laboratory

National Center for Disease Control and Public Health (former center of medical statistics and former public health department currently incorporated in this institution)

Central Blood Transfusion Station

Respective Service of the Penitentiary System

State Program for Sexually Transmitted Infections

Tuberculosis National Program

State Program for Preventing and Controlling Drug Abuse

Non-governmental Organizations

District / Regional Level Laboratories

Primary Healthcare Facilities

Hospitals

District / Regional Public Health Authorities

District / Regional Blood Transfusion Stations

STI clinics

Women's Condultations

Other

4. How the major functions of HIV/AIDS surveillance and respective responsibilities are distributed among the involved parties according to the programs currently implemented in the country?

Ask specific questions about all participants (question 3) and all major functions (question 1). Responsibilities may include: policy development, program planning, financing, implementation, technical assistance, supervision, monitoring and evaluation, quality assurance and so on. Try to obtain answers in the following form:

Involved party	Responsibility by individual functions (It should be indicated if this responsibility is defined under any individual program)						
	Case Reporting	HIV Testing	Behavioral Surveys	Determining High-Risk Subpopulations	Disease Register	Data Anlysis	Information Use

Stakeholders

5. Who are the stakeholders of the HIV/AIDS surveillance system? What role (consumer, implementator, supervisor) do they play in the operation of the surveillance system? What are their demands (i.e. simplicity, compliance with the international standards), expectations (i.e. improved programming and management) and motivations (professional, financial)? The answer to this question should be provided in the following form:

Stakeholder	Role in the surveillance system	Demands	Expectations	Incentives
Providers	1.1			
Laboratories				
Public Health Centers	1.2			
The Ministry and its affiliated organizations				
HIV infected people and patients				
Non-governmental organizations				
other				

6. Now, I'd like to ask you how satisfied are you with the current HIV/AIDS surveillance system in general?

Ask specific questions about the principal reasons for their dissatisfaction:

organizational and functional arrangement of the system

technical design of the system

administration / management of the system

limited funding

other

7. Following from your answer to the previous question, what should be changed?

Ask the respondent what his or her recommendations would be:

for the nearest future

in the long-term perspective

Outcomes of the State Policy

8. Finally, we'd like to talk about the outcomes of the state policy on HIV/AIDS. As you know, the main priorities of the state policy are: prevention, … (this section is to be filled-in from the national policy review document).

Ask specific questions how successful the progress has been to achieve these results and what impeding or facilitating factors there are

priority 1

priority 2

...

9. After assessing the legal environment, a question (or a combination of questions) should be added to this questionnaire about the following issue: "Is there conformity between the defined norms and the reality?"

Thank you for giving valuable information.

Annex # 2. Record Review / Inventory / Survey Tool for Central Level Institutions

Record Review Tool

Records should be reviewed in each selected facility.

A respondent should be identified during an initial / preparatory meeting with heads / representatives of facilities using the following question: "Who is responsible for recording and reporting HIV/AIDS data at your facility?"

Each question should be answered and responses should be recorded by an interviewer / appraiser after assessing an appropriate sustaining document.

Each log book and statistical form, whether filled in fully or partially, should be photocopied immediately upon completion of a record review. The name of the facility should also be indicated on the photocopy.

1. Reporting from subordinate levels

1.1 Please, show us the cases of HIV/AIDS registered at your center / in your program nation-wide by years.

Year	HIV-infected	AIDS
2008		
2007		
2006		
2005		

1.2 Please, show us the number of HIV/AIDS cases in 2007 by the types of facilities where the cases were recorded initially

2007	HIV-infected	AIDS

1.3 Please, show us the number of cases in 2007 by the types of entities / facilities subordinated in the information system hierarchy and having reported HIV/AIDS cases to you

2007 year	HIV-infected	AIDS

1.4 Please, describe how many types and what kinds of reports you receive from the facilities subordinated within the information system.

The interviewer records his or her observations:

_____

_____

_____

_____

_____

_____

_____

_____

1.5 Can you show us the last report you received on HIV/AIDS cases?

After making observations, the interviewer answers:

a) the report exists

Yes No

if "Yes", when and by whom and how this report was submitted

_____

_____

b) the standard form is used for the report

Yes No

if "Yes", which form _____

c) write down **in detail** data fields(e.g. name, surname, age, gender, address, mode of transmission and so on) which are recorded in this report

_____

_____

_____

_____

_____

_____

_____

_____

1.6 Are there any written directions for entities subordinated in the information system hierarchy about where and how HIV/AIDS cases should be reported?

After making observations, the interviewer answers:

Yes No

if "Yes", to which reports they apply_____

_____

1.7 Do you have the list of the entities / facilities (indicating their competencies) from which you get reports on HIV/AIDS?

After making observations, the interviewer answers:

Yes No

1.8 Do you have an HIV/AIDS surveillance guideline / methodical directions (may be in the form of a ministerial order)?

After making observations, the interviewer answers:

The guideline exists

Yes No

if "Yes", which _____

1.9 How are received HIV/AIDS reports stored at your center?

The interviewer describes the observations

_____

_____

_____
_

2. Reporting to higher levels

2.1 Can you show us the last HIV/AIDS report you've prepared / sent?

After making observations, the interviewer answers:

a) the report exists

Yes No

if "Yes", when and by whom and how this report was sent

_____

_____

b) the standard form is used for the report

Yes No

if "Yes", which form _____

c) write down **in detail** data fields (e.g. name, surname, age, gender, address, mode of transmission and so on) recorded in this report

_____

_____

_____

_____

_____

_____

_____

_____

3. Analysis

3.1 Is HIV/AIDS epidemiological data analyzed at your center?

After making observations, the interviewer answers:

Yes No

if "Yes", what the format of this analysis is (e.g. place, time, individual patient)

_____

_____

_____

If "No", what the reason is

_____

_____

_____

3.2 Is the program / national technical report reflecting the HIV/AIDS profile prepared based on the above-mentioned analysis?

After making observations, the interviewer answers:

Yes No

if "Yes", what the format of this report is (e.g. incidence / prevalence by geographic regions, time, risk-groups, other subpopulation groups, socio-economic status, and so on)

_____

_____

_____

_____

_____

3.3 If "Yes", who the user of this technical report is:

_____

_____

4. Feedback

4.1 What kind of feedback do you give with the entities / facilities at the lower level of the HIV/AIDS epidemiological surveillance system?

The interviewer's observations (e.g. preparation / dissemination of reports / epidemiological bulletins, conducting conferences and working sessions, local visits and technical assistance, and so on)

_____

_____

_____

_____

Inventory Tool

5. Material and Technical Capacities

5.1 Which computer facilities serving the purposes of HIV/AIDS surveillance do you have at your center / in your program?

The interviewer completes the table below after direct observation of computer equipment

Equipment Name	Model	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
A. Computer system unit					
B.					
C.					
D. Monitor					
E.					
F.					
G. Printer					
H.					
I. UPS					
J.					
K. Xerox					
L.					
M. Fax					
N.					
O.					
P.					

5.2 Is there an internal (local) network connecting computers with each other?

After making observations, the interviewer answers:

Yes No

5.3 Are computers connected to the Internet?

After making observations, the interviewer answers:

Yes No (go to 5.7)

5.4 If "Yes", describe how they are connected to the Internet (e.g through a telephone line by a modem, DSL),

_____

_____

5.5 What is the qulity / speed of the internet connection?

_____

_____

5.6 How much on average does it cost you to use the internet per month?

_____

5.7 If there is no internet connection, what is the reason?

_____

_____

Qualitative Research Tool

6. Human Resources

6.1 What staff participating in any form in HIV/AIDS epidemiological surveillance are employed at your facility ?

This table should be filled in for every staff member dealing formally with the implementation of HIV/AIDS surveillance function (case reporting, HIV testing / serosurveillance, risk behavior surveillance surveys, disease register, data analysis, dissemination and use of information).

