



Health and sustainable development: progress in Georgia





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Abstract

Since the late 1990s, Georgia's health-care system has undergone several rounds of fundamental reforms and population health status has improved, narrowing the gap between Georgian and regional averages for many indicators. This report assessed health and well-being in Georgia and provides policy recommendations to accelerate the achievement of the Sustainable Development Goal (SDGs) in Georgia. In addition to aligning policies with United Nations conventions and the SDGs, Georgia is gradually harmonizing legislation with the European Union acquis. Although significant achievements were identified with regard to implementation of the SDGs, challenges and bottlenecks remain that will need further responses and sustained government commitment. Leaving no one behind is a core principle of the United Nations 2030 Agenda for Sustainable Development and, therefore, equity in the Georgian health sector needs to be assessed and analysed in terms of equity of utilization, access and distribution according to need, negating regional and socioeconomic disparities. The results should be integrated within policy planning.

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Abbreviations

2030 Agenda	United Nations 2030 Agenda for Sustainable Development
ART	antiretroviral therapy
CIS	Commonwealth of Independent States
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
GDP	gross domestic product
GEOSTAT	National Statistics Office of Georgia
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
IHR	International Health Regulations
MAPS	mainstreaming, acceleration and policy support [exercise]
MDR-TB	multidrug-resistant tuberculosis
MoLHSA	Ministry of Internally Displaced Persons from Occupied Territories, Labour, Health and Social Affairs
MSM	men who have sex with men
NCD	noncommunicable disease
NCDC	National Centre for Disease Control and Public Health
NEAP	National Environmental Action Programme
NGO	nongovernmental organization
OOP	out of pocket
PHC	primary health care
PLHIV	people living with HIV
PWID	people who inject drugs
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
STEPS	STEPwise approach to surveillance
TB	tuberculosis
UHC	universal health coverage
UHCP	Universal Health Care Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
XDR-TB	extensively drug-resistant tuberculosis



Executive summary

In 2015, Georgia, together with all 193 Member States of the United Nations, adopted and committed to the implementation of the 2030 Agenda for Sustainable Development (2030 Agenda) and its Sustainable Development Goals (SDGs). The SDGs have since become an integral part of institutional and legal reforms carried out by the Government of Georgia. Georgia has undertaken measures to adapt the 2030 Agenda to national circumstances, defining 95 national targets for the 17 global goals. The SDGs and their targets are integrated into the Government of Georgia's annual action plan, and an SDG framework has been developed to integrate the 2030 Agenda across Government strategies and policies.

This report was prepared as background information for a mainstreaming, acceleration and policy support (MAPS) exercise carried out in May 2019. It describes an assessment of strategic national documents to evaluate how health and well-being for all were integrated into and addressed by national policies and an analysis of the implementation of the health-related SDGs in Georgia. Based on the findings, the report makes policy recommendations for future work to accelerate the achievement of the SDGs and improve health and well-being in Georgia. The assessment included a literature review and desk analysis of key national regulations, a quantitative analysis of monitoring indicators for implementation of the 2030 Agenda and Health 2020, the European policy for health and well-being, and consultations and interviews with government representatives, United Nations partners and civil society organizations.

The overview found significant achievements within the health-care sector with regard to SDG implementation but also identified challenges and bottlenecks that need further response mechanisms and sustained commitment by the Government.

The Government of Georgia has made considerable efforts to developing strategies and action plans in the health sector, yet mechanisms for intersectoral implementation, monitoring and evaluation are limited. It is essential to sustain and enhance the implementation of the existing strategies, action plans and programmes; to create an effective monitoring and evaluation process; and to ensure intersectoral coordination.

A successful sustainable development agenda requires meaningful engagement of different sectors of society as critical stakeholders, acting in support of government-led efforts at all levels in accordance with national priorities, policies and mechanisms. Indeed, implementation of the health and well-being priorities will only be possible with the collaboration of sectors and partners beyond the public health sector, using an intersectoral approach to policy development and implementation.

Building foundations, strengthening institutions, supporting transformation and raising funds are all needed; last but not least, health must be integrated into local plans and activities.

Based on the SDGs, the Government of Georgia continues to work on strengthening the health-care system in order to provide quality health care for all citizens of Georgia. Going forward, it remains important to closely monitor the progress and the impact of these actions on the health and well-being of the population in the country.

1. Introduction

The aim of this report is to assess the status of health and well-being in Georgia and to use the assessment to support health and well-being policy recommendations to accelerate the achievement of the SDGs in Georgia. This is a background document prepared for the MAPS exercise in Georgia, which was carried out in May 2019 (1). MAPS exercises were adopted by the United Nations as a common approach to support to the implementation of the 2030 Agenda (2) at the country level.

Health in the 2030 Agenda

Three core documents define the role of health in sustainable development in the WHO European Region: the 2030 Agenda (2); Health 2020, the European policy for health and well-being (3); and the WHO Regional Office for Europe's roadmap to implement the 2030 Agenda, which was adopted in 2017 (4). The WHO roadmap aims to strengthen the capacities of Member States to achieve better, more equitable and sustainable health and well-being for all at all ages in the WHO European Region. It advocates high-level leadership for health and well-being and strong intersectoral mechanisms to address the many risk factors and determinants of health. It focuses on approaches involving the whole of government and the whole of society and the consideration of Health in All policies (4). The SDGs comprise 17 goals and 169 targets and were approved on 25 September 2015 under the United Nations General Assembly resolution 70/1 (2). The SDGs form a call upon all countries to strengthen their efforts for improving equity and quality of life for all people. The SDGs follow on from the Millennium Development Goals, which covered the period 2000–2015, and transformed these into a more comprehensive action plan targeting the elimination of poverty and creation of balanced economic growth worldwide. The 2030 Agenda has three core principles that are particularly relevant to country strategies and approaches to achieving health and well-being for all: interconnectedness and indivisibility, leaving no one behind and inclusiveness.

The core health SDG is **SDG 3**: to ensure healthy lives and well-being for all at all ages. This SDG enshrines the global commitment to foster healthy societies and protect the rights of everyone to enjoy the highest attainable standard of physical and mental health. SDG 3 has 13 targets that are intended to address major health priorities, including sexual and reproductive health (SRH); maternal and child health; communicable, noncommunicable and environmental diseases; universal health coverage (UHC); and access for all to safe, effective, quality and affordable medicines and vaccines. Health and well-being for all are also addressed directly and indirectly by many of the other SDGs and there are over 20 health-related targets across all the 17 SDGs. Pursuing other goals can directly and indirectly benefit human health and well-being, and implementation of the SDGs will contribute to the full achievement of human rights and fundamental freedoms for all, including the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The 2030 Agenda envisions a new dynamic between the SDGs in which good health and other goals are closely connected and interdependent. Progress towards one goal should contribute to the achievement of others. One way to apply this vision to health would be to expand the definition of the health system. Classically defined, health systems deliver essential health-care services and public health functions. A more comprehensive vision for health systems would



consider nontraditional systems that also produce good health, incorporating relationships with agriculture, education, energy, the environment and other sectors represented by the other 16 SDGs. WHO has produced a toolkit that supports such endeavours (5).

Support for the 2030 Agenda in Georgia

In September 2015, Georgia was one of the 193 Member States of the United Nations that adopted the 2030 Agenda (2) and declared a commitment to the implementation of the SDGs and their targets.

The SDGs have become an integral part of institutional and legal reforms in Georgia. The SDG Council, headed by the Head of the Administration of the Government of Georgia, was set up to coordinate nationalization of the SDGs and monitoring their implementation. The Government Administration Office for Government Plans and Innovations was defined as the Secretariat of the Council.

The process of nationalization of the SDGs was launched in 2015. Following long consultations and consideration of the challenges and the national context, priorities within the SDGs for Georgia were determined, and a number of targets were adjusted to fit the country context. Given the comprehensive nature of the 2030 Agenda, the baseline (2015 data) and the target (for 2030), values were set for indicators measuring the achievement of each sector-specific indicator along with the milestones distributed along the time line. Such an approach allows progress to be measured towards the achievement of the SDGs, which is extremely important for planning evidence-informed sector-specific policies.

Georgia has assumed responsibility to gradually harmonize Georgian legislation with the European Union (EU) acquis as well as to align its policies with United Nations conventions and SDGs.

To establish conjunction between the activities planned by the Government for the coming years and the SDGs, opportunities for harmonization of policies were determined. SDGs and targets are also integrated into the Georgian annual action plans. In the course of developing of a plan, basic directions and priorities of the Government are taken into consideration (6), based on the following national documents:

- EU–Georgia Association Agreement;
- the Public Administration Reform Roadmap;
- the National Strategy 2014–2020 for the Protection of Human Rights in Georgia and its accompanying action plan;
- the Social and Economic Development Strategy: Georgia 2020 (7); and
- the four point agenda of the Action Plan for 2016–2020: Freedom, Rapid Development and Welfare.

Among many other objectives, the EU–Georgia Association Agreement foresees modernization of the health sphere and step-by-step adjustment to EU standards with regard to health and well-being. With these objectives, Georgia will continue reforms in the health-care sector as well as improving the quality of health-care services.

Methodology and development of the report

This report was compiled from:

- a literature review;
- a desk analysis of key national regulations;
- a quantitative analysis of the monitoring indicators for implementation of the 2030 Agenda; and Health 2020; and
- consultations and interviews with high-level government representatives, United Nations partners and civil society organizations.

In preparation for the MAPS mission, strategic national documents were reviewed to evaluate how health and well-being for all were integrated into and addressed by the national policies. Annex 1 outlines the priorities set forward by the Georgian health-care strategies and their relevance to the SDGs. These are strategies addressing both health and non-health sectors.

The analysis of implementation of the health-related SDGs in Georgia reported here was used to derive the recommendations for future work.



2. Health in sustainable development in Georgia

Since the late 1990s, Georgia's health-care system has undergone fundamental reforms several times. Despite the controversial direction of these reforms, population health status has been improving and the gap between Georgian and regional averages has narrowed for many indicators. The main goals for these reforms were to ensure universal access to high-quality medical services, to improve primary health care (PHC) and to decrease the financial risks to the population posed by high out-of-pocket (OOP) expenditure on health (8).

Governance for health and well-being in Georgia

The Georgian health system has moved strongly away from the *Semashko* model inherited at independence. The system is now highly decentralized and was extensively privatized under reforms introduced from 2007 to 2012. These reforms were characterized by deregulation and trust in market mechanisms. In 2012, a change of government brought a significant change of direction in health policy. While the previous model had sought to harness market mechanisms for improving the efficiency of the health system, from 2013 onwards policy moved to the government-led UHC (9).

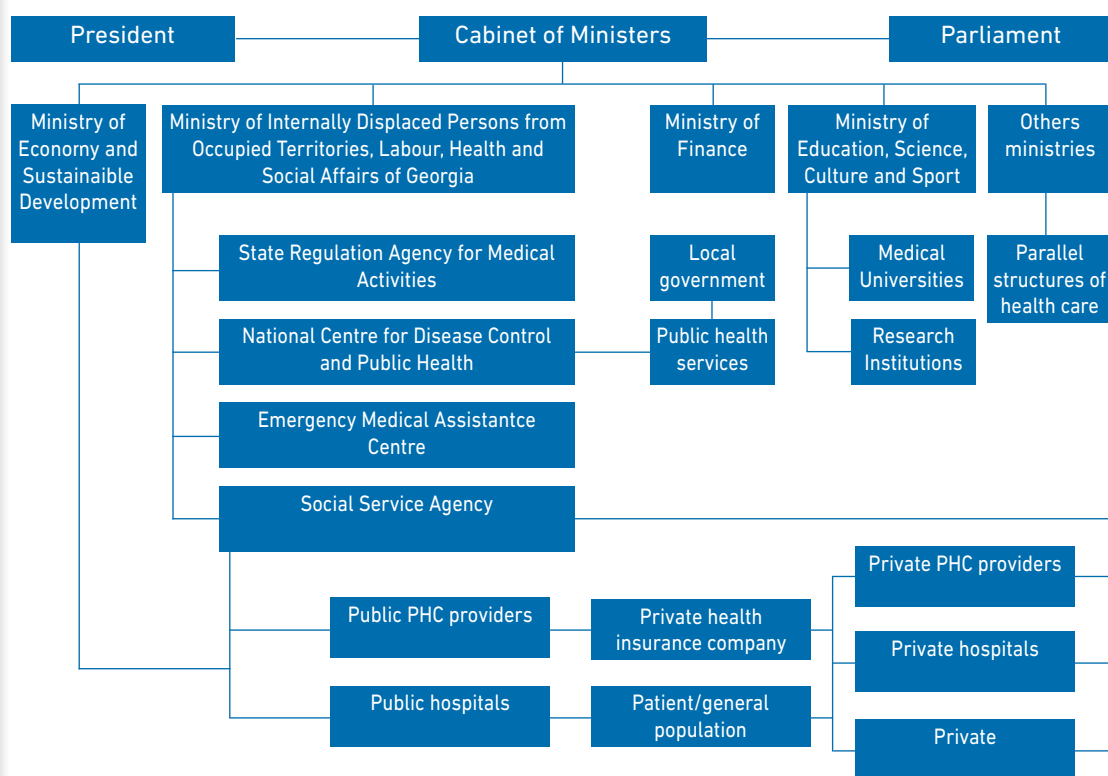
The Ministry of Internally Displaced Persons from Occupied Territories, Labour, Health and Social Affairs (MoLHSA) is responsible for developing and implementing the national health-care policy and strategy; drafting and enforcing health-care laws and regulations; setting up and overseeing the national public health programmes; advocating for adequate allocations from the State budget for health-care programmes; and regulating health-care professions, health facilities and the pharmaceutical market. With the shift to a parliamentary republic, the ultimate responsibility for setting national strategies/policies rests with the Parliament, while the implementation of these is the business of the ministries.

There are a number of legal entities of public law under the MoLHSA: the Social Service Agency, the National Centre for Disease Control and Public Health (NCDC), the State Regulation Agency for Medical Activities, and the Emergency Situations Coordination and Urgent Assistance Centre. The administration and management of the health and social care State programmes, including the Universal Health Care Programme (UHCP), are provided by the Social Service Agency, which has territorial offices in 68 municipalities and employs more than 2000 people (Fig. 1).

Public expenditure in the social sector in 2019 is relatively high. This reflects the Government's commitment to the well-being of all generations, society's attitude towards redistributing wealth to different vulnerable groups (e.g. pensioners, children, poor families or people with disabilities) and the degree to which society is willing to invest in future generations.

The social sector constitutes by far the biggest spending item within public expenditure, accounting for more than half of the total current public expenditure. Spending on health rose by 1.6% of gross domestic product (GDP) in 2012 and by 3% in 2015–2017 compared with that in 2014. The UHCP saw the largest increase within the sector, with an increase of 0.7% of GDP in 2015. A 12.5% increase in pension benefits contributed to 0.5% of GDP in 2016. Apart from the UHCP, growing expenditures for targeted social assistance, education, culture and religious affairs represented additional pressures on the State budget (10).

Fig. 1. The structure of the health-care system in Georgia



Source: provided by the MoLHSA.

Based on the current Government vision and policies, social spending (including the UHCP) is likely to remain high, and containing costs will be challenging without structural reforms in this area.

Governance for health and well-being is a central building block of good governance; it should be guided by a value framework that includes health as a human right, a global public good, a component of well-being and a matter of social justice. The extensive scope of the SDGs will require efforts to mobilize institutions around the SDGs, improve their function and promote horizontal coherence across ministries and vertical coherence across government levels. Such an approach helps to breakdown organizational silos, remove contradictions and dysfunctions in existing structures, and promote holistic and innovative thinking. In other words, these initiatives facilitate the implementation of whole-of-government and whole-of society approaches.

Public health leadership as well as clear communication between actors, key stakeholders and the general public helps to galvanize support for SDG implementation and to ensure that joint implementation efforts are efficient and effective.