	Staff	Total Number	Gender		Type of Employment		Age Group			Length of Service at the Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5 y	> 10 y
A	Physician										
B	Nurse										
C	Laboratorian										
E	Statistician										
F	Epidemiologist										
G	Manager										
H											

6.2 How would you assess professional skills of your staff in using computer / communication facilities and processing / analyzing data?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Have basic computer skills and knowledge (turning on and shutting down a computer, composing simple documents in a text editing software, printing out a document)						
b) Have basic skills and knowledge for using electronic communication facilities (can use email, work in the internet)						
c) Have good computer skills and knowledge in terms of electronic processing / analyzing data (setting up a database (Excel), performing statistical analysis (e.g. calculating averages in Excel database), graphical presentation of data (Excel))						

6.3 How would you describe the turnover of key technical staff at your facility?

Directions: use the below scale to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, that there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Staff turnover is not a serious problem at our facility						
b) It is extremely difficult to retain qualified specialists at their workplaces for a long period of time						
c) Staff turnover prevents us from implementing the key HIV/AIDS surveillance functions						

6.4 How would you describe the motivation of the key technical staff at your facility with regard to the tasks to be fulfilled under HIV/AIDS epidemiological survillance?

Directions: Use the below scale to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member

across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) They are motivated to perform the assigned job / responsibilities						
b) They recognize the specific benefit out of implementing an up-to-date information system						
c) They are afraid of introducing innovations in the facility operation						

Annex # 3. Record Review / Inventory / Survey Tool for Primary Healthcare Centers

Record Review Tool

Records should be reviewed in each selected facility.

A respondent should be identified during an initial / preparatory meeting with heads / representatives of facilities using the following question: "Who is responsible for recording and reporting HIV/AIDS data at your facility?"

Each question should be answered and responses should be recorded by an interviewer / appraiser after assessing an appropriate sustaining document.

Each log book and statistical form, whether filled in fully or partially, should be photocopied immediately upon completion of a record review. The name of the facility should also be indicated on the photocopy.

1. Case Notification

Have you ever received an HIV/AIDS notification at your center?

Yes No (go to 1.4)

1.2 If "Yes", please, show us the number of cases by years and types of facilities

a) HIV infection cases

Year	**Total**	Laboratory	PHF	Hospital	STI clinic	Women's consultation	other
2008							
2007							
2006							
2005							

b) AIDS cases

Year	**Total**	Laboratory	PHF	Hospital	STI clinic	Women's consultation	other
2008							
2007							
2006							
2005							

1.3 Were HIV/AIDS case notifications reported from facilities using the standard form?

After making observations, the interviewer answers:

Yes No

if "Yes", by which form_____

1.4 Are there written directions for the facilities in the area of your operation about where and how an HIV/AIDS case notification should be fulfilled?

After making observations, the interviewer answers:

Yes No

1.5 Do you have an updated (2008) list of laboratories (specifying their competencies) in the area of your operation?

After making observations, the interviewer answers:

Yes No

2. Recording

2.1 Can you show us the log where HIV/AIDS cases are recorded?

After making observations, the interviewer answers the following questions:

a) the log book exists

Yes No

b) a standard form is used for the log book

Yes No

If "Yes", which _____

c) write down **in detail** data fields (e.g. name, surname, age, gender, address, mode of transmission, date of self-referral and so on) recorded in the log book about the case

_____

_____

_____

_____

_____

_____

_____

_____

2.2 Do you have a standard HIV/AIDS case definition at your center?

After making observations, the interviewer answers:

a standard definition exists in a written form

Yes No

2.3 Do you have an HIV/AIDS survieillance guideline / methodical directions (may be in the form of a ministerial order) at your facility?

After making observations, the interviewer answers:

the guideline exists

Yes No

if "Yes", which _____

2.4 How are recorded data (e.g. the same log book) on HIV/AIDS cases stored at your center?

The interviewer describes the observations

_____

_____

_____
_

3. Lab Testing / Confirmation

3.1 Is HIV testing performed at your center?

Yes No (go to 4.1)

3.2 If "Yes", by which method?

_____

3.3 Are individual patients referred from other facilities for laboratory testing?

Yes No

3.4 Do you receive biological samples from other facilities for laboratory testing?

Yes No (go to 4.1)

3.5 What samples do you receive?_____

3.6 How are these samples taken? _____

3.7 How do you store these samples? _____

3.8 How are these samples transported? _____

3.9 What information do you receive along with these samples?_____

After making observations, the interviewer answers the following questions:

a) a standad format is used for the data

Yes No

If "Yes", which form_____

3.10 Do you have any directions on how a biological sample should be taken, stored, and sent for HIV testing?

After making observations, the interviewer answers:

Yes No

3.11 Do you send HIV positive samples to the central reference laboratory for confirmation?

After making observations, the interviewer answers:

Yes No

If "Yes", where and how is the sample sent (transportation, container, accompanying information)?

_____

_____

_____

3.11 Do you have directions / guidelines about how to send lab samples for confirmation?

After making observations, the interviewer answers:

Yes No

3.13 How is an individual informed about a test result?

_____

4. Reporting

4.1 Can you show us the last HIV/AIDS report you sent within the last 4 years?

After making observations, the interviewer answers:

a) the report exists

Yes No

If "Yes", when, by whom, and how this report was sent _____

_____

b) a standard form is used for the report

Yes No

If "Yes", which form_____

c) write down **in detail** the data fields (i.e. age, gender, geagraphic location, risk group, mode of transmission and so on) that are recorded in this report

_____

_____

_____

_____

_____

_____

_____

5. Analysis

5.1 Is HIV/AIDS epidmiological data analyzed at your center?

After making observations, the interviewer answers:

Yes No

If "Yes", what is the format of this analysis (e.g. place, time, individual patient)?

_____

_____

_____

If "No", what is the reason? _____

_____

_____

5.2 Is a technical report reflecting an HIV/AIDS epidemiological profile prepared based on the above-mentioned analysis?

After making observations, the interviewer answers:

Yes No

If "Yes", what is the format of this report (e.g. incidence / prevalence by geographic regions, time, risk-groups, other subpopulation groups, socio-economic status and so on)?

_____

_____

_____

_____

5.3 If "Yes", who is the technical user of this report?

_____

_____

6. Epidemiological Investigation

6.1 Do you carry out an HIV/AIDS epidcmiological investigation upon receiving a notification?

After making observations, the interviewer answers:

Yes No

6.2 Can you show us the last filled-in epidcmiological investigation card?

After making observations, the interviewer answers the following questions:

a) the epidemiological investigation card exists

Yes No

b) a standard form is used for the card

Yes No

if "Yes", which _____

c) write down **in detail** the data fields (i.e. name, surname, age, gender, address, mode of transmission, contacts, and so on) which are recorded during an epidemiological investigation

_____

_____

_____

_____

_____

_____

_____

_____

6.3 Where and how is a filled-in epidemiological investigation card stored?

An interviewer's observations

_____

_____

6.4 What are other response actions you carry out upon receiving a notification?

An interviewer's observations

_____

_____

_____

_____

7. Training

7.1 Have you or the staff at your center ever undergone training in HIV/AIDS epidemiological surveillance?

After assessing the sustaining certificate and training materials, an interviewer answers:

Yes No

Inventory / Observation Tool

5. Material and Technical Capacities

5.1 What computer facilities do you have at your center?

The interviewer completes the table below after direct observation of computer equipment

Equipment Name	Model	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
A. Computer system unit					
B.					
C.					
D. Monitor					
E.					
F.					
G. Printer					
H.					
I. UPS					
J.					
K. Xerox					
L.					
M. Fax					
N.					
O.					
P.					

5.2 Is there an internal (local) network connecting computers with each other?

After making observations, the interviewer answers:

Yes No

5.3 Are computers connected to the internet?

After making observations, the interviewer answers:

Yes No (go to 5.7)

5.4 If "Yes", describe how they are connected to the internet (e.g through a telephone line by a modem, DSL),

_____

_____

5.5 What is the quality / speed of the internet connection?

_____

_____

5.6 How much, on average, does it cost you to use the internet per month?

5.7 If there is no internet connection, what is the reason?

Quantitative Research Tool

6. Human Resources

6.1 What staff participating in any form in HIV/AIDS epidemiological surveillance are employed at your facility ?

This table should be filledin for every staff member dealing formally with the implementation of HIV/AIDS surveillance function. (case reporting, HIV testing / serosurveillance, risk behavior surveillance surveys, disease register, data analysis, dissemination and use of information)

	Staff	Total Number	Gender		Type of Employment		Age Group			Length of Service at the Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
A	Physician										
B	Nurse										
C	Laboratorian										
E	Statistician										
F	Epidemiologist										
G	Manager										
H											

6.2 How would you assess professional skills of your staff in using computer / communication facilities and processing / analyzing data?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5

Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Have basic computer skills and knowledge (turning on and shutting down a computer, composing simple documents in a text editing software, printing a document)						
b) Have basic skills and knowledge for using electronic communication facilities (can use email or work in the internet)						
c) Have good computer skills and knowledge in terms of electronic processing / analyzing data (setting up a database (Excel), performing statistical analysis (e.g. calculating averages in Excel database), graphical presentation of data (Excel))						

6.3 How would you describe the turnover of the key technical staff at your facility?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Staff turnover is not a serious problem at our facility						
b) It is extremely difficult to retain qualified specialists at their workplaces for a long period of time						
c) Staff turnover prevents us from implementing key HIV/AIDS surveillance functions						

6.4 How would you describe the motivation of the key technical staff at your facility with regard to the tasks to be fulfilled under HIV/AIDS epidemiological survillance?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5

Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) They are motivated to perform the assigned job / responsibilities						
b) They recognize the spesific benefit out of implementing an up-to-date information system						
c) They are afraid of introducing innovations in the facility operation						

Annex # 4. Record Review / Inventory / Survey Tool for HIV Labs / Blood Stations

Record Review Tool

Records should be reviewed in each selected facility.

A respondent should be identified during an initial / preparatory meeting with heads / representatives of facilities using the following question: "Who is responsible for recording and reporting HIV/AIDS data at your facility?"

Each question should be answered and responses should be recorded by an interviewer / appraiser after assessing an appropriate sustaining document.

Each log book and statistical form, whether filled in fully or partially, should be photocopied immediately upon completion of a record review. The name of the facility should also be indicated on the photocopy.

1. Case Recording

1.1 Have you ever had a positive HIV test result at your facility?

Yes No (go to 1.4)

1.2 If "Yes", please, show us the number of cases by years

Year	Total number of positive test results	Confirmed by the central reference laboratory
2008		
2007		
2006		
2005		

1.3 Can you show us the log book where HIV cases were recorded?

After making observations, the interviewer answers:

a)the log book exists

Yes No

ð) a standard form is used for the log book

Yes No

If "Yes", which _____

*c) write down **in detail** data fields (e.g. name, surname, age, gender, address, mode of transmission, date of self-referral and so on) recorded in the log book about the case*

_____

_____

_____

_____

_____

_____

1.4 Do you have a standard HIV/AIDS case definition at your facility?

After making observations, the interviewer answers:

the standard definition exists in a written form

Yes No

1.5 Do you have an HIV/AIDS survieillance guideline / methodical directions (may be in the form of a ministerial order) at your facility?

After making observations, the interviewer answers:

the guideline exists

Yes No

1.6 How are recorded data (e.g. the same log book) on HIV/AIDS cases stored at your center?

The interviewer describes the observations

_____

_____

_____
_

2. Lab Testing / Confirmation

2.1 Is HIV testing performed at your facility?

Yes No (go to 2.3)

2.2 If "Yes", by which method?

_____

2.3 Do individual patients come to your facility for laboratory testing?

Yes No

2.4 Do you receive biological samples from other facilities for laboratory testing?

Yes No (go to 3.1)

2.5 Which samples do you receive? _____

2.6 How are these samples taken? _____

2.7 How do you store these samples before testing? _____

2.8 How are these samples transported? _____

2.9 What information do you receive along with these samples

_____

After making observations, the interviewer answers the following questions:

a) a standad form is used for the data

Yes No

If "Yes", which form_____

2.10 Do you have any directions on how a biological sample should be taken, stored, and sent for HIV testing?

After making observations, the interviewer answers:

Yes No

2.11 Do you send HIV positive samples to the central reference laboratory for confirmation?

After making observations, the interviewer answers:

Yes No

If "Yes", where and how is the sample sent (transportation, container, accompanying information)?

_____

_____

2.12 Do you have directions / guidelines about how to send lab samples for confirmation?

After making observations, the interviewer answers:

Yes No

2.13 In what time and how do you send laboratory test results to referring facilities?

_____

2.14 How is a patient informed about a test result?

_____

3. Notification / Reporting

3.1 Can you show us the last HIV case notificatin / report you sent within the last 4 years?

After making observations, the interviewer answers the following questions:

a) whether it exists or not

Notification Exists		Report Exists	
Yes	No	Yes	No
If "Yes", when, where, and how this report was sent		If "Yes", when, where, and how this report was sent	

b) format

Standard format is used for a notification		Standard format is used for a report	
Yes	No	Yes	No
If "Yes", which		If "Yes", which	

c) write down **in detail** the data fields (i.e. name, surname, age, gender, address, mode of transmission, date of self-referral and so on) which are recorded in this notification / report

Notification	Report

3.2 Do you have written directions on where and how an HIV/AIDS case notification / reporting should be fulfilled?

After making observations, the interviewer answers:

Yes No

4. Training

4.1 1 Have you or the staff at your center ever undergone training in HIV/AIDS epidemiological surveillance?

Yes No

a) After making observations, the interviewer answers:

Are there any sustaining certificates and training materials?

Yes No

Inventory / Observation Tool

5. Material and Technical Capacities

5.1 Which coomputer facilities do you have at your facility?

The interviewer completes the table below after direct observation of computer equipment

Equipment Name	Model	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
A. Computer system unit					
B.					
C.					
D. Monitor					
E.					
F.					
G. Printer					
H.					
I. UPS					
J.					
K. Xerox					
L.					
M. Fax					
N.					
O.					
P.					

5.2 Is there an internal (local) network connecting several computers with each other?

After making observations, the interviewer answers:

Yes No

5.3 Are the computers connected to the internet?

After making observations, the interviewer answers:

Yes No (go to 5.7)

5.4 If "Yes", describe how they are connected to the internet (e.g through a telephone line by a modem, DSL),

_____
_____
_____

5.5 What is the quality / speed of the internet connection?

_____
_____

5.6 How much on average does it cost you to use the internet per month?

_____

5.7 If there is no internet connection, what is the reason?

_____

Quantitative Research Tool

6. Human Resources

6.1 What staff participating in any form in HIV/AIDS epidemiological surveillance are employed at your facility ?

This table should be filledin for every staff member dealing formally with the implementation of HIV/AIDS surveillance function. (case reporting, HIV testing / serosurveillance, risk behavior surveillance surveys, disease register, data analysis, dissemination and use of information)

	Staff	Total Number	Gender		Type of Employment		Age Group			Length of Service at the Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
A	Physician										
B	Nurse										
C	Laboratorian										
E	Statistician										
F	Epidemiologist										
G	Manager										
H											

	Staff	Total Number	Gender		Type of Employment		Age Group			Length of Service at the Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10

6.2 How would you assess professional skills of your staff in using computer / communication facilities and processing / analyzing data?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Have basic computer skills and knowledge (turning on and shutting down a computer, composing simple documents in a text editing software, printing a document)						
b) Have basic skills and knowledge for using electronic communication facilities (can use email and work in the internet)						
c) Have good computer skills and knowledge in terms of electronic processing / analyzing data (setting up a database (Excel), performing statistical analysis (e.g. calculating averages in Excel database), graphical presentation of data (Excel))						

6.3 How would you describe the turnover of the key technical staff at your facility?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Staff turnover is not a serious problem at our facility						
b) It is extremely difficult to retain qualified specialists at their workplaces						

for a long period of time						
c) Staff turnover prevents us from implementing key HIV/AIDS surveillance functions						

6.4 How would you describe the motivation of the key technical staff at your facility with regard to the tasks to be fulfilled under HIV/AIDS epidemiological survillance?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) They are motivated to perform the assigned job / responsibilities						
b) They recognize the spesific benefit out of implementing an up-to-date information system						
c) They are afraid of introducing innovations in the facility operation						

Annex # 5. Record Review / Inventory / Survey Tool for Outpatient Clinics / Hospitals / STD Clinics / Women's Consultations

Record Review Tool

Records should be reviewed in each selected facility.