Health in work across sectors

Personal, social, economic and environmental factors influencing health status are known as the determinants of health. They reach beyond the boundaries of traditional health-care and public health sectors. Sectors such as education, housing, transportation, agriculture and environment are important allies in improving population health. The health determinants approach requires governments to align different sectors and types of organization in the pursuit of health and development objectives. Integrated work among different sectors is the keystone of this process, where governments, civil society organizations, donors and private sector jointly contribute to improving the health status of the population. The government takes stewardship to ensure that all relevant stakeholders collaborate for strengthening the health system.

The Georgian Parliament has an exclusive role and it is the best platform for cross-sectoral discourses, reflections and policy formulation. The Healthcare and Social Issues Committee of the Parliament leads in several of the most important development fields in the country. The goal of the Committee is to support the process of resolving issues related to public health; social protection; employment and labour relations; protection of mothers and children; and the development and prosperity of the family, the elderly, veterans and people with disabilities. The Committee is also authorized to participate in the current process of reforming, reorganizing and restructuring the system of health-care and social protection (11).

There are several steering committees under the Prime Minister that have been established for various health sector initiatives in Georgia. There are also a number of joint decrees by the MoLHSA with other ministries, including the Ministry of Economy and Sustainable Development; the Ministry of Education, Science, Culture and Sport (referred to hereafter as the Ministry of Education); the Ministry of Environmental Protection and Agriculture; and the Ministry of Internal Affairs.

The effective functioning of the Country Coordination Mechanism for national health programmes in recent years, integrating various government and nongovernment stakeholders, can be acknowledged as a model of intersectoral collaboration in Georgia. Several strategies also have a specific impact on health.

The **Social and Economic Development Strategy** outlines steps to be implemented for improving the quality and accessibility of health care: refining public health-care spending systems, boosting the quality of health care, increasing the affordability of pharmaceutical products and strengthening PHC (7). The ultimate aim is to increase the population's life expectancy and improve overall health status.

The **Rural Development Strategy of Georgia 2017–2020** has an important role in the sustainable development of the country (12). Experience from European rural development programmes has confirmed the contribution of rural development to reducing economic imbalance between rural and urban areas. Rural areas have enormous potential for delivering innovative, inclusive and sustainable solutions for current and future societal challenges such as economic prosperity, food security, climate change, resource management and social inclusion.

The **National Road Safety Strategy and Action Plan of Georgia** adopted in 2016 by various State/local government institutions (Ministry of Education, Ministry of Internal Affairs, Ministry of Regional Development and Infrastructure, MoLHSA and Tbilisi City Hall) outlines shared responsibilities of parties, long-term objectives and approaches to the reduction of deaths and

injuries from road traffic crashes (13). Annual monitoring of road traffic incidents through routine statistical information collection by the Ministry of Internal Affairs and the MoLHSA is an example of successful collaboration between government agencies to achieve joint objectives.

The first **National Environmental Action Programme** (NEAP) was approved in 2000 to ensure protection and improvement of the state of the environment. The third programme (NEAP-3), developed in 2016, presents the Government's roadmap in the field of environment for 2017–2021 (14). NEAP-3 provides a complex set of solutions for current environmental problems in Georgia, determining short-term and long-term goals and planning the necessary actions to achieve them. The document implies the coordinated action of different State and non-State partners. One of the goals set out by NEAP-3 directly relates to health and well-being: to have clean air throughout Georgia that is safe for both human health and the environment. The National Environmental Health Action Plan 2018–2022 was approved by the Government of Georgia on 29 December, 2018 (15). Implementation of the commitments set out in this Action Plan have been initiated through the twinning mechanism supported by the EU (15).

There are several other multisectoral public health actions by the Government of Georgia focused on improving health status of the population. The new tobacco control legislation (2018) is one of the strongest tobacco control laws in the Region and has been a very good example of intersectoral collaboration (16).

For the surveillance, prevention and control of both communicable diseases and noncommunicable diseases (NCDs), the MoLHSA and the Ministry of Environmental Protection and Agriculture closely cooperate to ensure food safety and improve access to European markets for Georgian food products. The regulations for food labelling and packaging are also jointly revised. The MoLHSA has a leading role in coordinating the integrated disease surveillance and control system, along with the agriculture and environmental sectors, in accordance with the One World One Health concept (17).

The MoLHSA and the Ministry of Finance are actively cooperating in defining budgets for State health programmes and for medium-term expenditure planning.

The Ministry of Education and the MoLHSA work together to provide infrastructure and incentives for high-quality education for physicians and nurses, to promote a healthy lifestyle among adolescents and to support health-care sciences. In particular, the Ministries jointly carry out a number of activities, including the development of requirements for the accreditation of educational programmes, the definition and regulation of the number of physicians and nurses in the country and the integration of healthy lifestyle information into the school curriculum for adolescents. The investment in education is intended to support an improved health status for the population.

Monitoring and evaluation and role of the MoLHSA

Along with other duties and responsibilities, the MoLHSA periodically reviews health regulations for the practice and delivery of health services in the country and is responsible for the overall monitoring and evaluation of the performance of the health sector.

There are a number of health and global indicators that guide specific health programmes. The NCDC annually collects data for routine health indicators from health-care providers and issues a statistical yearbook. The health-care statistical yearbooks for Georgia have been prepared



annually since 1996 by the Department of Medical Statistics of the NCDC and contain the basic statistical data grouped according to different indicators of population health status and health-care resources. The data are grouped based on the WHO International statistical classification of diseases and related health problems, 10th revision (18), which thus ensures comparability of indicators across different countries. The yearbook describes data on diseases according to the WHO groupings (e.g. infectious and parasitic diseases, neoplasms, the circulatory system diseases, endocrine diseases, the respiratory system diseases, the genitourinary system diseases, mental and behavioural disorders) as well as on maternal and child health, health services and basic demographic groupings. The MoLHSA introduced and institutionalized annual national health accounts in Georgia in 2003. These accounts are based on WHO methodology and provide an important tool for evidence-informed decision-making. There are programme-specific indicators that evaluate health-care programmes, the quality of medical services provided in the framework of these programmes and overall programme effectiveness. Georgia also publishes an annual perinatal health report and a cancer report.

The MoLHSA, the NCDC and other government agencies (e.g. the National Statistics Office of Georgia (GEOSTAT)) conduct population-based surveys and independent studies as well as research that covers all priority health topics and takes into account other relevant data sources.

Currently, however, indicators are not included in the State health-care programmes in most cases. The State programmes contain an administration/inspection component, but this does not ensure their full evaluation. The financing component does not include an indicator that would support improvement of quality services. To ensure better functioning of the system, it is necessary and desirable that all State health-care programmes include a monitoring and evaluation framework and indicators.

Support for the main health targets in national policies

Georgia has undertaken measures to adapt the 2030 Agenda to national circumstances, defining 95 national targets for the 17 global SDGs (data available on request). SDGs and their targets are integrated into the Government of Georgia's Annual Action Plan, and an SDG Framework has been developed to integrate the 2030 Agenda across government strategies and policies.

3. Trends and status of the SDG health targets in Georgia

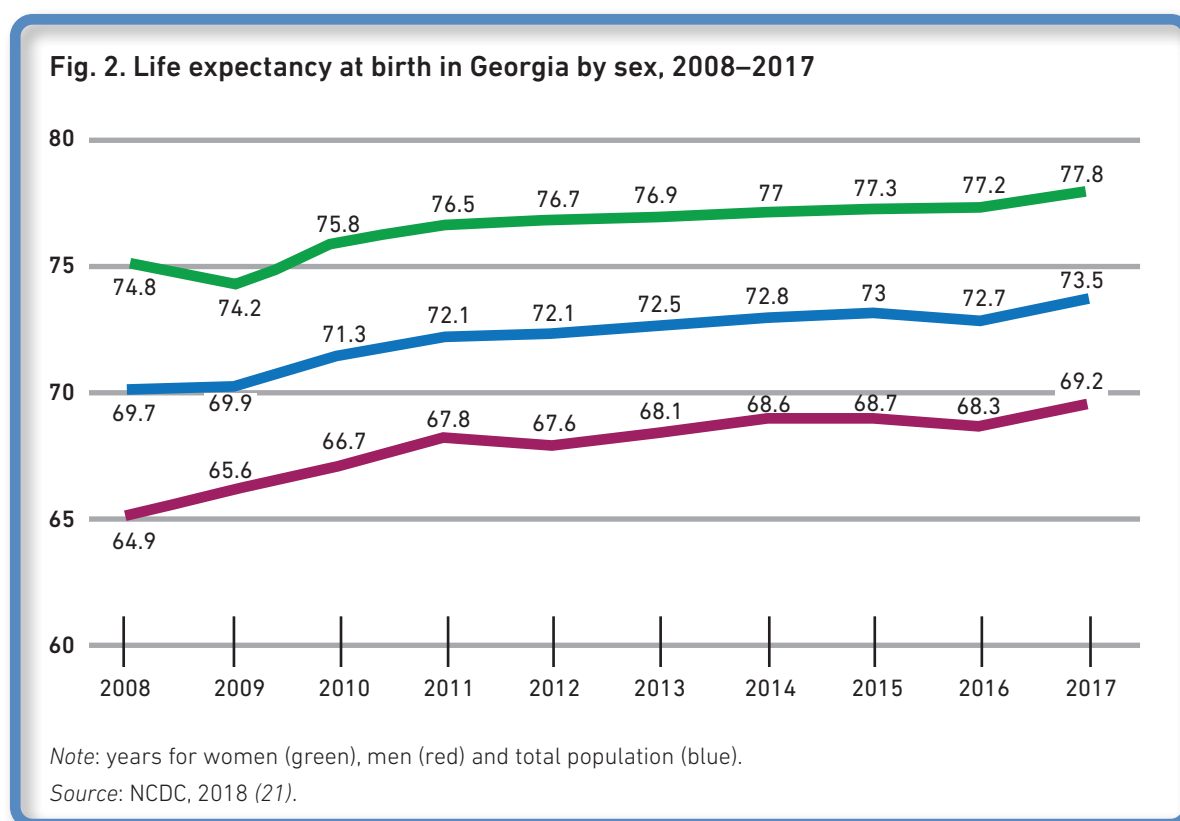
Overview of population health

Georgia belongs to the group of lower-middle-income countries. According to GEOSTAT, the GDP per capita was US\$ 4047 in 2017. In the same year, the relative poverty rate was at 21.9% against 60% of median consumption while the unemployment rate was 13.9% (19).

When interpreting the country's health trends in recent years, several key factors must be taken into consideration: the country's reform of health-care service delivery; the change in population size recorded in its 2014 census; and improvements in the quality of data in the health information system, including data on the utilization of services, epidemiological data and birth and death registration (20).

Georgia has made progress with regards to several public health priorities that are captured by specific indicators, such as maternal and infant mortality rates, incidence of tuberculosis (TB), and treatment of those with new or relapsed TB. The data capture and exchange methods have been upgraded to use up-to-date digital technology, which has improved case registration and coverage as well as the quality of information on the existing burden of disease in the country.

In Georgia, as in the rest of the world, population ageing has become one of the most significant demographic trends. Data from the NCDC indicate that life expectancy is still lower for men than for women (Fig. 2). This ageing has implications for social security systems, the structure of the work force, and health systems.



Despite public health interventions and improved access to health care, NCDs remain the major challenge for the health system. According to the WHO NCD country profile 2016, 94% of premature mortality in Georgia is attributable to NCDs (22). Georgia also faces challenges from the high levels of communicable diseases, with an increasing incidence of HIV and a high burden of multidrug-resistant TB (MDR-TB). Despite these issues, Georgia can still be considered to be making progress in many areas in the health sector. One of the key aspects is access to health services, which has been promoted through the UHCP.

Since 2013 the Government of Georgia has laid the foundation for public health and welfare-oriented health policy. The State budget allocations for the health sector has increased substantially in recent years: from GEL 450 million in 2012 to GEL 1092 million in 2017. According to 2017 data, the share of State expenditure on health care was 2.9% of GDP (the average for the WHO European Region was 5.7%) while the share of State expenditures on health care in the State budget was 10% (19). OOP payments constituted the highest share of private expenditure, with only 7% spent on direct insurance payments and the remainder spent on health-care services. The share of OOP payments in total health expenditure has significantly decreased from 73% in 2012 to 55% in 2017, mainly through reduction in the costs of hospitalization, which is a direct consequence of the UHCP (23).

The health system is still largely oriented towards curative care. Spending on inpatient care is still a high area of public health funding, representing 72% in 2017, with 25% allocated to outpatient care and 2% to community-based and rehabilitation services (9). The share of national expenditure on health care used for outpatient medications is critically high (38%) and mainly reflects OOP expenses. Hence, sustainable finance for government health programmes, reduction of OOP expenditure and delivery of high-quality health services remain at the top of the policy makers' agenda.

Georgian and the global SDG dashboard

The 2018 SDG Index and Dashboards report presents a revised and updated assessment of a countries progress towards achieving the SDGs and also ranks countries by an aggregate SDG Index of overall performance (24). Georgia in 2017 was ranked 47 among 156 countries (Figs 3 and 4).

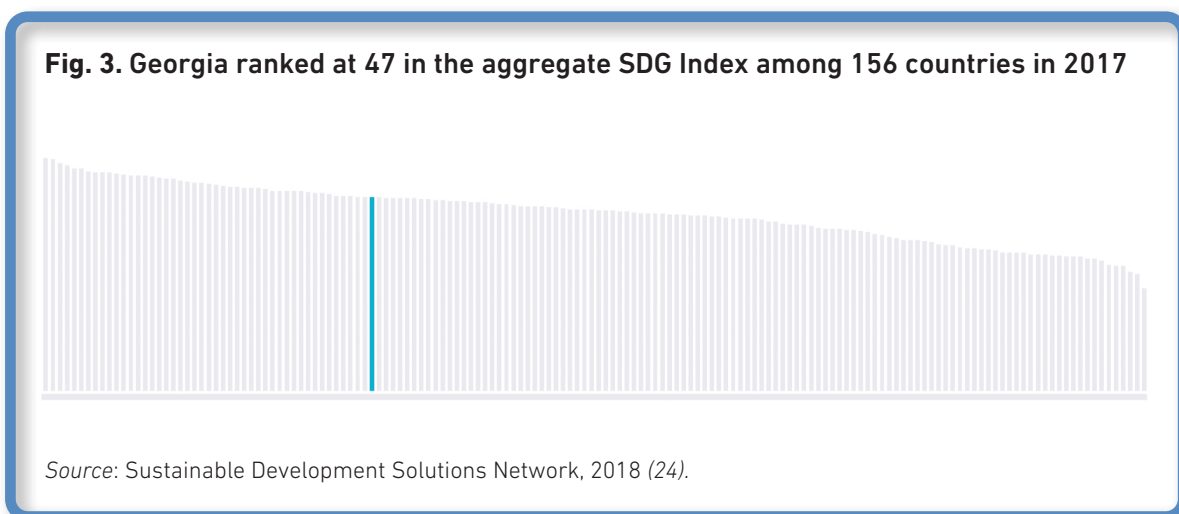
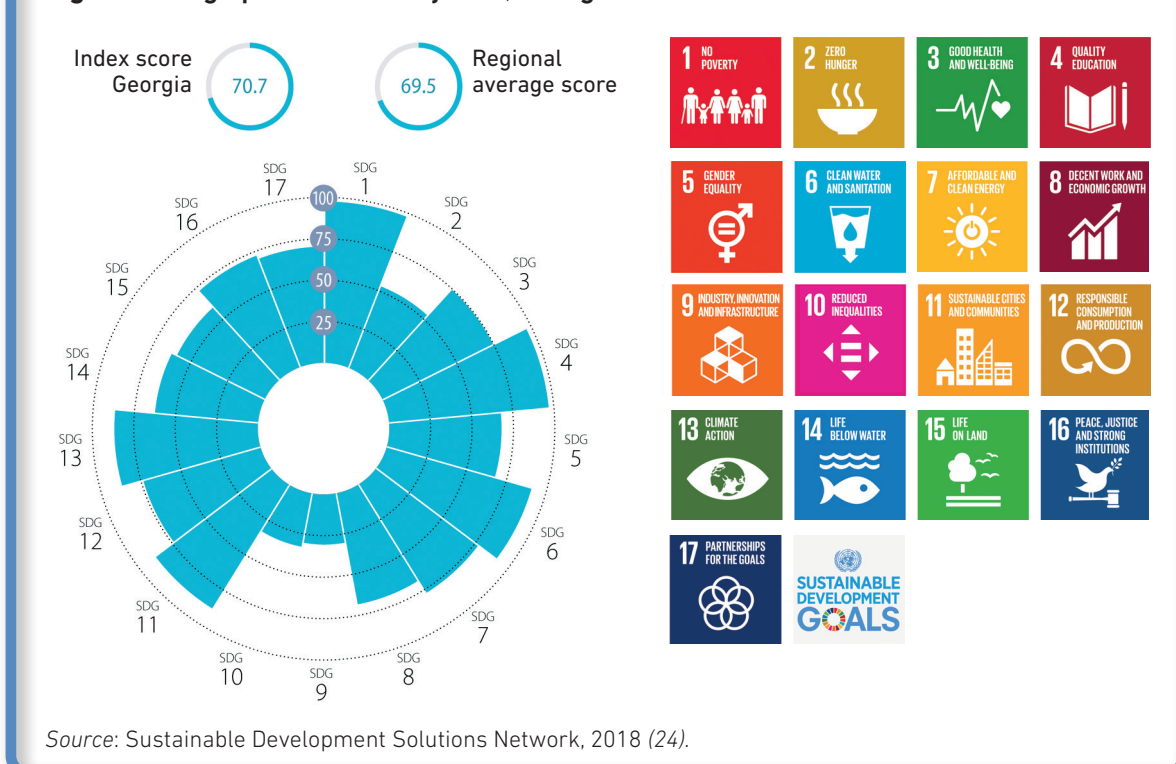


Fig. 4. Average performance by SDG, Georgia 2018



Source: Sustainable Development Solutions Network, 2018 (24).