A respondent should be identified during an initial / preparatory meeting with heads / representatives of facilities using the following question: "Who is responsible for recording and reporting HIV/AIDS data at your facility?"

Each question should be answered and responses should be recorded by an interviewer / appraiser after assessing an appropriate sustaining document.

Each log book and statistical form, whether filled in fully or partially, should be photocopied immediately upon completion of a record review. The name of the facility should also be indicated on the photocopy.

1. Case Identification / Recording

1.1 Have you ever had a positive HIV test result at your facility?

Yes No (go to 1.4)

1.2 If "Yes", please, show us the number of cases by years

Year	HIV infected	AIDS
2008		
2007		
2006		
2005		

1.3 Can you show us the log book where HIV cases were recorded?

After making observations, the interviewer answers:

a) the log book exists

Yes No

ð) a standard form is used for the log book

Yes No

If "Yes", which _____

c) write down **in detail** data fields (e.g. name, surname, age, gender, address, mode of transmission, date of self-referral and so on) recorded in the log book about a case

_____

_____

_____

_____

_____

_____

1.4 Do you have a standard HIV/AIDS case definition at your facility?

After making observations, the interviewer answers:

the standard definition exists in a written form

Yes No

1.5 Do you have an HIV/AIDS survieillance guideline / methodical directions (may be in the form of a ministerial order) at your facility?

After making observations, the interviewer answers:

the guideline exists

Yes No

1.6 How are recorded data (e.g. the same log book) on HIV/AIDS cases stored at your center?

The interviewer describes the observations

_____

_____

_____
_

2. Laboratory Testing / Confirmation

2.1 1 Is HIV testing performed at your facility?

Yes No (go to 2.3)

2.2 If "Yes", by which method?

_____

2.3 Do you refer a patient to another facility for HIV testing?

Yes No

2.4 Do you send biological samples taken from a patient to other facilities for laboratory testing?

Yes No (go to 3.1)

2.5 Which samples are sent? _____

2.6 How are these samples taken?_____

2.7 How do you store thes samples before sending ?_____

2.8 How are these samples transported? _____

2.9 What information do you supply along with these samples

_____

After making observations, the interviewer answers the following questions:

a) a standad form is used for the data

Yes No

If "Yes", which form _____

2.10 Do you have any directions on how a biological sample should be taken, stored, and sent for HIV testing?

After making observations, the interviewer answers:

Yes No

2.11 In what time and how do you receive laboratory test results?

_____

2.12 How is a patient informed about a test result?

_____

3. Notification / Reporting

3.1 Can you show us the last HIV case notificatin / report you sent within the last 4 years?

After making observations, the interviewer answers the following questions:

a) whether it exists or not

Notification Exists		Report Exists	
Yes	No	Yes	No
If "Yes", when, where, and how this report was sent		If "Yes", when, where, and how this report was sent	

b) format

Standard format is used for a notification		Standard format is used for a report	
Yes	No	Yes	No
If "Yes", which		If "Yes", which	

c) write down **in detail** the data fields (i.e. name, surname, age, gender, address, mode of transmission, date of self-referral and so on) that are recorded in this notification / report

Notification	Report

3.2 Do you have written directions on where and how an HIV/AIDS case notification / reporting should be fulfilled?

After making observations, the interviewer answers:

Yes No

4. Training

4.1 Have you or the staff at your center ever undergone training in an HIV/AIDS epidemiological surveillance?

Yes No

a) After making observations, the interviewer answers:

Are there any sustaining certificates and training materials?

Yes No

Inventory / Observation Tool

5. Material and Technical Capacities

5.1 Which coomputer facilities do you have at your facility?

The interviewer completes the table below after direct observation of computer equipment

Equipment Name	Model	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
A. Computer system unit					
B.					
C.					
D. Monitor					
E.					
F.					
G. Printer					
H.					
I. UPS					
J.					
K. Xerox					
L.					
M. Fax					
N.					
O.					
P.					

5.2 Is there an internal (local) network connecting several computers with each other?

After making observations, the interviewer answers:

Yes No

5.3 Are the computers connected to the internet?

After making observations, the interviewer answers:

Yes No (go to 5.7)

5.4 If "Yes", describe how they are connected to the internet (e.g through a telephone line by a modem, DSL),

_____

_____

_____

5.5 What is the quality / speed of the internet connection?

_____

_____

5.6 How much on average does it cost you to use the internet per month?

5.7 If there is no internet connection, what is the reason?

Quantitative Research Tool

6. Human Resources

6.1 What staff participating in any form in HIV/AIDS epidemiological surveillance are employed at your facility ?

This table should be filledin for every staff member dealing formally with the implementation of HIV/AIDS surveillance function. (case reporting, HIV testing / serosurveillance, risk behavior surveillance surveys, disease register, data analysis, dissemination and use of information)

	Staff	Total Number	Gender		Type of Employment		Age Group			Length of Service at the Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
A	Physician										
B	Nurse										
C	Laboratorian										
E	Statistician										
F	Epidemiologist										
G	Manager										
H											

6.2 How would you assess professional skills of your staff in using computer / communication facilities and processing / analyzing data?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5

Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Have basic computer skills and knowledge (turning on and shutting down a computer, composing simple documents in a text editing software, printing a document)						
b) Have basic skills and knowledge for using electronic communication facilities (can use email, work in the internet)						
c) Have good computer skills and knowledge in terms of electronic processing / analyzing data (setting up a database (Excel), performing statistical analysis (e.g. calculating averages in Excel database), graphical presentation of data (Excel))						

6.3 How would you describe a turnover of key technical staff at your facility?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) Staff turnover is not a serious problem at our facility						
b) It is extremely difficult to retain qualified specialists at their workplaces for a long period of time						
c) Staff turnover prevents us from implementing key HIV/AIDS surveillance functions						

6.4 How would you describe the motivation of the key technical staff at your facility with regard to the tasks to be fulfilled under HIV/AIDS epidemiological survillance?

Directions: Use the scale below to indicate how much you agree or disagree with each statement. Indicate the number that best fits your answer in the cell specially allotted for an individual staff member across each statement. Remember, there are no correct or wrong answers to these questions. Write only what you think is correct.

1	2	3	4	5
Completely disagree	Disagree	Neither disagree nor agree	Agree	Completely agree

a) They are motivated to perform the assigned job / responsibilities						
b) They recognize the spesific benefit out of implementing an up-to-date information system						
c) They are afraid of introducing innovations in the facility operation						

Annex # 6. Guidelines for Focus Group Discussion

My name is XXXXX.

You are participating in the assessment carried out by "Curatio" International Foundation under the program for strengthening HIV/AIDS surveillance financed by the Global Fund. The goal of this assessment is to help improve the HIV/AIDS surveillance system in Georgia. Today during the next ?? minutes, I'd like to discuss with you what you think of the HIV/AIDS surveillance system, specifically what the skills and motivations of the professional staff involved in the system are and what improvements are needed in this area.

I remind you about the procedures of participating in focus group discussions and your right to participate voluntarily in this study. The information shared during this discussion is entirely confidential and mustn't be spread outside the group. Therefore, confidentiality of your opinions will be maintained if every participant observes this rule.

During the discussion you can refuse to answer any unwanted question you feel uncomfortable with or cease to participate in the study at any time. However, the information you provided before you ceased to participate will be used for the purposes of the study as it follows from the interactive nature of a group discussion.

The discussion will be recorded on the audiotape for the purposes of the study. To ensure confidentiality, a transcript will be made from the audio recording in the next 6 months and then the recording will be destroyed. Your name and other personal information will be removed from the transcript. The results of the study may be used for publications; however the information will be presented in such a way that names of participants will not be identifiable.

Is anyone against making the audio recording? (If anyone objects to recording, take the minutes by hand)

I have several specific questions that I'm going to ask in this discussion; First of all, I'd like us to talk about you. [then the moderator asks the participants to name their names, professions, and the place of residence].

Now I'd like to start with skills and knowledge of the professional staff involved in the HIV/AIDS surveillance system.

Knowledge and Skills

1. First of all, let's talk about to what extent your facility is involved in the HIV/AIDS surveillane. Namely, what are the functions you are responsifble for fulfilling in the existing HIV/AIDS surveillance system? We are also interested in the information about the (state or donor funded) programs under which these functions are carried out.

Ask specific questions to ensure that the respondents are talking about respective main functions of the program / their facility. During the discussion a clear answer should be obtained whether each of these functions exist, whether they are carried out, and under which program they are implemented. It's also important to find out whether the respondents understand the content of each of these functions (i.e.

a superficial answer, like "yes we do it" isn't sufficient; rather, you should ask what they do under this function and how)

While talking about each function, ask them how important they deem the fulfillment of these functions at the level of their facility considering the current HIV/AIDS epidemiological situation in the country.

Depending on the composition of focus groups ,the emphasis should be put on the following functions:

Function	1. District Lab / Blood Station	2. District / Regional PHC	3. PHF / Hospital / STI clinic / Women's Consultation	4. TB/ STI/ Narcology Program / Prison
Case Reporting	+	++	++	++
HIV testing / Serosurveillance	++	++	+	++
Subpopulation Surveys		++		++
Data Analysis		++		++
Information Dissemination		++		++
Information Use		++		++

2. Now, please, let's talk about the knowledge and skills of the professional staff at your facility / in your program to fulfill these functions of HIV/AIDS epidemiological surveillance. What flaws / problems are there and what is the reason for it?

Ask specific questions to ensure that the respondent talks about skills and knowledge that are essential to carry out each main function being a priority for them (table, question 1).

Case Reporting

- HIV/AIDS case standard definition
- format and procedures of case recording
- the notification form and procedures
- reporting form and procedures
- ethical and legal issues related to notification / reporting

HIV testing / Serosurveillance

- HIV/AIDS case standard definition
- the format and procedures of case recording
- the notification form and procedures
- the reporting form and procedures
- ethical and legal issues related to notification / reporting

Risk Beharior Subpopulation Surveys

- the knowledge of high-risk groups
- various study designs
- the methodology of respondents' selection
- study tools
- study-related ethical issues
- data management

Data Analysis

- the standard format of analysis
- computer databases
- statistical analysis using computer software
- graphical presentation of data

Information Dissemination

- information product design
- information dissemination channels

Information Use

- policy development
- program planning and implementation
- advocacy

Motivations

3. Now let's talk about how motivated the professional staff at your facility / in your program is. What is the primary sources of their motivation to better perform main functions of HIV/AIDS epidemiological surveillance?

Ask about the following factors:

official duties

realizing the importance of the problem of HIV/AIDS

patricipating in the modern information system

an opportunity to improve knowledge and skills

money / salary

Recommendations

4. Now, please, give your recommendations on what should be done to improve the knowledge and the skills of your professional staff and increase their motivation for better fulfillment of HIV/AIDS epidemiological surveillance functions.

Set out the recommendations in two groups:

Improving knowledge and skills

- training
- supportive supervision (on-the-job training and technical assistance)
- providing guidelines / methodical directions

Increasing Motivation

- professional motivation
- financial motivation
- assessment of the performed work

Thank you for providing useful information!

Annex # 7. HIV/AIDS Notification Forms in Use (Indicating Variables)

Laboratory testing referral form #4: (developed by the AIDS center, is not approved by a normative act).

- is a referral form (variables: last name, first name, father's name, date of birth, gender, nationality, citizenship, place of residense, region, city, facility code, facility name, program name, name of the facility receiving blood, place of employment (study), group code (as in the form #23), screening test (date, result, test-system, series #), the address of the facility sending the blood sample (postal code, phone), last name, first name, position and signature of the person who sends the blood sample)

Non-standad referral forms:

Different types of facilities (Infectious Disease Hospital, Sepsis Center, Burn Centre, TB National Center, the penitentiary system and so on) send non-standard referral forms having different structures to the AIDS Reference Laboratory. E.g.: a referral form of the Burn Center contains the following variables: first name, last name, gender, date of birth, address, date of taking the blood sample, HIV test result, whereas a referral form received from the Infectious Disease Hospital contains the following data: an individual's first name and last name, medical history #, the name of the department, a physician's signature, the result.

HIV/AIDS Notification Form 58/4:

In case of HIV/AIDS detection, the confirming facility is obligated to report the test result in the form of a special notification in 72 hours past the final confirmaiton to the public health authority operating in the area where the individual actually resides. The information is confidential. The form is to be filledin with the following data:

The place where a notification is sent (a district, a facility);

The person who sends the notification (last name, first name), his or her signature, contact address, phone, fax, e-mail;

The registration number in 60/A;

Patient data: gender (female, male, unknown), age-group: 0-1, 1-14, 5-14, 15-19, 20-29, 30-59, 60+, unknown;

The diagnosis, the date when the diagnosis was made: day, month, year;

The form is filledin for each confirmed case and sent by any available means: post office, courier, e-mail, phone, fax, and so on according to the general rule of sending an urgent notification. The personnel of the receiver PHC records the case and uses the information for a situational analysis. They don't have the right to require additional information about the HIV/AIDS patient. A regional / district PHC performs epidemiological investigations of HIV/AIDS cases commissioned (through special assignments) only under the state program pursuant to the legislation in force.

Annex # 8. HIV/AIDS Reporting Forms in Use (Indicating Variables)

Form #23 (Yearly)

Sectoral statistical reporting, "Report on Blood HIV/AIDS IFA Testing Results" (approved by the Order # 58/o of the Minister of Labour, Health and Social Affairs of Georgia as of 14.02.1996). The report contains the following data:

a) "HIV tested contingent" (name, code), "the total number of HIV-tested individuals" (by gender), "among them seropositive on IFA". The form #23 is also annexed by two non-standard sub-reports: a) "a Report on HIV-infected and AIDS Patients Registered during a Calendar Year" (newly registered cases ("total", "AIDS", "HIV", "dead") by gender and mode of transmission) and b) "a Report on HIV-infected and AIDS patients" (overall statistics of cases by the end of a given year ("total", "AIDS", "HIV") by gender and mode of transmission).

Form IV-02 (monthly)

Agency-level statistical observation (approved by the Order # 101/n of the Minister of Labour, Health and Social Affairs of Georgia as of 05.04.2005): the total number of HIV tested pregnant women is indicated in the paragraph 7, chapter 2 "Antenatal Care".

The form for accounting consumption of medical goods for HIV and Hepatitis B testing" (testing of pregrnant women)

The form contains the following data along with the information on consumption: the number of pregnant women who have undergone HIV testing using a rapid / simple HIV test-system, including the number of positive cases.

From IV-14, (Yearly), Agency-Level Statistical Observation

This form is agreed with the State Statistics Department – a lower organization of the Ministry of Economic Development of Georgia – by the letter #3/1-03/02 as of 02.02.2005.

The form IV-14 is approved by by the Order # 101/n of the Minister of Labour, Health and Social Affairs of Georgia as of 05.04.2005.

This form is intended for blood stations producing blood and blood transfusion departments to submit their reports. This form is to be reported by curative and preventive facilities in due time as defined by the order of the Ministry of Labour, Health and Social Affairs. The form contains the following information:

1. *Information about a reporting facility*: address, the form of ownership (state, private), organizational-legal form, main economic activity, phone number, and reporting period.
2. *The staff by the end of the reporting period* – physicians, nursing staff, paramedical personnel, other staff.
3. *Number of donors* – the total number of donors, including active (paid donors) and unpaid donors, relatives having donated blood, plasma donors, and immunity donors.
4. *Preparation of blood and processing of blood plasma* – quantitative data on the following blood products are given here: the amount of prepared fresh whole blood, the amount of prepared unpaid

fresh whole blood, the amount of plasma processed for blood products by laboratories, blood departments, and fractioning facilities.