Following the adoption of the 2030 Agenda in 2015, the Government of Georgia spearheaded measures to achieve the targets of the global SDG agenda through nationalizing SDG targets and indicators and setting up a national coordination mechanism within the Administration of the Government of Georgia. As a result, Georgia made sufficient progress to be among the first group of countries delivering a voluntary national review to the High-Level Political Forum on Sustainable Development (25) in 2016. A further report has been prepared in readiness for the 2020 conference.

The SDG Council was established at the Administration of the Government of Georgia in 2017. The Council was tasked with overseeing and monitoring progress in achieving the SDGs, guiding relevant government bodies, promoting mechanisms for the realization of the SDGs on local and national levels and collaborating with the private sector and civil society organizations. The SDG Council has brought together the Assistant to the Prime Minister on Human Rights and Gender Equality Issues and representatives from the Administration, the EU Delegation to Georgia, GEOSTAT, the Ministry of Agriculture and Natural Resources, the Ministry of Economy and Sustainable Development, the Ministry of Education, the Ministry of Finance, the Ministry of Foreign Affairs, the Ministry of Internal Affairs, the Ministry of Justice, the MoLHSA, United Nations bodies in Georgia and the United States Agency for International Development (USAID). In addition, representatives from State agencies, nongovernmental organizations (NGOs), international organizations and the private sector participate in the Council sessions.

The Council instituted four working groups to provide the technical guidance and expertise necessary to fulfil the mandate of the 2030 Agenda in Georgia. The working groups oversee the



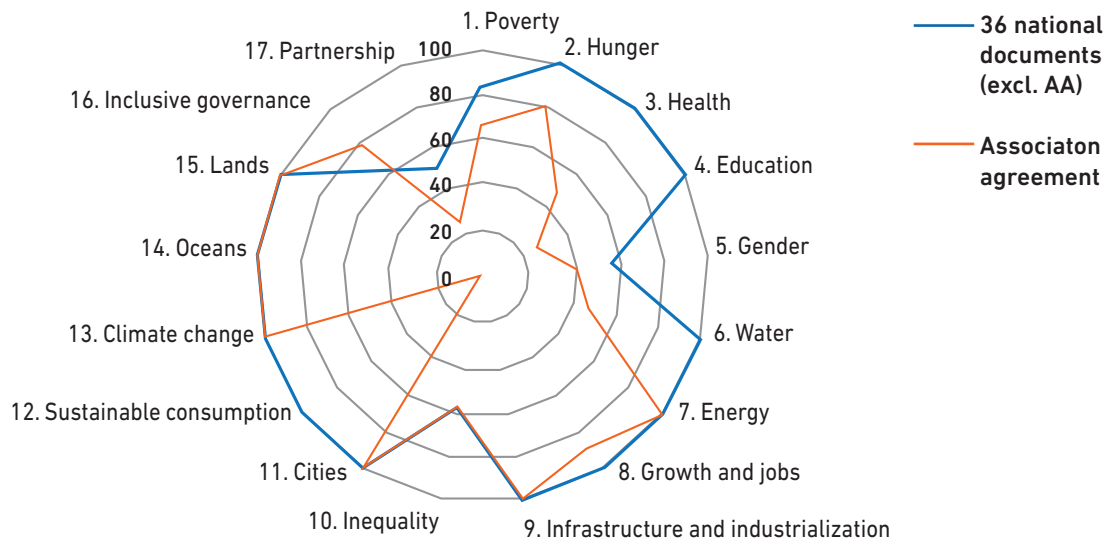
strategic planning, integrated implementation and effective monitoring of their assigned SDGs and related thematic fields (Table 1).

Table 1. Mandate of the SDG Council working groups

Working group	Area overseen
Social inclusion	SDG 1: no poverty SDG 2: zero hunger SDG 3: good health and well-being SDG 4: quality education SDG 6: clean water and sanitation SDG 8: economic growth
Economic development	SDG 1: no poverty SDG 8: decent work and economic growth SDG 9: industry, innovation, and infrastructure SDG 10: reduced inequalities SDG 17: partnerships for the goals
Democratic governance	SDG 5: gender equality SDG 10: reduced inequalities SDG 16: peace justice and strong institutions all gender-related targets
Sustainable energy and environmental protection	SDG 7: affordable and clean energy SDG 11: sustainable cities and communities SDG 12: responsible consumption and production SDG 13: climate action SDG 14: life below water SDG 15: life on land

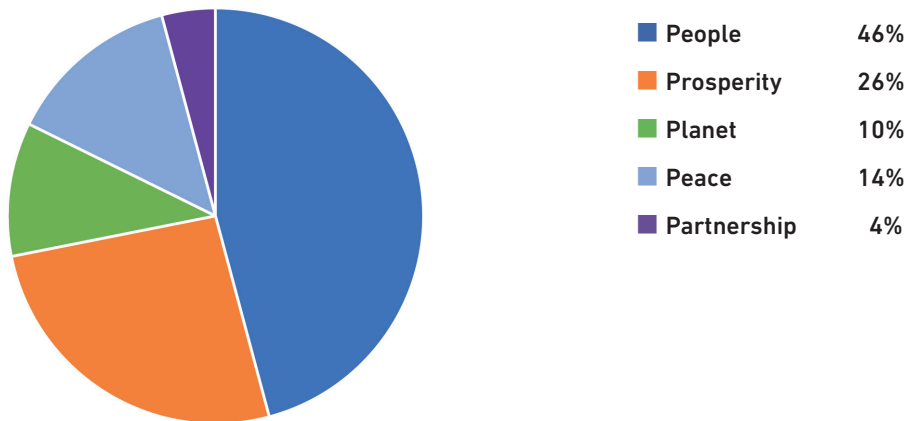
Currently, efforts are directed towards the full incorporation of the SDGs in national policy documents. This is an important milestone in transferring the SDGs into the daily agenda of public institutions (6). A rapid integration assessment conducted in March–April 2019 examined 37 strategic documents, programmes and action plans of national significance and 18 planning documents at subnational level to assess the extent to which current development efforts in Georgia aligned with the 2030 Agenda. The assessment concluded that the integration of national SDGs into development planning of Georgia is relatively effective: 93% based on the reviewed documents (Fig. 5). The rapid integration assessment considered SDG targets linked to the 5Ps of the 2030 Agenda: people, planet, prosperity, peace and partnership (2). Fig. 6 demonstrates that, overall, the Georgian agenda to respond to the 2030 Agenda 2030 is predominantly within the people section. The rapid integration assessment found that four ministries played the greatest role in integrating the implementation of up to 30 national targets across some 10 SDGs: the Ministry of Economy and Sustainable Development, the Ministry of Education, the Ministry of Environmental Protection and Agriculture and the MoLHSA.

Fig. 5. Alignment of key development planning documents of Georgia with national SDGs



Source: UNDP Georgia, 2019 (1).

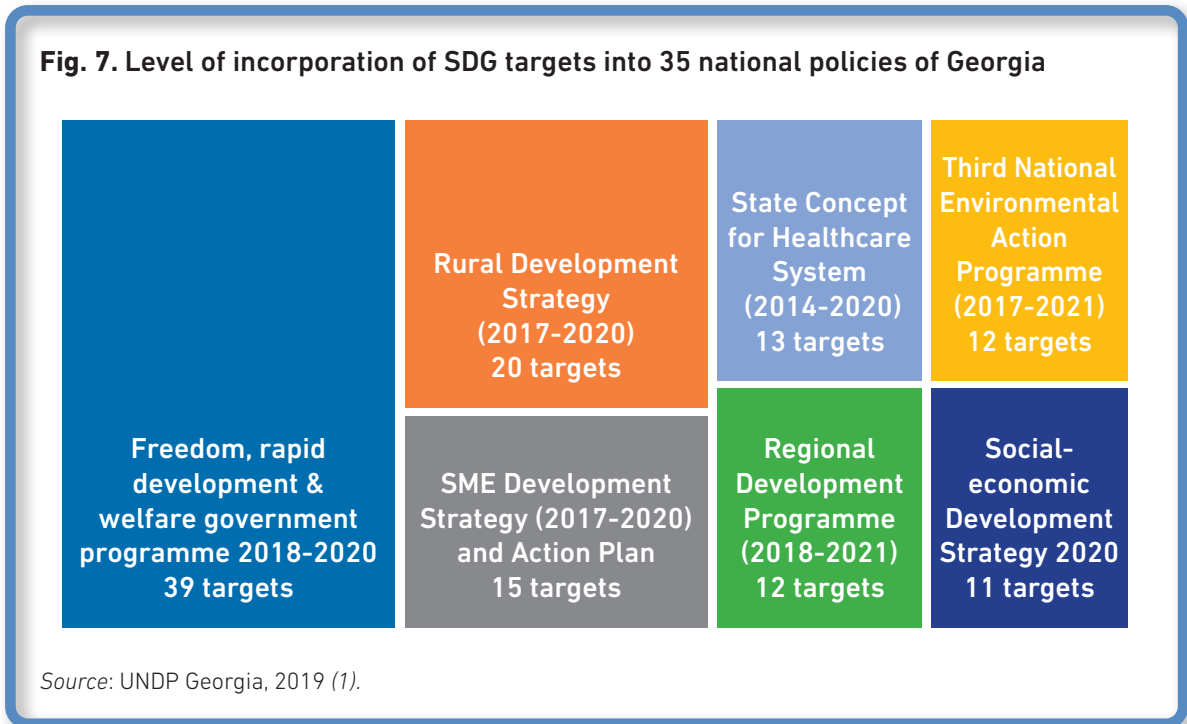
Fig. 6. Distribution of 5Ps of SDGs across 37 planning and regulatory documents of Georgia



Source: UNDP Georgia, 2019 (1).

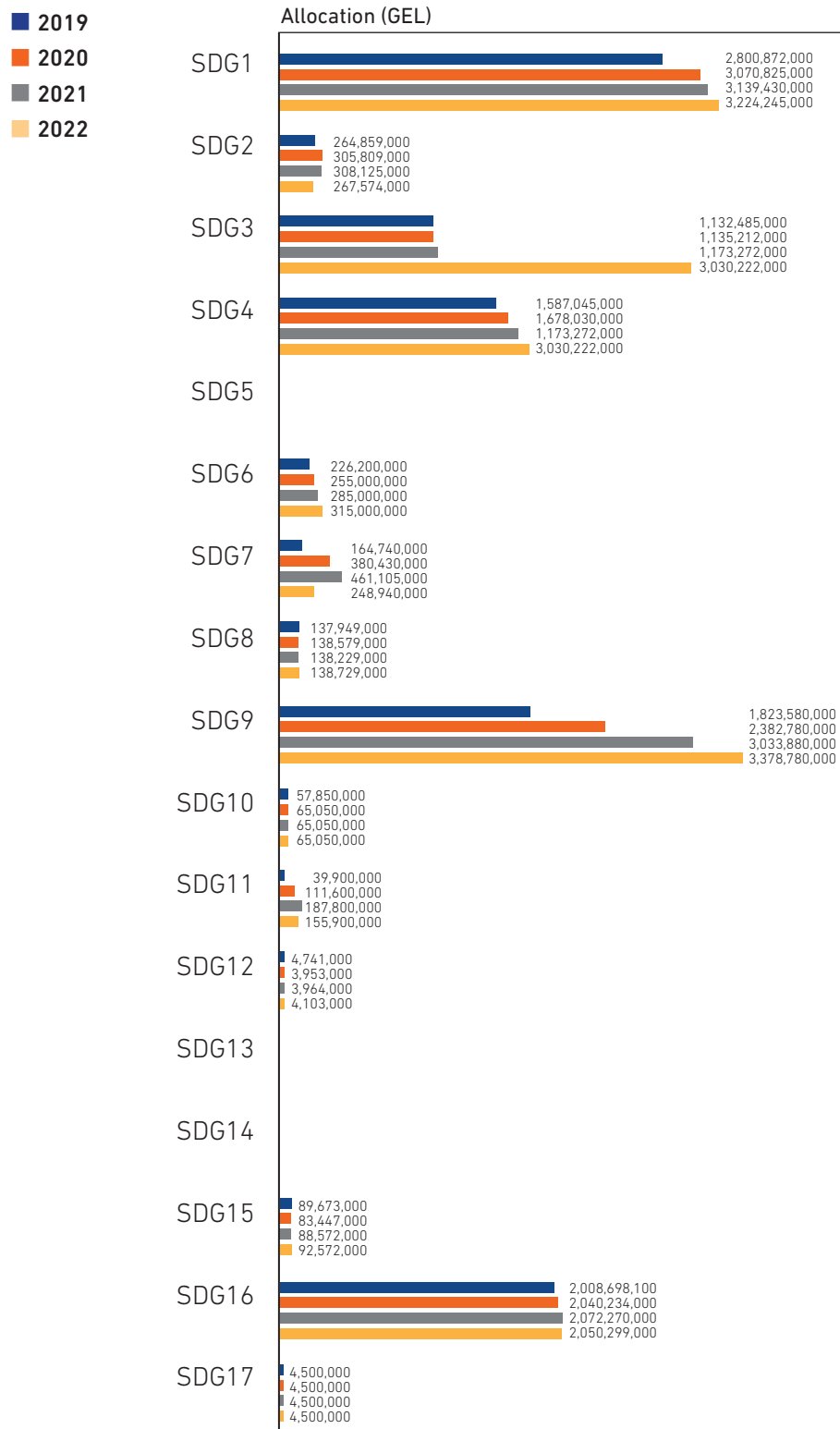


Implementation of the targets of SDG 3 is carried out almost entirely by the MoLHSA and actions are highly concentrated in one policy document: the 2014–2020 State Concept of the Healthcare System of Georgia for Universal Health Care and Quality Control for the Protection of Patients’ Rights (26). It is crucial to ensure that national development policy and planning documents have the capacity, means and institutional support needed to boost SDGs in the direction of identified acceleration points (Fig. 7).



The rapid integration assessment attempted to map budgets against all 17 SDGs. The Basic Data and Directions Document for 2017–2020 (2019–2022 budgeting cycle) was identified as the resource for financial data (27) and assessment was made at the level of goals, not targets. State funding exists for all SDGs (Fig. 8); peace (SDG 16), education (SDG 4), infrastructure (SDG 9) and health (SDG 3) clearly represent national priorities as they constitute the largest amounts of the programmed budget (1).

Fig. 8. Budget allocation by national SDGs 2019–2022



Source: UNDP calculations based on the Basic Data and Directions Document for 2017–2020 (27).