5. *Use of donated blood* – provides data on consuming blood prepared at or received by a facility. Data on the amount of blood prepared at a facility, received from other facilities and given out to other healthcare facilities for transfusion is provided by type of blood product (banked blood, blood with no preservative added). Data on the amount of blood used for preparing blood components, blood preparations, and standard sera as well as for performing bacteriological control and lab testing is also provided along with the amount blood written off due to aging, clots, injury, or reasons for completely discarding blood. The last column is added to provide data on remaining volume of blood by product (banked blood, blood with no preservative added) at the end of the reporting period.

6. *Reasons for completely discarding blood* – this part of the reporting form gives the reasons the blood was regarded as unfit for use in the facility. These reasons are: syphilis, Australian Antigen (HBsAg); Anti Hepatitis C antibodies (anti-HC); **Human Immunodeficiency Virus (HIV 1,2);** bacterial contamination; bilirubin; other reasons

7. Use of blood formed elements and plasma raw mateirals:

7.1. Provides the data on raw materials (by type (formed elements; blood plasma, including anti-staphylococcal and anti-rhesus serum) remaining in the facility at the beginning of the reporting year, as well as the amount of blood product prepared by means of plasmacytopheresis, spontaneous sedimentation of red blood cells, centrifuging, and separating; the amount of blood received from other facilities for processing is also indicated.

7.2. Provides the data on raw materials (formed elements; blood plasma, including anti-staphylococcal and anti-rhesus serum) consumed in the facility, as well as the amount of blood supplied to another facility for processing. The amount of blood used in the form of a finished product, as well as blood written off due to aging is also provided along with the remaining volume of blood by the end of the reporting period.

8. Fulfilling the plan for producing and consuming blood components and preparations

Form IV-17, (Yearly), Agency-Level Statistical Observation

This form is agreed with the State Statistics Department – a lower organization of the Ministry of Economic Development of Georgia – by the letter #3/1-03/02 as of 02.02.2005.

The form IV-14 is approved by by the Order # 101/n of the Minister of Labour, Health and Social Affairs of Georgia as of 05.04.2005.

This form is intended for curative and preventive facilities to submit their reports on HIV-infected and AIDS-affected individuals. This form is to be reported by curative and preventive facilities in due time as defined by the order of the Ministry of Labour, Health and Social Affairs. The form contains the following information:

1. Information about a reporting facility: address, form of ownership (state, private), organizational-legal form, main economic activity, phone number, and reporting period.

2. Risk-groups are listed: recipients of blood preparations, drug addicts, number of sexually transmitted infections contracted through sexual intercourse, vertical trransmission, or unknown mode of transmission by gender; these data are further detailed as follows: recorded cases (including

the total number of HIV/AIDS cases, the number of HIV infected and the number of AIDS affected patients) at the beginning of the reporting year; newly registered cases (including the total number of HIV/AIDS cases, the number of HIV infected and the number of AIDS affected patients); the number of deceased patients; the number of recorded cases by the end of reporting year (including the total number of HIV/AIDS cases, the number of HIV infected and the number of AIDS affected patients).

Annex # 9. Quantitative Data (Tables)

Table 11: Case Recording

Type of Facility	*Case recording in the last 4 years ("yes")*	*The Total Number of Facilities*
Polyclinic	0	**5**
Hospital	3	**3**
STD Clinic	1	**3**
Women's Consultation	3	**3**
Blood Transfusion Station	3	**3**
District Laboratory	3	**5**
District Public Health Center	1	**3**
Regional Public Health Center	1	**3**
	15	**28**

Table 12: HIV testing

Type of Facility	*HIV testing is being performed ("yes")*	*The Total Number of Facilities*
Polyclinic	0	**5**
Hospital	3	**3**
STD Clinic	2	**3**
Women's Consultation	3	**3**
Blood Transfusion Station	3	**3**
District Laboratory	4	**5**
District Public Health Center	0	**3**
Regional Public Health Center	1	**3**
	16	**28**

Table 13: Written Directions for Taking, Storing, and Transporting Lab Samples

Type of Facility	*Are there written directions for taking, storing and transporting lab samples ("yes")*	*Total Number of Facilities*
Polyclinic	0	**5**
Hospital	0	**3**
STD Clinic	0	**3**
Women's Consultation	1	**3**
Blood Transfusion Station	1	**3**
District Laboratory	0	**5**
District Public Health Center	0	**3**
Regional Public Health Center	1	**3**
	3	**28**

Table 14: Sending Biological Material

Type of facility	*Is a biological material sent to another facility for testing? ("yes")*	*The Total Number of Facilities*
Polyclinic	0	5
Hospital	3	3
STD clinic	2	3
Women's Consultation	3	3
Blood Transfusion Station	3	3
District Laboratory	3	5
District Public Health Center	0	3
Regional Public Health Center	1	3
	15	28

Table 15: Reports from Local Facilities

Type of facility	*The last regular report submitted within the last 4 years ("yes")*	*The Total Number of Facilities*
Polyclinic [34]	0	5
Hospital[35]	0	3
STD Clinic [36]	0	3
Women's Consultation[37]	0	3
Blood Transfusion Station[38]	0	3
District Laboratory [39]	1	5
District Public Health Center[40]	0	3
Regional Public Health Center[41]	0	3
	1	28

Table 16: Listing of Facilities at the Central Level Institutions

Type of facility	*Is a biological material transferred to another facility for testing? ("yes")*	*The Total Number of Facilities*
Polyclinic	0	5
Hospital	3	3
STD Clinic	2	3
Women's Consultation	3	3
Blood Transfusion Station	3	3
District Laboratory	3	5
District Public Health Center	0	3

34 Form #IV–17
35 Form #IV–17, or Form #23
36 Form #IV–17, or Form #23
37 Form #IV–2, or Form #IV–17, or Form #23
38 Form #IV–14
39 Form # 23
40 Form #IV–17, or Form #23
41 Form #IV–17, or Form #23

Regional Public Health Center	1	**3**
	15	**28**

Table 17: Listing of Facilities at the level of Public Health Centers

Type of facility	*Is a biological material transferred to another facility for testing? ("yes")*	*Total Number of Facilities*
District Public Health Center	0	**3**
Regional Public Health Center	0	**3**
	0	**6**

Table 18: Computer Equipment

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	**0**
	Monitor	1	1	0	**0**
	Printer	1	1	0	**0**
	UPS	1	1	0	**0**
	Xerox	1	1	0	**0**
	Fax	0			
Achara (Batumi) Regional PHC	Computer system unit	1	1	0	**0**
	Monitor	1	1	0	**0**
	Printer	1	1	0	**0**
	UPS	1	1	0	**0**
	Xerox	1	0	1	**0**
	Fax	1	0	1	**0**
Vake-Saburtalo District PHC[42]	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Tbilisi Municipal PHC	Computer system unit	1	1	0	**0**
	Monitor	1	1	0	**0**
	Printer	1	1	1	**0**
	UPS	1	1	0	**0**
	Xerox	0			
	Fax	0			

[42] The rooms of the facility are not protected. Therefore, their computers are stored in the municipal health service.

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Kobuleti District PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	0	0	1
	UPS	1	1	0	0
	Xerox	0			
	Fax	0			
Khobi District PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	0			
	Xerox	0			
	Fax	0			
Tbilisi Blood Transfusion Station	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
AIDS Laboratory of Batumi Blood Transfusion Station	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	0			
	Fax	1	1	0	0
Zugdidi Blood Transfusion Department	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	0			
	Fax	0			

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Zugdidi Reference Laboratory	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	0			
	Fax	0			
Tbilisi Laboratory "Testi"	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	0			
	Fax	1	1	0	0
AIDS Center Laboratory of Batumi Infectious Disease Hospital	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	1	0	0	1
Laboratory of Kobuleti Hospital	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
AIDS Laboratory and Blood Transfusion Room of Senaki District Hospital	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Zugdidi Ambulatory-Polyclinical Amalgamation	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Khobi District Polyclinic	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Batumi # 2 Polyclinic	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Kobuleti District Polyclinic	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
JSC Tbilisi #26 Polyclinic	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Women's Consultation of Acad. K. Chachava Perinatal Medicine and Obstetrics and Gyneacology Research Institute	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Zugdidi Women's Consultation	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	0			
	Xerox	0			
	Fax	0			
Women's Consultation of Batumi Maternity House	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Tbilisi Skin and Venereal Diseases Research Institute	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Batumi STD Clinic	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Zugdidi STD Clinic	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Acad., O. Gudushauri National Medical Center	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Zugdidi Multifield Hospital “Respublika”	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
Batumi Republican Hospital	Computer system unit	0			
	Monitor	0			
	Printer	0			
	UPS	0			
	Xerox	0			
	Fax	0			
The NCDCPH	Computer system unit	4	4	0	0
	Monitor	4	4	0	0
	Printer	3	3	0	0
	UPS	4	4	0	0
	Xerox	2	2	0	0
	Fax	1	1	0	0