Assessment of the SDG 3 health targets

The review outlined in the Methodology looked specifically at the SDG 3 targets and health-related targets in other SDGs. The key indicators for health-related SDGs in Georgia were identified to assess progress (data available on application).

Based on the indicator analysis and the review of national policy and programme documents, this section presents a discussion of the status and trends for targets in SDG 3 (health and well-being) and the subsequent section examines health-related targets and indicators within other SDGs, particularly SDG 1 (end poverty), SDG 2 (nutrition), SDG 4 (education) and SDG 6 (clean water and sanitation).

SDG 3.1 and 3.2. Reduce maternal mortality and end preventable deaths of newborns and children under-5 years of age

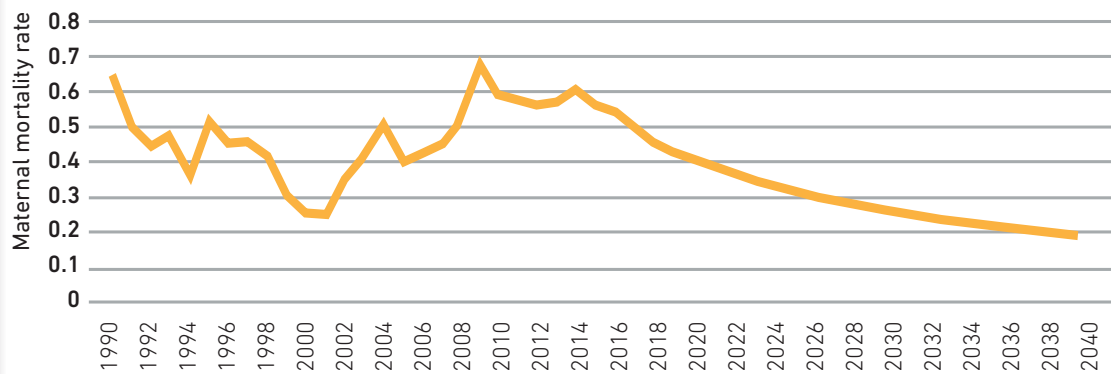
The progress achieved by the Georgian Government over past decades with regard to maternal and child health was further enhanced by the introduction in 2016 of the Electronic Module for Pregnant and Newborn Health Surveillance (known as the Georgian Birth Registry), making Georgia one of the few countries worldwide pioneering this approach to maternal and child health surveillance. All information about antenatal and obstetric care provided for all women in the country, as well as the health status of their newborn, must be registered. The Registry enables policy-makers to develop policy solutions based on comprehensive data that are grouped and analysed and it provides a vital resource for scientific research and statistical analysis in Georgia.

The regionalization of maternity and neonatal health services since 2015 has been part of the data-driven package of reforms to improve maternal and infant health outcomes by provision of risk-appropriate care and using reimbursement mechanisms to ensure quality of care. Collection of relevant health data is supported by contacts with those who meet specific criteria after regionalization as part of quality control of medical services and assistance. Since 2014, 159 national guidelines and protocols, including 12 for the main obstetric and neonatal conditions, have been adapted and approved, following the WHO-recommended evidence-informed practices (28).

These and other comprehensive activities implemented by the Georgian Government since the end of the 1990s have resulted in remarkable improvements in maternal and child health; the maternal mortality rate per 100 000 live births has fallen from 49.2 in 2000 to 13.1 in 2017 (Fig. 9); the under-5 mortality rate per 1000 live births has fallen from 25 in 2000 to 11.1 in 2017; and the neonatal mortality rate per 1000 live births has fallen from 22.1 in 2000 to 6.8 in 2017 (Fig. 10) (29). According to NCDC data in 2017, there were 11 maternal deaths registered (due to direct and indirect causes), including seven early deaths (during pregnancy or within 42 days from pregnancy termination) (21).

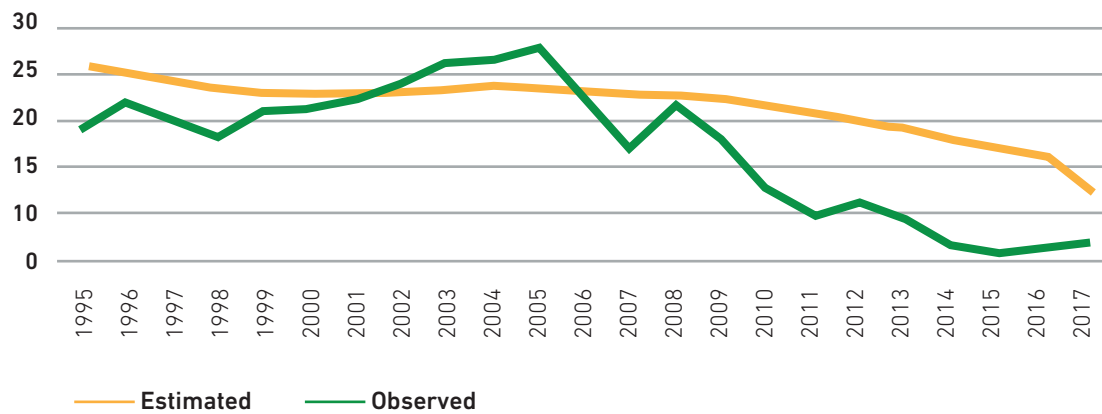
In 2017 in Georgia, 81 158 new cases of diseases were registered in infants (compared with 81 771 in 2016); the incidence rate per 1000 infants was 1481 in 2017 and 1420 in 2016. Respiratory system diseases were responsible for 62% of infant morbidity and infectious and parasitic diseases for 3.8%. According to WHO global data, almost 75% of under-5 deaths occur in infants. Among children under-5, respiratory system diseases accounted for 65% of morbidity and infectious and parasitic diseases for 10% (21).

Fig. 9. Maternal mortality age-specific rate for women of reproductive age, 1990–2017 and predicted rates to 2040



Source: NCDC, 2018 (21).

Fig. 10. Neonatal mortality rate per 1000 live births, Georgia 1995–2017



Source: NCDC, 2018 (21).

Improving the health and the well-being of mothers and newborns is an important public health goal for Georgia, and accelerating the reduction of maternal and neonatal mortality is crucial for attaining the SDGs. Therefore, a vital part of the Georgian Maternal and Newborn Health Strategy is to ensure improved coordination of interventions and to encourage the integration of service delivery within and beyond the health sector to provide a continuum of care through strong, collaborative and sustainable partnerships.



SDG 3.3. End the epidemic of communicable diseases

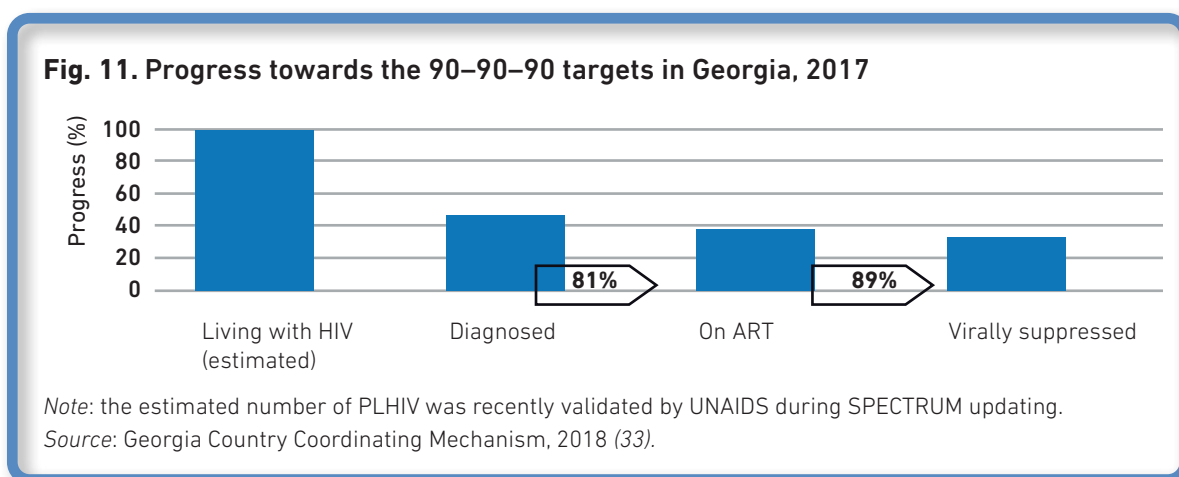
HIV

The HIV prevalence in the general population is low (0.4%; 400 per 100 000 population), and AIDS-related mortality is 1.9 per 100 000 (30). Nevertheless, Georgia faces a risk of an expanding epidemic because of the growing HIV prevalence among men who have sex with men (MSM), sexual transmission of HIV through bridging populations and patterns of high mobility within key populations.

Since 2000 there has been an upward trend in HIV incidence (per 100 000 population) from 1.7 in 2000 to 19.3 in 2016, with a slight decrease to 17.0 in 2017 (631 new cases of HIV infection were registered in 2017) (29). The HIV prevalence in MSM has also increased over the last decade: from 3.7% in 2007 to 20.7% in 2015 (31). The recent MSM cohort study, conducted by Infectious Diseases, AIDS and Clinical Immunology Research Centre (National AIDS Centre), showed the very high incidence of HIV infection in this population: up to six new infections per 100 person-years of observation, which can explain the rising prevalence of HIV (32). HIV prevalence in people who inject drugs (PWID) has not changed since 2009, varying between 2.4 (95% confidence interval, 1.56–3.46) and 2.3 (95% confidence interval, 1.63–3.12) (33). HIV infection rate among female sex workers remains low, at less than 2% since the early 2000s. The latest Bio-behavioral Surveillance Survey among prisoners was conducted in 2015 and found an HIV prevalence of 1.4% (34). In the previous survey of 2012, the prevalence was 0.3%. The increasing tendency of HIV spread did not demonstrate statistically significant change.

By November 2018 the National AIDS Centre had registered a total of 7368 cases of HIV/AIDS, including 5517 men and 1851 women, the majority aged 29–40 years; 3816 patients had developed AIDS and 1500 patients had died (30). Heterosexual and homosexual/bisexual contacts have been responsible for the majority of cases in recent years, followed by injecting drug use. Late diagnosis remains a significant challenge. Between 2015 and 2018, more than half (51–55%) of those with newly diagnosed HIV infection presented to care late (CD4 cell count <350 cells/ μ l), while up to 35% already had advanced disease (CD4 cell count <200 cells/ μ l).

The 90-90-90 target is that, by 2020, 90% of all people living with HIV (PLHIV) will know their HIV status, 90% of those diagnosed will receive sustained antiretroviral therapy (ART) and 90% of those receiving ART therapy will have viral suppression. Analysis of national data for Georgia indicates that a significant gap in this cascade of HIV care continuum occurs at the stage of HIV diagnosis, with only 48% of the estimated number of PLHIV aware of their status (Fig. 11) (33).



Georgia has made remarkable progress on the second and third items within the 90-90-90 target, approaching fast-track targets for ART and viral suppression. Among those diagnosed with HIV infection, coverage with ART increased from 62% in 2015 to 81% in 2017; viral suppression rates among those on treatment increased from 84% in 2015 to 89% in 2017 (33). Nevertheless, the significant gap at the diagnosis stage undermines accomplishments in treatment provision and, on a population level, only 35% of PLHIV are virally suppressed, which is not sufficient to derive maximum individual and public health benefits from ART (33).

Georgia has developed targeted strategic actions in several directions to fight HIV/AIDS (11); universal access to ART has been guaranteed for all PLHIV in Georgia since 2005. The Georgian ART programme is recognized as one of the best in eastern Europe and central Asia because of its high coverage rate, good retention data and high quality of services provided to PLHIV countrywide. The programme is funded by the State and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In 2015 Georgia adopted the WHO Treat All strategy and extended the ART programme to all registered PLHIV regardless of their disease stage (CD4 cell count); as a result, the country is approaching fast-track targets for provision of ART and viral suppression. Excellent results have been achieved among children: the number of HIV-infected children is very low (estimated 45 children under 15 years of age), which indicates the effectiveness of national efforts towards elimination of mother-to-child transmission of HIV. There is also active collaboration between TB and HIV services. This ensures effective implementation of collaborative HIV/TB activities, including HIV screening of all individuals with active TB disease, TB case finding among HIV-positive people and provision of treatment for both diseases. The prevalence of HIV among patients with TB remains low: below 5% at all time points since 2008. The prevalence of TB among those with newly diagnosed HIV infection is 5–7%, and, in the vast majority, TB is diagnosed first and then HIV is identified (33).

TB

Georgia has achieved remarkable progress in the fight against TB. The prevalence of TB has been steadily decreasing over recent years, on average by 9% a year and, based on a robust and sustainable surveillance system, this trend seems to reflect a genuine reduction in incidence. According to official statistics, the TB incidence per 100 000 population has declined from 96.5 in 2000 to 58.1 in 2017 (29). Among new TB cases registered, almost 70% are males (male/female ratio: 2.24). The disease affects mainly the young and the most economically productive part of the population: almost two thirds of all new TB cases occur among individuals aged 15–44 years (2016) (35). Since the mid-2000s significant progress has been made countrywide in treatment outcomes for drug-sensitive TB. The treatment success rate for all patients with TB increased from 62.5% in 2004 to 82.1% in 2015, and the proportion of patients interrupting treatment during the same period decreased from 16.3% to 9.3% (35). The high burden of drug resistance in TB infections is the key challenge for the National TB Programme and the main obstacle for effective TB control in the country. The data for 2016 show the prevalence of carriage of the multidrug resistance gene (*mdr2*) as 11.2% and 38.4% in new and previously treated cases, respectively. About one third of all patients with laboratory-confirmed MDR-TB also have resistance to second-line anti-TB drugs (fluoroquinolones or injectable agents) and 6–7% of these patients have extensively drug-resistant TB (XDR-TB) (35). At the same time, the treatment results for patients with MDR-TB or XDR-TB are worrisome and represent the major concern for the national programme. From 2008 to 2014, only 49% of these patients were successfully treated (35).

Georgia is continuously upgrading and developing its practices and approaches in order to align these with the emerging challenges of the TB epidemic and to ensure an effective national TB response. By the end of 2015 the country had achieved all main components of the Stop TB



strategy and since 2016 strategic priorities have been aligned to the new End TB strategy. The main achievements of the National TB Programme are: (i) a documented decrease of TB cases and TB rates; (ii) universal access to diagnosis and treatment for all forms of TB including MDR-TB and XDR-TB; (iii) the use of novel rapid diagnostic methods for TB and drug-resistant TB, as well as the wide use of newly developed drugs; and (iv) improved treatment outcomes for those with drug-sensitive TB, including a steady decrease in the proportion of patient lost to follow-up. Georgia is considered a regional leader in aligning the TB care delivery system with the epidemiological challenges and international best practices, including the implementation of a predominantly outpatient TB case management system, with reduced frequency and duration of hospitalization as a result of optimized and downsized TB hospital capacity (35).

Malaria

Since 2002, malaria incidence has been substantially reduced, reaching zero in 2013–2014. Since 2013 there have been no local (endemic) cases of malaria recorded in Georgia. Since 2016, the surveillance system has identified 32 suspicious cases, of which 11 were confirmed as malaria (all imported from the endemic countries) (29).

Hepatitis

There was no nationwide hepatitis B prevalence estimate until 2015. A study performed among health-care workers in 2012 found high rates (29%) of antibodies indicating previous exposure to hepatitis B (anti-HBc) (36). According to a nationwide survey conducted in Georgia in 2016, the prevalence of hepatitis B surface antigen (indicating infection with hepatitis B virus) in Georgia was 2.9% and the prevalence of anti-HBc antibodies was 25.5% nationally (37). In addition, significant associations were found between anti-HBc status and history of blood transfusion and injection drug use (37). Hepatitis B vaccine has been included in the national immunization schedules of Georgia since 2002 (21).

Based on available data, Georgia is among the countries with high prevalence for hepatitis C virus. According to the latest population-based seroprevalence survey, conducted by the NCDC and the US Centers for Disease Control and Prevention in 2015, estimated national seroprevalence of hepatitis C is 7.7% and the prevalence of active disease is 5.4%. The Government of Georgia declared its firm intention to eliminate hepatitis C in Georgia and in 2015 started an unprecedented Strategic Plan for Elimination of Hepatitis C in Georgia 2016–2020. All Georgian citizens infected with hepatitis C are covered by the Programme and can receive treatment regardless of the degree of hepatic fibrosis. As of January 2018, more than 1.4 million screenings were registered, among which 896 000 were unique individuals with a positivity rate of 11.1%. From the launch of the Strategic Plan in 2015 up to December 2017, 38 506 patients completed the treatment, with a cure rate of 98.2% (29).

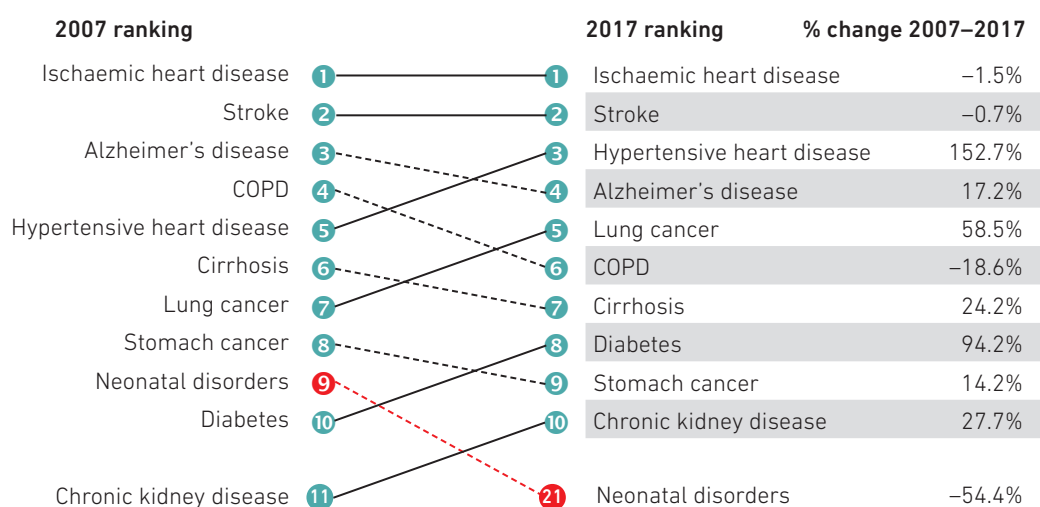
SDG 3.4. Reduce mortality from NCDs

In Georgia, as in most countries, the burden of mortality is mainly linked to NCDs. According to the WHO NCD country profile, NCDs are estimated to account for 94% of all premature deaths in 2016, with 64% linked to cardiovascular diseases, 12% to cancer, 2% to diabetes mellitus and 4% to chronic respiratory diseases (22).

From 2000 to 2017 the prevalence of diseases of the circulatory system steadily increased in Georgia. In 2017 hypertension constituted about 53% and ischaemic heart disease about 16% of all diseases of the circulatory system (21). Cerebrovascular disease was the third most common and also demonstrated an increasing trend since 2000. In 2015–2017, 56% of all new cases of malignant neoplasms were registered in women and 44% in men; 70.2% of all new cases were registered in those aged 30–70 years; around 25% in those over 70 years; 0.8% in children under

15 years of age and 0.2% in adolescents aged 15–19 years (21). There is also an upward trend in diabetes, mainly through increases in type 2 diabetes. Chronic obstructive pulmonary disease contributed 75% of all registered cases of lower respiratory diseases in 2017. Tobacco smoke (including passive smoking) was the main cause of chronic pulmonary diseases. Indoor air contamination, outdoor air pollution, occupational dust and chemicals represent additional risk factors (21). Based on data from the NCDC and the Institute for Health Metrics and Evaluation for 2017, the incidence of mortality per 100 000 population was 537.7 for cardiovascular diseases, 175.6 for cancer and 24.2 for diabetes (Figs 12 and 13) (21).

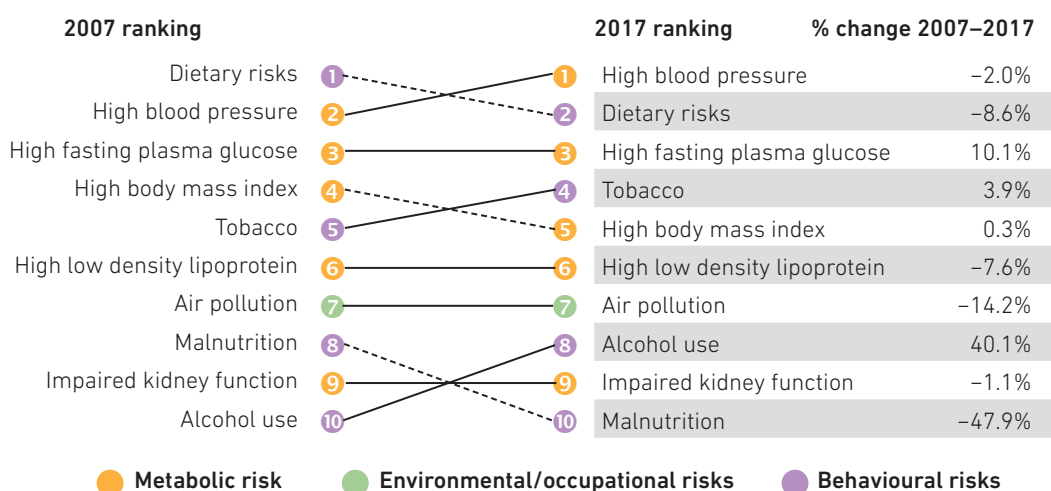
Fig. 12. Main causes of death, Georgia



Note: COPD: chronic obstructive pulmonary disease.

Source: Institute for Health Metrics and Evaluation, 2017 (38).

Fig. 13. Main risk factors for death and disability, Georgia



Source: Institute for Health Metrics and Evaluation, 2017 (38).



In response to the high burden of the NCDs in Georgia, the NCDC and the MoLHSA elaborated the National Strategy and Action Plan for Non-communicable Diseases Prevention and Control 2017–2020 (39). The aim of the strategy is “to reduce the burden of non-communicable disease related to morbidity, mortality and disability caused by preventable and manageable conditions at the national level via multi-sectoral cooperation, in order to reach the highest standards of health and productivity of population at any age and to ensure that these diseases no longer represent a barrier to health and socio-economic development” (39). The Government of Georgia continuously undertakes measures to improve NCD surveillance, prevention and management and develops and implements relevant policies, including:

- implementation of the WHO STEPwise approach for surveillance (STEPS), with rounds of STEPS surveys in 2010 and 2016, with technical and financial assistance from the WHO Regional Office for Europe and WHO headquarters; this provided a unique opportunity to monitor and evaluate patterns and trends of NCDs and risk factors in Georgia and to compare data with other countries;
- launch of the population-based Cancer Registry in 2015 to improve cancer registration and surveillance; and
- introduction of the programme for the socially vulnerable population in 2017, which provides medicines for chronic NCDs (hypertension, heart failure, ischaemic heart disease, type 2 diabetes, asthma, thyroid diseases, Parkinson's disease and epilepsy) (29).

Despite public health interventions and improved access to health care, NCDs remain the major challenge for the Georgian health system. The further development of other planned NCD registries will make it possible to improve the overall quality of health data in the country.

Further strengthening of PHC is a core necessity in order for Georgia to better meet the health needs of the population in view of the growing burden of NCDs.

Mental health

The burden of mental and behavioural disorders is quite high in Georgia and, therefore, requires adequate attention from decision-makers. According to official statistics from the NCDC, the prevalence and incidence of mental and behavioural disorders has an upwards trend, with prevalence per 100 000 population increasing from 1578.2 in 2004 to 2423.5 in 2016 for mental disorders and from 73.3 in 2004 to 140.6 in 2016 for behavioural disorders (40). According to independent experts, the prevalence of a number of mental disorders is at least twice as high as indicated by official data (41). The suicide mortality rate has started to show a declining trend; since 2015 it has declined from 5.0 cases per 100 000 population in 2015 to 3.6 cases in 2017.

The NCDC annually produces statistics on the main causes of mortality. Based on data in the 2016 Statistical Yearbook, one such cause was mental and behavioural disorders: with 2.7 per 100 000 population in 2015 compared with 2.1 in 2014 (40). (This follows the worldwide upward trend in the spread of neuropsychiatric disorders.) According to the Mental Care Strategy and Action Plan for 2015–2020 (41), WHO-defined neuropsychiatric disorders accounted for 22.8% of the total morbidity burden. In 2012 in Georgia, 1743 mental disorders were detected per 100 000 population (41).

A significant step towards the deinstitutionalization of mental health-care services occurred in mid-2011 when the vast dilapidated Asatiani Psychiatric Hospital in central Tbilisi was closed. Acute psychiatric units with 30 beds were relocated to newly opened general hospitals. A separate

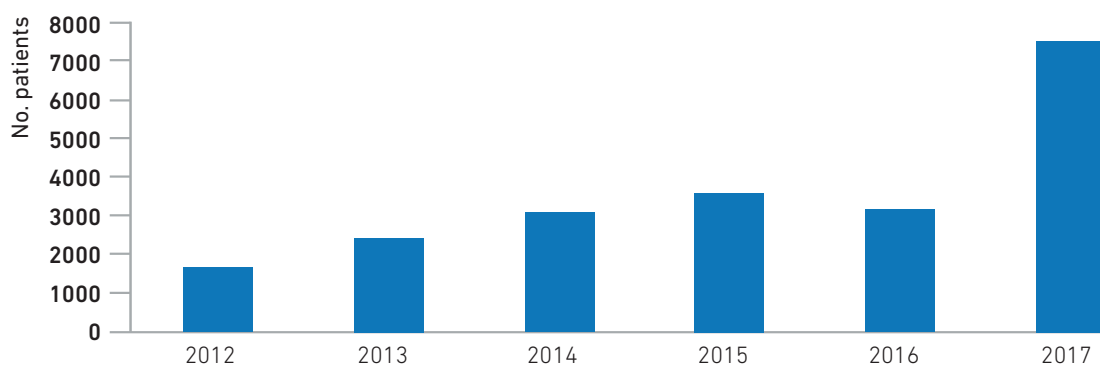
mental health centre was established in Tbilisi with a variety of services: an acute ward, a long-term treatment department and an outpatient service, including a crisis intervention centre with a mobile team. Long-term residential facilities were opened in several towns (each with 40 beds), and crisis teams started to function in some other cities. Since 2015, a community-based mobile team has operated from the Tbilisi Mental Health Centre and the funding of more mobile teams began in 2016. In 2018 financing for the Mental Health Programme was increased, which enabled 11 mobile teams to be financed across the country. These reforms immediately resulted in a reduced average length of hospital stay for patients with acute mental illness (i.e. from initial hospitalization to discharge or transfer to long-term care facility) from an average of two to three months before the reforms to an average of 21 days in 2012 (9).

SDG 3.5. Strengthen prevention and treatment of substance abuse

According to studies estimating the size of the population of PWID conducted in Georgia in 2008, 2012, 2014 and 2016, the number of PWID has increased from 40 000 in 2008 to 45 000, 49 700 and 52 500 in 2012, 2014 and 2016, respectively. According to the Integrated Bio-Behavior Surveillance survey among PWID conducted in 2017, one third of survey participants were opioid dependent (i.e. approximately 17 000) (42).

Drug dependence treatment in Georgia is implemented by public as well as private institutions, NGOs and civil society organizations. Two treatment options are available: abstinence-oriented/detoxification treatment (inpatient, as well as outpatient) and substitution therapy. The latter covers methadone substitution therapy, which has been in place since 2005, and suboxone substitution therapy, in place since 2012. Until July 2017 the opiate substitution therapy programme had been implemented by three different funding mechanisms: supported by the Global Fund, under the State Substitution Therapy Programme (with patient co-payment) and through the private sector. On 1 July 1 2017 the Government of Georgia took over responsibility for funding the entire programme and co-payment requirements for beneficiaries of the State programme were removed. This has opened access to the service for those with low incomes. The number of patients benefiting from opiate substitution therapy has increased from 1 695 in 2012 to 7 578 in 2017 (Fig. 14).

Fig. 14. Number of patients receiving opiate substitution therapy, Georgia 2012–2017

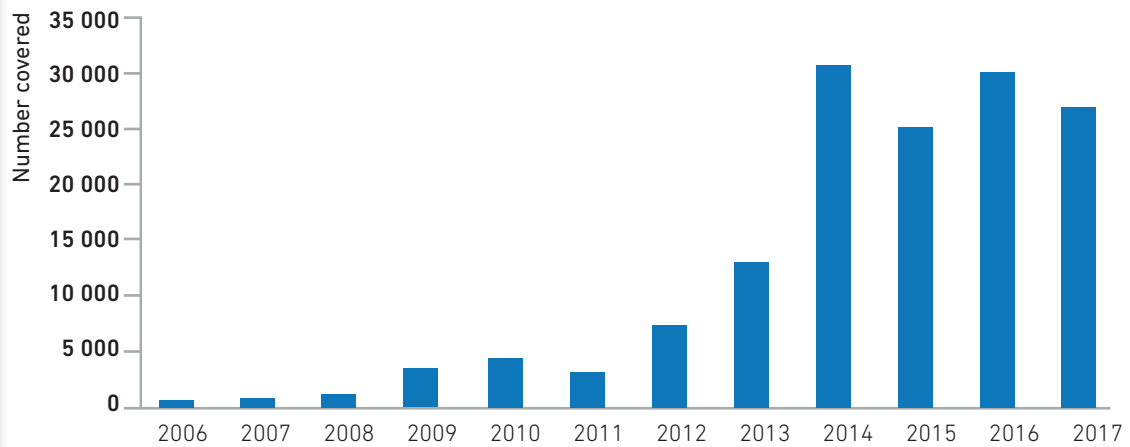


Source: personal communication from a representative of the MoLHSA.



The implementation of harm reduction interventions started in 2006 and since then services have been expanding in scope and scale. The low-threshold harm reduction services are delivered by the Georgian Harm Reduction Network (by NGOs, including community-based organizations) and are fully funded by the Global Fund. The coverage of PWID with preventive services increased from 919 in 2006 to 27 250 in 2017 (Fig. 15) (33). However, programme coverage measured through the Integrated Bio-Behavior Surveillance was considerably lower: 23.3% in 2017 (42).

Fig. 15. The coverage of PWID with preventive services, Georgia 2006–2017



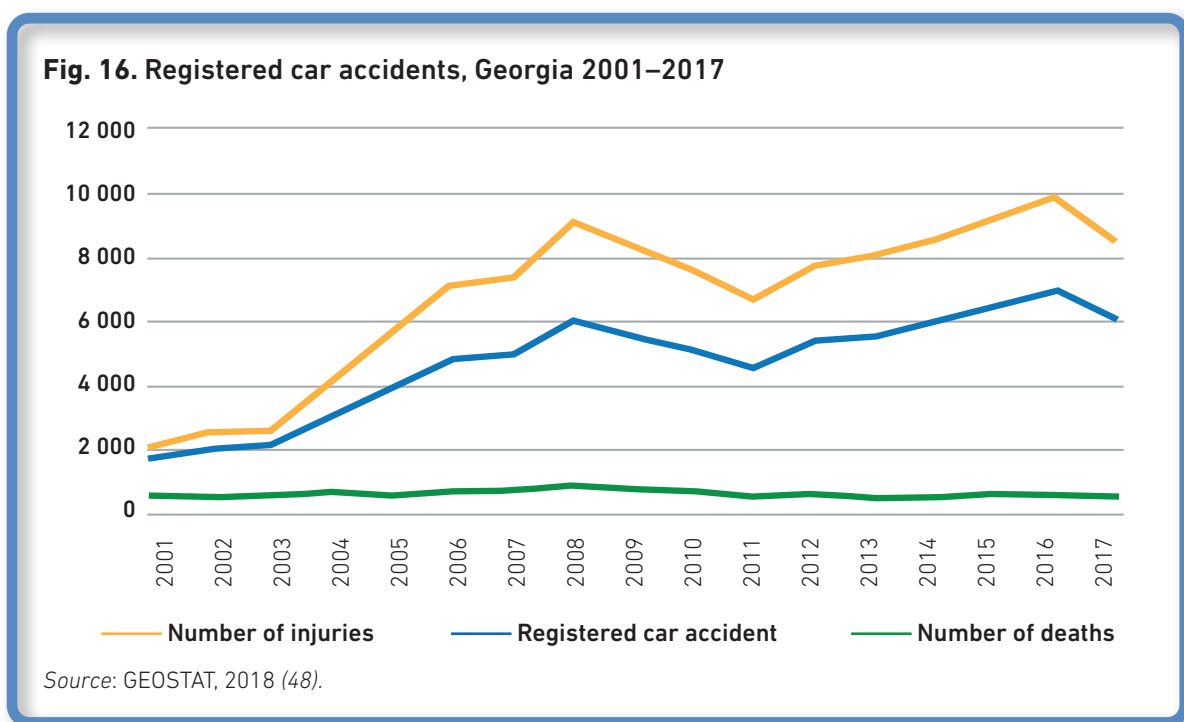
Source: Georgia Country Coordinating Mechanism; 2018 (33).