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Republican Center of Blood Preparations	Computer system unit	2	2	0	0
	Monitor	2	2	0	0
	Printer	2	2	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
AIDS Center	Computer system unit	5	5	0	0
	Monitor	5	5	0	0
	Printer	3	3	0	0
	UPS	5	5	0	0
	Xerox	1	1	0	0
	Fax	1	1	0	0
Skin and Venereal Diseases Research Institute	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	0			
	Xerox	0			
	Fax	0			
Narcology Resesarch Institute	Computer system unit	2	2	0	0
	Monitor	2	2	0	0
	Printer	2	2	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Reference Laboratory of the AIDS Center	Computer system unit	3	3	0	0
	Monitor	3	3	0	0
	Printer	3	3	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			

Facility	Name of equipment	Quantity	Out of which:		
			1. In a good working order	2. Not working, fixing is possible	3. Not working, fixing is not possible
Samegrelo (Zugdidi) Regional PHC	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	0			
Tuberculosis National Program	Computer system unit	1	1	0	0
	Monitor	1	1	0	0
	Printer	1	1	0	0
	UPS	1	1	0	0
	Xerox	1	1	0	0
	Fax	1	1	0	0

Table 19: Human Resources Involved in HIV/AIDS Surveillance by Facilities

Name of Facility	Staff member	The Total Number	Gender		Type of Employment		Age Group			Length of Service at a Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
Samegrelo (Zugdidi) Regional PHC	Director	1		1	1			1			1
	Deputy Director	1	1		1			1			1
	Epidemiologist	1	1		1		1				1
Achara (Batumi) Regional PHC	Director	1	1		1			1		1	
	Deputy Director	1	1		1			1		1	
	Epidemiologist	1	1		1		1				1
Vake-Saburtalo District PHC	Chief Specialist	1	1		1			1			1
Tbilisi Municipal PHC	Head of the Program Implementation Team	1	1		1			1			1
	Chief Specialist	1	1		1		1				1
	Laboratory Manager	1	1		1			1			1
Kobuleti District PHC	Department Manager	1		1	1			1			1
	Epidemiologist	1	1		1		1				1
Khobi District PHC	Director	1	1		1			1			1
	Epidemiologist	2	2		2			2			2

Name of Facility	Staff member	The Total Number	Gender		Type of Employment		Age Group			Length of Service at a Given Position	
			Female	Male	Full-time	Part-time	< 45	45 -65	> 65	< 5	> 10
Samegrelo (Zugdidi) Regional PHC	Director	1		1	1			1			1
	Deputy Director	1	1		1			1			1
	Epidemiologist	1	1		1		1				1
Tbilisi Blood Transfusion Station	Department Manager	1	1		1			1		1	
	Physician Laboratorian	1	1		1			1			1
	Laboratorian	1	1		1			1			1
AIDS Laboratory of Batumi Blood Transfusion Station	Director	1		1	1			1			1
	Physician Laboratorian	2	2		2			2			2
Zugdidi Blood Transfusion Department	Director	1		1	1			1			1
	Physician Laboratorian	2	2		2		1	1			1
	Transfusiologist	1	1		1		1				1
	Nurse-Laboratorian	5	5		5		2	3			5
Zugdidi Reference Laboratory	Laboratory Manager	1	1		1		1				1
	Nurse-Laboratorian	1	1		1		1				1
	Nurse-registrar	1	1		1		1				1
Tbilisi Laboratory “Testi”	Head of Laboratory	1	1		1			1			1
	Physician-Laboratorian	1	1		1			1			1
	Laboratorian	1	1		1		1				1
AIDS Center Laboratory of Batumi Infectious Disease Hospital	Physician	2	1	1	2			2			2
	Phisician-Laboratorian	1	1		1			1			1
	Senior Nurse	1	1		1			1			1
Laboratory of Kobuleti Hospital	Phisician-Laboratorian	4	4		4		3	1		1	3
	Laboratorian	5	5		5		5			2	3
AIDS Laboratory and Blood Transfusion Room of Senaki District Hospital	Phisician-Laboratorian	1	1		1		1				1
	Laboratorian	1	1		1			1			1
Zugdidi Ambulatory-Polyclinical Amalgamation	Staff is not involved in epidemiological surveillance										
Khobi District Polyclinic	Staff is not involved in epidemiological surveillance										

Name of Facility	Staff member	The Total Number	Gender		Type of Employment		Age Group			Length of Service at a Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
Samegrelo (Zugdidi) Regional PHC	Director	1		1	1			1			1
	Deputy Director	1	1		1			1			1
	Epidemiologist	1	1		1		1				1
Batumi # 2 Polyclinic	Staff is not involved in epidemiological surveillance										
Kobuleti District Polyclinic (Family Medicine Center)	Staff is not involved in epidemiological surveillance										
JSC Tbilisi #26 Polyclinic	Staff is not involved in epidemiological surveillance										
Women's Consultation of Acad. K. Chachava Perinatal Medicine and Obstetrics and Gyneacology Research Institute	General Director	1		1	1			1			1
	Deputy Director	2	2		2			2		1	1
	Epidemiologist	1	1		1		1				1
	Head of Curative-Diagnostic Center	1	1		1		1				1
	Head of Laboratory	1	1		1		1				1
	Physician-Laboratorian	3	3		3		1	2			3
Zugdidi Women's Consultation	Director	1	1		1			1			1
	Physician	12	12		12			12			12
	Laboratorian	1	1		1		1				1
Women's Consultation of Batumi Maternity House	Gynaecologist	16	16		16		4	11	1		16
	Physician-Laboratorian	3	3		3		3				3
	Epidemiologist	1	1		1		1				1
	Nurse	5	5		5		5				5
	Physician-Laboratorian (HIV)	2	2		2		2				2
Tbilisi Skin and Venereal Diseases Research Institute	Director	1		1	1			1			1
	Deputy Director	1		1	1			1			1
	Physician	2	1	1	2		2				2
	Laboratory Manager	1	1		1			1			1
Batumi STD Clinic	STD and Skin specialist	5	2	3	5		2	3		2	3
	Gynaecologist	1	1		1		1			1	
	Nurse	4	4		4		1	2	1	1	3
Zugdidi STD Clinic	Director	1		1	1		1				1
	Physician	3	2	1	3		1	2			3
	Nurse	1	1		1			1			1

Name of Facility	Staff member	The Total Number	Gender		Type of Employment		Age Group			Length of Service at a Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
Samegrelo (Zugdidi) Regional PHC	Director	1		1	1			1			1
	Deputy Director	1	1		1			1			1
	Epidemiologist	1	1		1		1				1
Acad. O. Gudushauri National Medical Center	Head of Laboratory Department	1	1		1		1				1
	Epidemiologist	1	1		1			1			1
	Physician-Laboratorian	1	1		1			1			1
Zugdidi Multifield Hospital "Respublika"	Statistician	1	1		1		1				1
	Head of Gynaecological Department	1	1		1			1			1
	Epidemiologist	1	1		1			1			1
	Senior Nurce	1	1		1			1			1
	Physicians	21	12	9	21		6	13	2	5	16
Batumi Republican Hospital	Epidemiologist	1	1		1		1			1	
	Physician	30	5	25	30		5	25		5	25
	Laboratorian	2	2		2			2			2
NCDCPH	Director	1	1		1			1			1
	Technologist	1	1		1			1			1
	Analyst	2	2		2			2			2
	Epidemiologist	2	2		2		2			2	
	Physician	1	1		1		1			1	
Republican Center of Blood Preparations	Laboratory Manager	1	1		1		1				1
	Senior Laboratorian	1	1		1			1			1
	Physician-Laboratorian	1	1		1			1			1
AIDS Center	Director	1		1	1			1			1
	Epidemiologist	6	3	3	6		6			3	3
	Physician	8	8		6	2	7	1		4	4
Skin and Venereal Diseases Research Institute	Director	1		1	1			1			1
	Laboratory Manager	1	1		1			1			1
	Physician-Laboratorian	1	1		1			1			1
Narcology Resesarch Institute	Coordinator	1	1		1		1				1
	Chief Adviser	1	1		1		1			1	
	Adviser	2	1	1	2		2			1	1
	Laboratorian	1	1		1		1				1
	Nurse	1	1		1		1			1	
	Social Worker	2	2		2		1	1		2	
	Peer Educator	6	4	2	6		6			6	