The annual pure alcohol consumption per capita in Georgia is about 6.4 litres according to the NCD risk factors survey (43). Estimates of total alcohol consumption per capita (15 years of age and older) for 2016 was 8.1 litres of pure alcohol (44). According to the comparative analysis of two round of STEPS conducted in 2010 and 2016, consumption of alcohol during the lifetime among general population aged 18–69 years increased from 78.5% (2010) to 89.7% (2016) and consumption of alcohol during the past 30 days increased by 1.3%. Excessive alcohol use was relatively low in 2016 compared with 2010 (13.4% less men and 7.4% less women consumed excessive alcohol) (43). Georgia joined the European School Survey Project on Alcohol and Other Drugs (ESPAD) in 2015. According to the ESPAD Georgia 2016 report, 41% of respondents (schoolchildren) reported heavy episodic drinking during the last 30 days (45). Industrialized countries are now developing national strategy and action plan projects for the reduction of hazardous consumption of alcohol, an approach that has been supported by the structure and content of the Global Strategy to Reduce the Harmful Use of Alcohol (46) and the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020 (47). Youth awareness activities and a health promotion programme to reduce the harmful consumption of alcohol are also underway (39).

Based on the above, it is evident that considerable advances in drug policy and alcohol policy are necessary to achieve the SDG 3.5 target. This will also foster the reduction of premature mortality from NCDs, contributing to achieving SDG 3.4 target by 2030.

SDG 3.6. Reduce deaths and injuries from road traffic accidents

According to official statistics from the Ministry of Internal Affairs, the number of registered car crashes and the corresponding number of injuries peaked in 2008 and 2016, with a noticeable decline in 2017 (Fig. 16).



In 2013 Georgia's road death rate (11.5 deaths per 100 000 of population) was four times higher than that of the best global performer (2.8) and more than twice the average rate across all EU countries. In 2013, 514 people died on Georgia's roads (511 deaths based on 2014 data). Analysis of data for 2013 based on around 70% of reported road deaths indicated that around half these deaths occurred in built-up areas, mostly in Tbilisi, and half in the road network in non-built-up areas. Of all road user deaths, pedestrians constituted 35% and motor vehicle occupants 62%. Around 48% of those who died were aged between 17 and 40 years; men accounted for 76% of total road deaths (13). According to GEOSTAT, the registered number of car crashes in 2017 was 6079, with 517 deaths and 8461 injured.

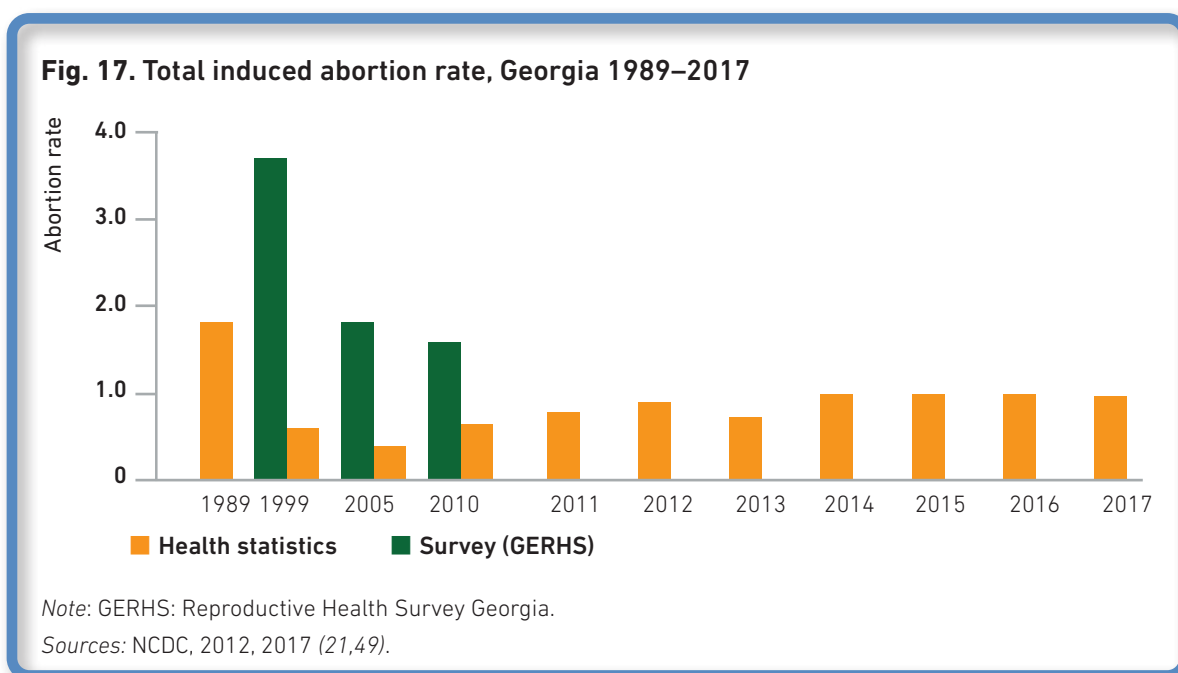
Georgia's National Road Safety Strategy was launched in 2016 by the Ministry of Internal Affairs, and road safety has become a national priority for the Government. Several measures have been taken in the health, police and road sectors to improve the reliability and scope of data collected on road crashes and injuries/deaths. It is likely that a number of key interventions have played some part in reducing road injuries and deaths, such as the introduction of compulsory seat belt use in 2010; small-scale road safety engineering improvements; road improvements with grade separation to eliminate dangerous mixed road use; small decreases in the age of a very old national vehicle fleet and access to newer, safer, imported vehicles; and annual improvements in emergency medical responses. Mandatory vehicle inspections started in Georgia on 1 January 2018 and are hoped to also reduce car crashes in the future.



The National Road Safety Strategy sets out the new long-term road safety goal for Georgia as “towards roads and traffic which are eventually free from death and serious injury”. The Strategy aims to work systematically, affordably, acceptably and for as long as needed on a path towards roads and traffic free from death and serious injury (13). Apart from the legislative improvements, the Strategy also supports a large-scale awareness-raising campaign in the field of traffic safety.

SDG 3.7. Ensure universal access to sexual and reproductive health-care services

According to the latest available survey data (49), prevalence of contraception use among married women aged 15–44 years has increased from 41% in 1999 to 53% in 2010; the use of modern contraceptive methods increased from 20% to 35% over this period. However, Georgia still has almost the lowest level of contraceptive use among the countries of eastern Europe. From 1999 to 2010, the total induced abortion rate (number of abortions a woman would have in her lifetime under the current age-specific induced abortion rates) also decreased, from 3.7 abortions per woman to 1.6 (49). NCDC data indicate that from 2011 to 2017 the documented abortion rate fluctuated around 1 (Fig. 17) (21). The highest rates of induced abortion were registered in those aged 25–34 years. Overall, the abortion rate is still high and clearly indicates low access to and utilization of family planning services.



According to the United Nations Population Fund (UNFPA) state of world population reports in 2016 and 2017, the percentage of women of reproductive age (15–49 years) in Georgia who have their needs for family planning satisfied with modern methods was 54% and 55%, respectively. Unmet need for modern contraception was 30.5%, which was very high for European standards. Unmet need is particularly high in rural areas, where it can reach 40%.

Because of a lack of reinforcement mechanisms and of (financial) incentives for PHC doctors, family planning counselling has not yet been fully integrated into PHC and is still highly concentrated within the obstetrics and gynaecology specialty, where traditionally there has not

been a focus on promotion of modern contraceptive methods. Contraceptives are available in Georgia mostly in pharmacies and, in most cases, on prescription issued by a doctor. There are currently no State funds budgeted for family planning counselling or service delivery and neither service is included in the benefit package of State or private insurance mechanisms. Contraceptives are also not included in the UHC drug list.

Maternal and neonatal health are closely related and strongly influenced by the quality of family planning and the SRH of young people. Both these areas have been included in the Georgia Maternal and Newborn Health Strategy 2017–2030 (28). This long-term strategy (2017–2030) and its short-term Action Plan (2017–2019) outline objectives and priority interventions for

- improving family planning in Georgia by ensuring universal access to quality family planning services; and
- improving young people's SRH through education and full access to quality SRH services that meet their needs.

The objectives of this Strategy will only be met if access is ensured for the entire population to affordable, quality reproductive health/family planning services, and to the information necessary for them to adopt healthy behaviours related to their SRH. The Government is committed to instituting the foundational support systems required for the population to have access to quality SRH services at every level of the health system. Approaching the SRH needs of the population in such a holistic, integrated manner, using evidence-informed clinical and public health practices, would enable both public and private sector providers to meet these needs much more effectively.

Progress has occurred in integrating education on SRH into the formal public education system. Healthy lifestyle and reproductive health issues have been incorporated in the revised National Curriculum for Basic Level Education (grades VII–IX) for 2018–2024, with the UNFPA's technical assistance, particularly in the subject standards for biology, civic education and physical education and sports. The preparatory work is underway for creation of teaching and learning materials to start implementation of the programmes from 2019–2020 academic year (unpublished data).

SDG 3.8. Achieve UHC

The Government of Georgia has been covering basic outpatient, inpatient and emergency services to all uninsured citizens through the UHCP since 2013. All citizens are provided with medical care, among them 130 000 individuals benefit from private or corporate insurance, and the rest of the population is covered by the UHCP. The Georgian health-care system covers both PHC and hospital sectors. Medical facilities providing outpatient services (e.g. polyclinics, family medicine centres) function in large cities, as well as regions. Rural doctors are responsible for the provision of health care in villages.

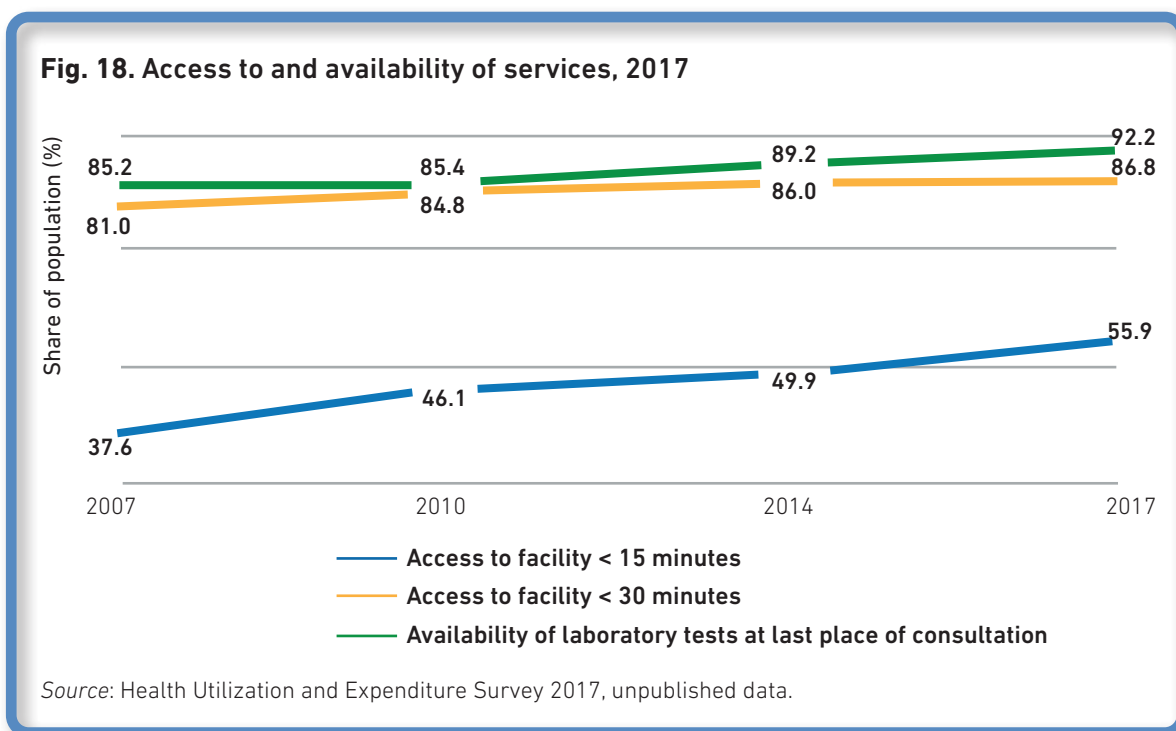
The UHCP in Georgia has proved successful (50). The Health Utilization and Expenditure Survey 2014 by USAID found that 80.3% of the surveyed beneficiaries were satisfied with outpatient services and 96.4% expressed satisfaction with hospital emergency care within the UHCP (51). The main achievements of the UHCP were:

- increased access to medical services and increased coverage;
- increased utilization of medical services; and
- reduced financial barriers.



According to the Health Utilization and Expenditure Survey data in 2017, almost 82% of the population sought care if ill in the six months preceding the survey compared with 79% in 2014.

Increased use of health services can be attributed to improvements in access (rather than greater need for health care). Physical access to care has improved since 2014. Almost 56% of the population could reach a facility within 15 minutes in 2017 compared with 49% in 2014 and 37.6% in 2007. Importantly, access to a health facility has increased for the rural population from 29.3% in 2007 to 48.0% in 2017. The share of the population reporting access to a health facility within 30 minutes has not changed since 2014 and was around 86% in 2017 (up from 81% in 2007) (Health Utilization and Expenditure Survey 2017, unpublished data; Fig. 18).



In May 2017, the new criteria for differentiation of beneficiaries for the UHCP were adjusted to provide more needs-oriented services and to apply a social justice approach. The changes included the introduction of benefits to cover essential medicines for chronic disease management for vulnerable households and publicly subsidized health services differentiated for certain groups of the population: the depth of coverage is greater for households with a monthly income less than GEL 1000 (US\$ 418 approximately). Other target groups such as children under 6 years of age, pensioners and students are eligible for free visits to family doctors and for specialized services under a co-payment system. Households with a monthly income above GEL 1000 can receive family doctor services without payment, while diagnostic tests and specialist consultations are subject to payment. Households with an annual income of GEL 40 000 (US\$ 16 735 approximately) and above are no longer eligible for benefits under the UHCP. The full package of outpatient and inpatient services without co-payments for the poor has been maintained (52).

In addition to the UHCP, the State health budget also finances 24 vertical programmes for priority diseases and conditions such as child leukaemia services, diabetes management, dialysis and

kidney transplantation, drug addiction treatment, maternal and child health, mental health and palliative care. The State also funds a range of public health programmes, including for hepatitis C, HIV/AIDS, TB and vaccination programmes.

Because of high demand, the UHCP annual budget has been overspent regularly in the recent years. A budget increase of 39% was set in 2015 but spending still exceeded the planned budget (9). Hence, balancing State health expenditure proves to be the main challenge to the sustainability of the UHCP.

SDG 3.9. Reduce deaths and illness from hazardous chemicals and pollution

NEAP-3 provides a key roadmap for environmental management in Georgia. One of the long-term goals is to achieve safe and clean air throughout Georgia (14). NEAP-3 targets reducing the emission of harmful substances from different sectors of the economy, developing an air quality monitoring and evaluation system, improving the State system of emissions inventory and introducing an emissions forecasting system. NEAP-3 also aims to establish an effective waste management system for the safety of human health and the environment.

The main sources of air pollution in Georgia are transport, energy and industrial sectors. The transport sector is responsible for the majority of airborne pollutants, accounting for 79% of carbon monoxide emissions and 62% of nitrogen oxides emissions in the country. The main causes are the age (91% of vehicles in Georgia are over 10 years old) and the technical condition of vehicles, traffic intensity, fuel type and the inadequately developed and poor-quality public transport. The industrial sector accounts for 64% of the solid particles in the air (14). Significant progress has been achieved over recent years in urban ambient air quality monitoring:

- additional automatic monitoring stations have been installed in the capital city, as well as in the regions;
- the State programme on measures to support reduction of atmospheric air pollution in Tbilisi has been approved;
- quarterly passive sampling surveys have been conducted since autumn 2015 in all major cities;
- State control on fuel quality has been implemented and the quality of fuel has been improved, with petrol already equal to the Euro 5 standard (Directive 2009/30/EC) and diesel equal to Euro 4 standard (Directive 98/70/EC) by 2019;
- an electronic air pollution reporting system from point sources has been developed and the system has been used since 2017 to provide information on annual emissions from stationary sources;
- new tax rates have been developed for the renovation of the existing vehicles in the country;
- mandatory technical inspection of vehicles partially entered into force on 1 January 2018; and
- the Tbilisi City Hall has been annually replacing diesel buses and introducing new vehicles using compressed natural gas since 2017.

The pollution of the environment by wastes and chemicals is another complex challenge. It includes pollution from household waste, unregulated landfill and hazardous waste management. Important steps have been undertaken to improve solid waste management: the new Waste Management Code and related bylaws have been adopted, landfill sites have been constructed



and rehabilitated across the country; deteriorated sites have been closed down and conserved; and rules for safe disposal and transfer of dangerous solid waste have been introduced. Waste collection and transportation systems in big cities have been improved with waste management plans elaborated by all municipalities and waste companies. The polluter pays principle has been introduced and extended producer's responsibility obligations put in place. Despite the positive steps taken in the field of waste management in Georgia over recent years, additional efforts are needed to improve waste management standards at the national level to address the problems accumulated over decades.

The MoLHSA determines standards and norms for drinking and household-use water. The National Food Agency of the Ministry of Environment Protection and Agriculture is responsible for the quality control of drinking water. According to 2017 chemical and microbiological monitoring results, drinking water is of a satisfactory standard across the country (14).

SDG 3.a. Strengthen tobacco control under the WHO framework

Cigarette smoking alone killed 8000–11 200 people per year in Georgia (22% of all deaths) and is a leading cause of cardiovascular diseases, cancer and respiratory disease. Prior to introduction of new tobacco control legislation in 2018, 31% of Georgia's adult population smoked tobacco, 57% of men and 7% of women (43). According to the results of the survey of children aged 13–15 (Global Youth Tobacco Survey, 2017 (53)), 12.6% (16.9% of boys and 7.6% of girls) were smokers and 13.2% (17.3% of boys and 7.7% of girls) used electronic cigarettes. According to ESPAD 2015 (45), 43% of children aged 16 years were random smokers and 12% (19% of boys and 4% of girls) were regular smokers.

The Tobacco Control Strategy with an Action Plan for 2013–2018 and the Georgian Tobacco Control Law 2017 meet the major requirements of the Framework Convention on Tobacco Control and have resulted in a large-scale anti-tobacco campaign (54). The National Health Promotion Strategy for 2014–2019 and the State Programme of Health Promotion with a tobacco control component were also in place by 2017 (9). Amendments have been introduced in laws "on tobacco control", "on advertising", "on organizing lotteries, games of chance and other prize games" and "on broadcasting" and in the Administrative Offences Code of Georgia. The main amendments through 2018 (29) are:

- smoke-free enclosed public places;
- complete prohibition of all types of advertisement of all tobacco products and accessories, promotion and sponsorship;
- increasing the size of health warnings, including to 65%, and obligatory graphic warnings on the front of smoking tobacco packages;
- ban on placement of tobacco products, accessories and consumption device displays on vitrines and shop windows;
- regulation of electronic nicotine delivery systems and novel tobacco products; and
- protection of State tobacco control policy from interference from the tobacco industry and transparency in the relationship between the tobacco industry and public organizations/ individuals in the process of preparation, adoption and establishment of health-care decisions.

Significant progress has been achieved regarding taxation of tobacco products: the percentage of tax in the price of tobacco products has increased to at least 45% and there are equalized

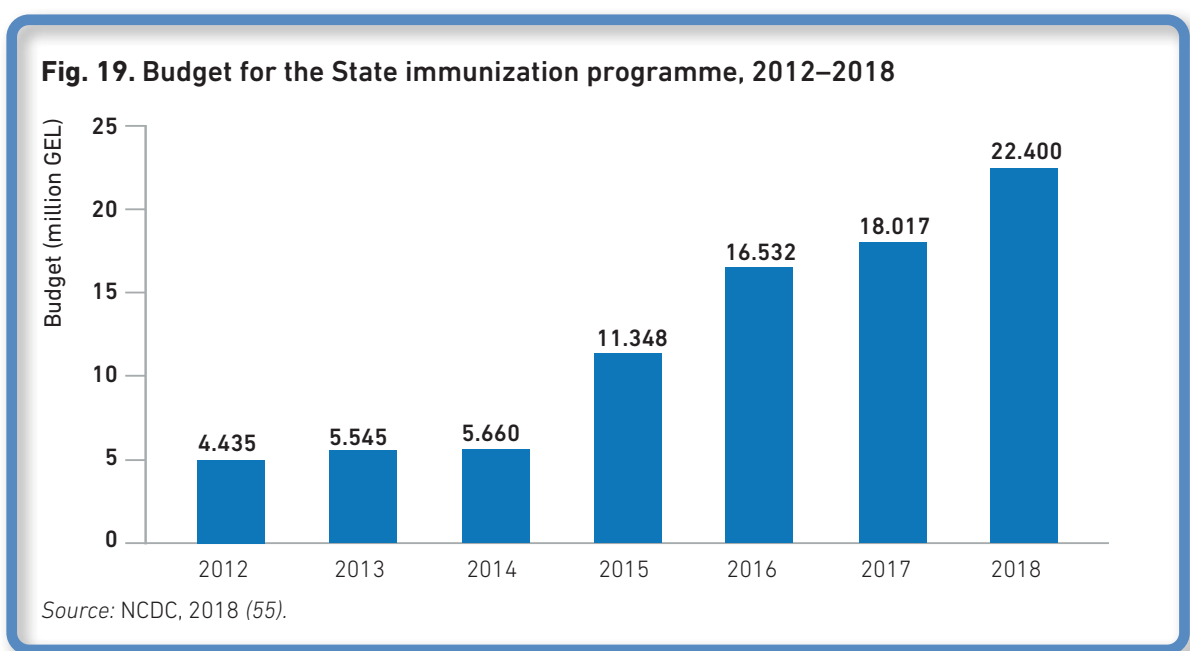
taxes on filtered and nonfiltered tobacco. Taxation systems for electronic cigarettes and related products have been established.

Preliminary data indicate that exposure to passive smoking has fallen as well as the overall number of smokers and the tobacco consumed per smoker.

As a sign of WHO recognition of the Government efforts for tobacco control and implementation of the Framework Convention on Tobacco Control, Georgia was awarded the WHO Special Award for Contributions to the Global Tobacco Control Epidemic in 2018.

SDG 3.b. Provide access to affordable essential medicines and vaccines

The State Immunization Programme was launched in Georgia in 1996 with the goal of efficiently protecting the population from vaccine-preventable diseases and ensuring high coverage and quality services in accordance with global and regional targets. The Programme was designed to cover the procurement of vaccines for routine immunization; the procurement of vaccines, serums and immunoglobulin for infectious disease prevention and treatment (botulism, malaria, rabies, tetanus, venom viper and yellow fever); and the receipt, storage and distribution of immunization supplies, with monitoring of the needs of the cold chain system. All routine immunization vaccines are procured through the United Nations Children’s Fund (UNICEF) procurement mechanism and all vaccines procured for routine vaccination are WHO prequalified. The funding for the Programme has significantly increased in recent years: from GEL 4.4 million in 2012 to GEL 22.4 million in 2018 (Fig. 19) (55), thus confirming that immunization is one of the highest public health priorities for the Government of Georgia.



The current immunization calendar covers vaccination against 12 infectious diseases: diphtheria; *Haemophilus influenzae* type b; hepatitis B; measles, mumps and rubella; pertussis; pneumococcal vaccine; poliomyelitis; rotavirus; TB and tetanus. Vaccination against human papillomavirus is available for eligible groups. In agreement with WHO recommendations, the seasonal influenza vaccination is provided for selected high-risk groups. Access to immunization



services in Georgia has been guaranteed since 2013 under the UHCP and the Rural Doctors State Programme. The Comprehensive Multi-Annual Action Plan for Immunization 2017–2021, adopted in 2017 (56), follows the main goals of the European Vaccine Action Plan (57). In 2016 the vaccination coverage rates for most diseases were higher in the frame of the State Immunization Programme than in 2015, although coverage rates for all vaccines had not yet reached 95% even in 2017 (21). For vaccine-preventable diseases, current immunization rates are quite high. In 2016 85% of children were fully immunized against measles (i.e. had received both doses of the measles, mumps and rubella vaccine); 97% of infants were immunized against diphtheria, pertussis and tetanus; and 97% of infants were immunized against polio (58). Since 2011 an electronic module of immunization has been introduced but challenges still remain in improving the system and increasing its notability and efficiency countrywide. As is the case in many countries in the WHO European Region, vaccine services have had to deal with public trust issues but in Georgia they have also had to overcome the systemic weaknesses in the basic infrastructure (9).

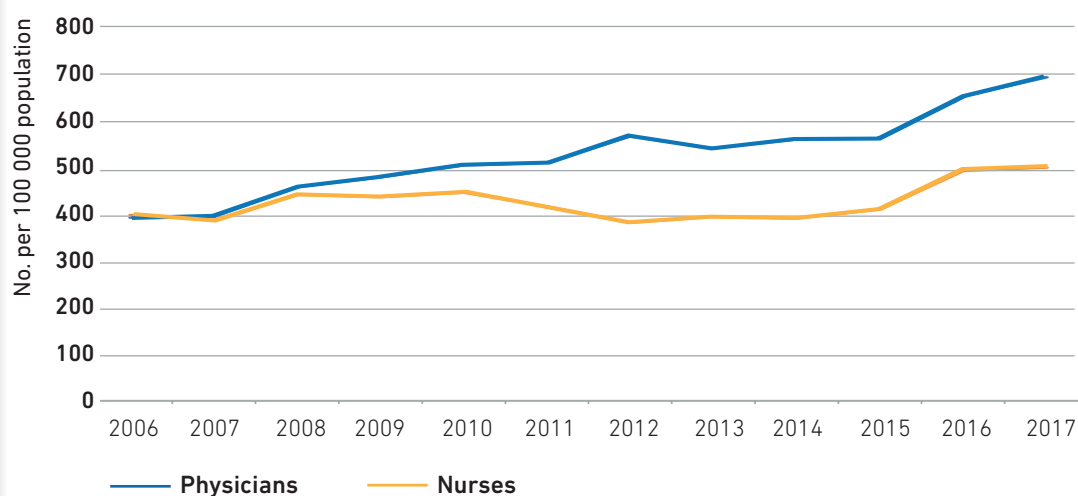
In the pharmaceutical sector, there is a liberal regulation system including a simple registration rule for pharmaceutical products as well as requirements for pharmacies. The State regulation of clinical trials on pharmaceutical products needs to be improved. The current legislation and limited institutional and financial resources do not allow for the full control and monitoring of the quality of pharmaceuticals. In order to protect patients, the following systemic problems within the regulation of pharmaceutical products have to be addressed: irrational pharmacotherapy, insufficient use of generic medications by patients and doctors, insufficient use of the prescription mechanism, high costs of medications and aggressive marketing by the pharmaceutical industry. A number of legislative amendments were made to address these problems and ensure patient safety, including an amendment (1 September 2014) that prohibited the sale of pharmaceutical products in category 2 (where inappropriate use could cause harm, e.g. antibiotics and some medicines for chronic conditions) without a prescription. So-called electronic prescriptions have also been introduced. In the future, it is important to improve the quality control and the monitoring mechanisms of pharmaceutical products (19).

The relatively high cost of pharmaceuticals is one of the major issues in access to care in Georgia. Two thirds of current OOP payments is for outpatient pharmaceuticals. Pharmaceutical costs represent one of the biggest gaps in coverage and are devastating for low-income households (19). To aid the socially vulnerable population in covering pharmaceutical costs, the Government launched a targeted programme in 2017 to provide medicines for treatment of chronic NCDs (hypertension, heart failure, ischaemic heart disease, type 2 diabetes, asthma, thyroid disease, Parkinson's disease and epilepsy).

SDG 3.c. Increase health financing and the recruitment, development and retention of the health workforce

The health-care system of Georgia is characterized by an excess of doctors, a lack of nurses and an uneven geographical distribution of the health-care workforce, with a decreasing ratio of nurses to physicians. The number of professionally active physicians per 100 000 population increased from 400 in 2006 to 706 in 2017 while the number of professionally active nurses steadily decreased until 2012, where it was 389, and then increased to 509 in 2017 (Fig. 20) (21). A further issue is regional disparities, with three times as many doctors in Tbilisi than in other regions (29).

Fig. 20. Number of professionally active physicians and nurses per 100 000 population, Georgia, 2006–2017



Source: NCDC, 2018 (21).

In Georgia, education of medical doctors is carried out according to the global standards of the World Federation for Medical Education and the EU Bologna Standards; these cover undergraduate education (six years), postgraduate education and continuous professional development. Postgraduate education has been implemented in the framework of residency programmes since 1999. Once qualified for residency, applicants are given the opportunity to get a State certificate for a specialty and then start medical practice in that specialty. The duration of residency programmes follows that within EU programmes. Residency programmes for medical specialties, subspecialties and assessment systems (certification examinations, state certification tests) have been regularly updated since 2013. Those working in public health follow an undergraduate programme, a masters programme and a doctorate pathway. Nurses have a four year undergraduate degree programme with no option of a further level of training.

Since 2016 an online platform for the British Medical Journal has been available in Georgia with the support of the Defense Threat Reduction Agency of the United States. This allows Georgian doctors to use the BMJ Best Practice and BMJ Learning platforms for three years. The requirements for accreditation of continuous medical education activities were renewed in 2017. Participation in continuous professional development has been mandatory since 2018 for obstetrician–gynaecologists and neonatologists working in perinatal services (29).

SDG 3.d. Strengthen health emergency preparedness

Georgia reached full compliance with the core International Health Regulations (IHR) by the June 2012 deadline set by WHO. The NCDC is designated as the national focal point and is accessible at all times for communication with the WHO contact point. There is a 24/7 duty officer system and the NCDC is able to receive notifications from the national surveillance system and from other stakeholders; it can then conduct risk assessments and notify the WHO contact point within 48 hours.



The Global Health Security Agenda was launched in February 2014 to ensure global safety from infectious disease threats, to bring together nations to make new commitments and to put forward global health security as a national priority (59). The Agenda has been welcomed by Georgia since its launch and the first external assessment of Georgia's baseline capabilities was conducted in 2014. The Government of Georgia took a path to contribute to zoonotic disease and national laboratory system action packages and led an action package of real-time surveillance.

The Bio-surveillance Network of the Silk Road is a regional partnership that includes human and animal health professionals from Azerbaijan, Georgia, Kazakhstan and Ukraine. It works to create a sustainable, integrated disease surveillance network, thereby contributing to the One Health perspective and supporting the implementation of global health security agenda within the region (29).