Name of Facility	Staff member	The Total Number	Gender		Type of Employment		Age Group			Length of Service at a Given Position	
			Female	Male	Full-time	Part-time	< 45	45-65	> 65	< 5	> 10
Samegrelo (Zugdidi) Regional PHC	Director	1		1	1			1			1
	Deputy Director	1	1		1			1			1
	Epidemiologist	1	1		1		1				1
Reference Laboratory of the AIDS Center	Physician	3	3		2	1		3			3
	Laboratorian	1	1		1		1				1
	Registrar	1	1		1		1				1
Tuberculosis National Program	Executive Director	1		1	1		1				1
	Deputy Director	1	1		1			1			1
	Epidemiologist	3	2	1	3		1	2		1	2
	GF Project Coordinator	**1**		**1**	**1**			**1**			1

Table 20: Evaluating the knowledge of the personnel by heads of facilities (1=completely disagree, 5= completely agree)

	Facility Level	N	Average Score	Standard Deviation	P (ANOVA)
Have basic computer skills and knowledge (turning on and shutting down a computer, composing simple documents in a text editing software, printing a document)	Local	28	3,21	1,42	0,012
	Central	7	4,71	0,76	
Have basic skills and knowledge for using electronic communication facilities (can use email, work in the internet)	Local	28	2,71	1,46	0,005
	Central	7	4,43	0,79	
Have good computer skills and knowledge in terms of electronic processing / analyzing data (setting up a database (Excel), performing statistical analysis – e.g. calculating averages, making graphical presentations)	Local	28	2,11	1,17	0,013
	Central	7	3,43	1,27	

Table 21: Assessment of employee turnover by facility heads (1=completely disagree 5=completely agree)

	Facility Level	N	Average Score	Standard Deviation	P (ANOVA)
Staff turnover is not a serious problem in our facility	Local	28	4,57	0,57	0,54
	Central	7	4,71	0,49	
It is extremely difficult to retain qualified specialists at their workplaces for a long period of time	Local	28	1,96	0,96	0,31
	Central	7	1,57	0,53	

Staff turnover prevents us from implementing key HIV/AIDS surveillance functions	Local	28	1,75	0,52	0,15
	Central	7	1,43	0,53	

Table 22: Assessment of staff motivation by facility heads (1=completely disagree 5= completely agree)

	Facility Level	N	Average Score	Standard Deviation	P (ANOVA)
They are motivated to perform assigned job / responsibilities	Local	28	3,25	1,29	0,65
	Central	7	3,00	1,29	
They recognize the spesific benefit out of implementing an up-to-date information system	Local	28	4,46	0,64	0,71
	Central	7	4,57	0,79	
They are afraid of introducing innovations in the facility operation	Local	28	1,64	0,73	0,53
	Central	7	1,86	1,07	

Table 23: Training of the personnel

Type of facility	*Is a biological material transferred to another facility for testing? ("yes")*	*The Total Number of Facilities*
Polyclinic	0	**5**
Hospital	0	**3**
STD clinic	0	**3**
Women's Consultation	0	**3**
Blood Transfusion Station	0	**3**
District Laboratory	2	**5**
District Public Health Center	1	**3**
Regional Public Health Center	0	**3**
	3	**28**

Annex # 10. References

1) UNAIDS, Monitoring the Declaration of Commitment on HIV/AIDS; Guidelines on Construction of Core Indicators, March, 2007

2) UNAIDS/WHO; Guidelines for Second Generation HIV Surveillance; 2000

3) UNAIDS/CDC/WHO, Guidelines for Conducting HIV Sentinel Serosurveys among Pregnant Women and Other Groups; 2003

4) WHO Regional Office for Europe; Methods for Second Generation HIV Surveillance Implementation For Countries of Central and Eastern Europe (CEE) and The Baltic States

5) CDC definition of public health surveillance, 1988

6) WHO Recommended Surveillance Standards WHO/CDC/CSR/ISR/99.2

7) USAID "Assessment of HIV/AIDS surveillance in the Europe and Eurasia region", January 2005

8) 2006-2010 National Strategic plan to fight HIV/AIDS

9) National Program for Economic Development and Poverty Reduction, 2003

10) National Health Policy Document (2000-2009), 1999

11) Strategic Plan for Health Sector Development in Georgia (2000-2009), 1999

12) Main Directions of the State Policy in Health Care Sector in Georgia, 2007

13) National Strategic Plan to Fight Tuberculosis and HIV Infection (2007-2011), 2007

14) 2008 State Program for Ensuring Epidemiological Security, 2008

15) State Program for Disease Prevention, 2008

16) State Program for Early Detection and Treatment of HIV/AIDS cases

17) Obstetrics State Program, 2008

18) Millennium Development Goals in Georgia, Tbilisi 2004

19) The Declaration of Commitment from UN General Assembly Special Sessions on HIV/AIDS; 2001

20) Monitoring and Declaration of Commitment on HIV/AIDS. Georgia Country report, reporting period January 1 – December 33, 2006. http://www.globalfund.ge

21) The Regional program of urgent response to the HIV/AIDS Epidemic Commonwealth of Independent States, May 2002;

22) The Dublin declaration adopted at the Ministerial Conference "breaking the barriers - partnership to fight HIV/AIDS in Europe & Central Asia", November 2004;

23) "Three Ones" key principles. "Coordination of National Responses to HIV/AIDS" Guiding principles for national authorities and their partners. Washington Consultation, UNAIDS, 25 April, 2004;

24) Law of Georgia "On the Prevention of HIV Infection" (N683, March 21, 1995)

25) Law of Georgia "On Health Care" (N 1139, December 10, 1997)

26) Law of Georgia "On Public Health" (N 5069, June 27, 2007)

27) Law of Georgia "On Donation of Blood and Its Components" (N 687, March 21, 1995)

28) Order of the Minister of Labour, Health and Social Affairs of Georgia (N 241/n, December 5, 2000) "On defining the contraindications for donating blood and its components"

29) Order of the Minister of Labour, Health and Social Affairs of Georgia (N 299/n August 16, 2001) "About adoption of the sanitary-hygienic and epidemiological requirements for industrial transfusiology facilities".

30) Penal Code of Georgia (N 2287, July 22, 1999)

31) Code of Administrative Infringements of Georgia (December 15, 1984)

32) Law of Georgia "On Statistics" (N 1071, November 12, 1997)

33) Order of the Minister of Labour, Health and Social Affairs of Georgia (# 101/n, April 5, 2005) "On the rule of producing and submitting medical statistical information"

34) Order of the Minister of Labour, Health and Social Affairs of Georgia (N 40/n, February 7, 2007) "On approval of 2007 State Health Programs"

35) Edict of the President of Georgia (N 587, October 8, 1998) "On strengthening the measures to fight and prevent AIDS"

36) Charter of the legal entity of public law – L. Sakvarelidze National Center for Disease Control and Public Health (Order N 107 /n, March 28, 2007)

37) Order of the Minister of Labour, Health and Social Affairs of Georgia (N 144/o May 1, 2007) "On establishing the state integrated coordinating council for Global Fund project to fight AIDS, Tuberculosis, and Malaria in Georgia and other programs targeting AIDS and Tuberculosis in the country"

38) Strategic plan for the development of health information system in Georgia, Curatio International Foundation, 2008