Assessment of health-related targets in other SDGs

SDG 1.2 and 1.3. Reduce poverty and ensure social protection for all

Eradication of poverty in all its forms and dimensions (SDG 1.2) is the greatest global challenge and an indispensable requirement for sustainable development. In 2014 poverty in Georgia decreased for the fourth consecutive year, but it still affects close to one third of population, with 32% living on less than US\$ 2.50 per day. According to World Bank data, GDP annual growth was 2.8% in 2016 and 4.8% in 2017; gross national income per capita (Atlas method, current value) was US\$ 3830 in 2016 and US\$ 3780 in 2017 (60).

Social protection to cover vulnerable groups (SDG 1.3) is an important poverty reduction tool. In Georgia this includes pensions, health insurance and targeted social assistance. According to the Social Service Agency, 8.2% of the population in need was covered by targeted social assistance in 2017 (excluding social package recipients and pensioners): 36.5% children and 54.3% women. The social package provided for 4.5% of the population in need (20.3% children and 37.4% women); the pension package provided for 19.6% of the population (71% women).

It is noteworthy that social protection is the largest spending item in the State budget, accounting for 24.6% of the central public expenditure (6.7% of GDP) in 2017. Social pensions constituted approximately 62% of social security spending. The pension scheme in Georgia is the largest social assistance programme, costing 4.2% of GDP in 2017. It provides a flat rate benefit to all pensioners (men over 65 years and women over 60 years). In contrast, targeted social assistance is the second largest cash-assistance programme within Georgia's social security system. It aims to improve the socioeconomic conditions of families experiencing financial and material hardship (Table 2).

Table 2. Social protection

	2009	2010	2011	2012	2013	2014	2015	2016	2017
Receipt of pension and social packages (total, thousands)	838.5	835.9	826.8	857.0	857.0	866.2	874.9	887.3	898.1
Receipt of old age pension package (total, thousands)	660.0	662.3	666.4	682.9	686.7	697.2	707.7	720.2	732.1

Source: GEOSTAT, 2018 (48).

At the end of 2013, the Government of Georgia started a technical review of the targeted social assistance programme. As a result, new legislation was passed that modified the targeting formula and benefit scheme alongside a new target programme: the Child Benefit Programme. Implementation of the new programme started in June 2015, and compensation measures were adopted in August 2015. The size of the benefits under targeted social assistance ranges from GEL 30 to GEL 60 a month depending on vulnerability scores. In addition, each household receives a monthly GEL 10 child benefit for children under the age of 16 years. The monthly budget for the targeted social assistance programme in 2017 was GEL 21 128 468. Benefits for specific categorical groups are another type of social security assistance in Georgia. These benefits include a social package, family assistance, utilities assistance and benefits for internally displaced people. The categorical benefits are received by survivors, people with a first-degree disability and war veterans or victims of political repression. In addition, most municipalities also provide cash and in-kind benefits; however, their coverage and value are quite low.

The number of children living in extreme poverty (below US\$ 1.25 per day) was more than halved between 2013 and 2015 (58). Despite the improving poverty trends in Georgia, children remained the poorest population group. Every fifth child lives under the general poverty line and every sixth child lives under the subsistence minimum. The improved targeted social assistance scheme with the newly introduced child benefit in 2015 is a significant step towards reduction of child poverty in Georgia. In 2016, 153 686 children below the age of 16 benefited from cash transfers, of whom 70 251 qualified because of the new methodology.

Currently, the targeted social assistance policy in Georgia aims to protect the population from extreme poverty and reduce child poverty. The Vision for Developing the Labour and Social Protection Sectors in Georgia by 2030 from the Parliament states: "The programme is effective; however, it is necessary to gradually replace targeted social assistance and other fragmented programmes with a prevention focused social protection system. This is necessary in order to strengthen the principles of social justice, equality and solidarity in society which are recognized by the Constitution" (61).

SDG 2.2. Achieve food security and improve nutrition

In the Georgia National Nutrition Survey conducted in 2009 (62), anaemia was identified as a common health problem in children under-5 years, non-pregnant women aged 15–49 years and pregnant women. Although severe anaemia is relatively rare in these at-risk groups, moderate and mild anaemia can still have deleterious effects on health. WHO estimates this as moderate public health problem (prevalence 20–39%). Although the prevalence rates of anaemia in young children and women in Georgia are generally lower than those in its neighbouring countries, they are substantially higher than those in developed countries in the WHO European Region and North America. Based on test results (C-reactive protein and ferritin), iron deficiency does not seem to be the reason for the anaemia, thus excluding causes such as insufficient dietary intake of iron, poor bioavailability of dietary iron or excessive loss of blood (62).

Although nutrition technical regulations are approved for preschool facilities, there is no clear ruling regarding school nutrition. Given the nutrition situation, there are several actions that have been taken by the Government, including the establishment of policies and strategies. However, these remain fragmented and dependent on donor funding. These are also not established within a comprehensive multisectoral nutrition roadmap for the country.



SDG 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

The general education system in Georgia is regulated by the Law of Georgia on General Education and the Law of Georgia on Education Quality Enhancement, which are implemented by the National Curriculum and other subsidiary acts. Full general education includes 12 years of study spread over primary (six years, grades I–VI), basic (three years, grades VII–IX) and secondary (three years, grades X–XII) levels. Primary and basic levels are mandatory. General education institutions may be public or private. The study in general educational institutions follows the National Curriculum, which is developed by the National Curriculum Department of the Ministry of Education. Upon completing basic education, school students receive a Basic Education Certificate (Atestate) (63).

According to a study conducted by UNICEF and the National Assessment and Examination Centre assessing the quality of preschool programmes in Georgia in 2017, 69.5% of young children are enrolled in preschool, which is low compared with the European target (95%) (64). Enrolment rates are lower for ethnic minority children, socially vulnerable children and those living in rural areas. There are barriers for inclusion of children with disabilities, such as lack of adapted infrastructure, overcrowded groups, low competences among caregivers and social stigma against disability. The study found that the number of children per classroom was too high, especially in urban areas (e.g. there are 39 children, on average, per classroom in Tbilisi, with some classrooms having up to 60 children). A large number of children in each classroom has significant implications on the quality of education. Data from 57 municipalities indicate that 45% of caregivers are unqualified. Most preschool staff members had not received continuous professional training in the previous 10 years. The social status of caregivers working in the field is extremely low. The salaries for all workers in early childhood education and care, including directors, are also extremely low (64).

Based on World Bank data for Georgia, primary school net enrolment (percentage of total number of children of primary school age) was 82.5% in 1995 and 98.0% in 2017. There were 2287 boys and 3074 girls out of primary school in 2012 (61). The adult literacy rate was 99.6% in 2014 (65). Public spending on education as a share of GDP has fluctuated substantially in recent years; however, it tended to increase through 1998 to 2016, reaching 3.8% in 2016 (66).

Despite these indicators, Georgia has a very low rating for education according to the Global Competitiveness Index. Out of 148 countries, it is placed at 32 for universal access to primary education (admissions), while it is at 94th place for quality of primary education (3.4 points), 105th place for the quality of the education system in general (3.2 points) and at 106th place for the quality of mathematical and scientific education (3.4 points) (67).

SDG 6.1 and 6.2. Achieve universal access to safe drinking water, sanitation and hygiene

The access to potable water, including the coverage for piped household water, has improved significantly in rural areas. The proportion of the rural population with improved water supplies increased from 42% in 2000 to 74% in 2015. Improved sanitation facilities are provided to 73% of rural households and up to 95% of urban households. While 11% of the sanitation facilities had sewer connections in 2000, this fell to 2% in 2015 (68).

4. Key priorities in Georgia to improve health and well-being for all at all ages

Health-care reform and health system strengthening

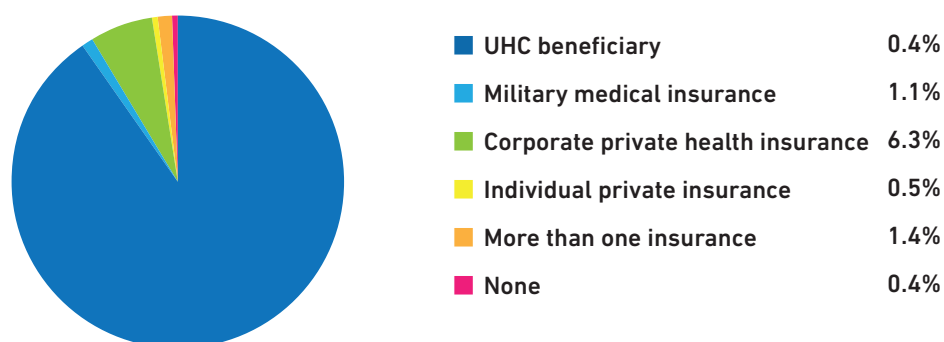
UHC and health financing

The Georgia health system has changed significantly since the mid-1990s, especially with regard to health coverage. The main changes are as follows.

The first dramatic change was implemented in 1995, when budget transfers were complemented with additional sources of financing: the mandatory health insurance contributions (employer 3% and employee 1%), funds allocated for health care from territorial budgets, and official co-payment for medical services that could not be financed by the State programmes (8). Mandatory social health insurance was abolished after the 2003–2004 Rose Revolution. In 2003, the social insurance tax was replaced by the social tax, which was accumulated in the State budget (9).

In 2007 through the Medical Insurance Programme, the Government of Georgia delegated management of State allocations for health insurance for targeted groups of people (poor households, teachers and orphans) to private insurance companies. Insurance companies took on responsibility for pooling risk and purchasing health services for these beneficiaries, who could choose their insurer. In 2012 coverage under the Medical Insurance Programme was extended to pensioners, disabled people, students and children under 6 years (9). At this point, about 51% of the population had health insurance; however, this left around 2.3 million without insurance and who, in most cases, were unable to cover their medical expenses. The number of visits to PHC per person per year was 2.1, placing Georgia second in a comparison of Member States of the WHO European Region (unpublished Health System Performance Assessment in 2013). This issue was dealt with by the introduction of the UHCP in 2013. There has also been a radical change of direction in health financing policy as the Government embraced the move towards UHC rather than targeted benefits, and 2 300 000 uninsured people became beneficiaries of the UHCP, which aimed to provide financial support to ensure the accessibility of health care for all. More than 90% of the population was covered by the UHCP in 2017, with the other 10% covered by private medical insurance in addition to the State programme (Fig. 21).

Fig. 21. Health insurance coverage, 2017



Source: Health Utilization and Expenditure Survey 2017, unpublished data.



From 2017 new criteria for differentiation of beneficiaries of the UHCP were elaborated. The Programme covers planned outpatient services; emergency inpatient and outpatient services; elective surgery; cancer treatment; obstetrical care; and funding for essential drugs. Responsibility for purchasing publicly financed health services lies with the Social Service Agency. Georgia's universal health-care reform has improved access to health services and reduced financial barriers and OOP costs for the population (69).

The health financing reforms introduced since 2013 plus significant increases in public health spending have helped to advance Georgia to European norms (10):

- near universal population entitlement to publicly financed health care;
- free visits to family doctors;
- referral and prescribing systems;
- a single purchasing agency; and
- higher public spending on health.

Sustaining the coverage achieved to date and deepening coverage through better financial protection against OOP costs are the policy priorities for the Government of Georgia.

The UHCP provided Georgian citizens with crucial social guarantees and provided for increased utilization of services, which had been inaccessible for the vast majority because of their costs. This resulted in a significant increase in the number of visits to a clinician: a 54% increase from 2011 to 2014 (70). The growing scale of the UHCP has raised concerns about issues of annual budget planning and management. The Social Service Agency has struggled to fully oversee medical facilities. The UHCP also has had a significant impact on private insurance business: since 2014, private insurance companies have been withdrawn from the State health-care programme, leaving them only with private insurance policies.

According to the World Bank, the main challenge in Georgia associated with health-care system financing is inefficient management of public funds (10). This is further compounded by the complex financing mechanisms arising from the different tariffs and co-payment schemes, coupled with a fragmented PHC system and lack of motivation on the part of health-care providers to stimulate proper PHC service delivery (71).

Patient-centred care

Patient-centred care has been developed and promoted worldwide as a model for transforming the mode of organization and delivery of PHC. Interest in this approach emerged in response to the lack of access to PHC, the challenges in navigating fragmented care systems and the rising costs of health care worldwide. There are not many examples of patient-centred care in Georgia. One is the new TB strategy, which fosters the use of the patient-centred approaches. Implementation of this model of care for TB will require an effective collaboration between the public and private health-care providers delivering TB services in Georgia.

Another example is the development of integrated screening for TB, HIV and hepatitis C virus, which provides a new opportunity for collaboration between public and private sectors to ensure improved system efficiency and cost saving, increased patient access and, ultimately, improved the quality of care. Georgia started a pilot project in the region of Samegrelo in 2018 to test the potential for integration of HIV, TB and hepatitis C virus screening services at the regional level and to engage PHC providers in detection and management of all three diseases

under one umbrella. Samegrelo was selected as a region with the highest burden of all three diseases. The regional Advocacy/Communication/Social Mobilization campaign was conducted to raise awareness of the three diseases among all stakeholders, including local government, public and private PHC providers, NGOs and the public, and to establish collaboration among them. Memorandums of understanding were signed between partners defining their roles and responsibilities. An integrated screening protocol and training module was developed and nearly all the PHC providers (440 professionals) in the region were trained in diagnostic procedures, ethical conduct and recording and reporting through a web-based platform. As a result of the project, the trained PHC physicians offered triple screening to patients seeking care at medical facilities, and pursued active case finding using a door-to-door approach for individual households, in settings where people congregated and in public establishments. Supportive supervision of the process was provided by the National Family Medicine Training Centre. The Regional Steering Committee advocated and led implementation of the programme with the support of the MoLHSA, the NCDC and the national centres for TB, hepatitis C and HIV/AIDS. District multidisciplinary teams were formed in public health centres, and representatives of local government and private service providers were established for monitoring and support of the process.

Implementation of the programme created high interest in the local population and this made a substantial contribution to the overall large number of people screened for all three diseases. In seven months of project implementation, 88 178 were screened, 2279 were found to be positive for hepatitis C, 37 for HIV and 192 with presumptive TB. All identified were referred for further confirmation and treatment.

Implementation of this project enabled the formation of an effective public–private partnership for integration of screening and early disease detection for the three diseases. Initial technical assistance included developing an integrated screening model, building provider capacity and raising awareness in providers and the community. The project was supported by the TB Programme of the Global Fund; diagnostic tests and supplies have been provided through the State programmes, and incentives for the PHC providers have been covered by local governments.

To tackle a multidimensional connection such as that between HIV, TB and viral hepatitis through a sustainable development approach, a set of activities has to be agreed with national authorities and key partners, building on both existing and innovative intersectoral actions. The WHO Regional Office for Europe initiated the United Nations Common Position on Ending HIV, TB and Viral Hepatitis Through Intersectoral Collaboration (72), which articulates an agreed focus on leaving no one behind and calls for the alignment of both ways of working and technical interventions in countries. These can be achieved through the use of a range of instruments and coordination mechanisms, including pooling funds and joint procurement efforts. The purpose of this collaboration is to set the direction and guide joint approaches and collaborative interventions within and across sectors in order to end the epidemics of HIV, TB and viral hepatitis. Georgia is one of the countries proposed as a champion, based on its good practices and development landscape, to pioneer the operationalization of the Common Position. The output of the operationalization will be a country-specific set of actions to be planned and implemented jointly by United Nations bodies and key stakeholders, addressing the non-health determinants of the three epidemics, building on what works in a country and filling the relevant gaps (72).



Public health

According to the EU–Georgia Association Agenda, special attention will be paid to the development/ improvement of a public health policy and public health programmes in priority areas, such as the control of communicable diseases and NCDs, mental health, drug addiction, the control of tobacco and alcohol overconsumption, and environmental health (26). The government health budget covers the public health programmes. Administration of these programmes is a core function of the NCDC, which has nine regional centres for public health and employs around 400 people. It is also the body with primary responsibility for biosecurity and meeting the requirements of the IHR. In addition, since 2013, the NCDC has been a principal recipient of grants from the Global Fund.

The NCDC implements 10 vertical State programmes for public health protection and health promotion, covering:

- early detection and screening for diseases
- immunization
- surveillance
- blood safety
- prevention of occupational diseases
- TB management
- HIV/AIDS management
- mother and child health
- health promotion
- hepatitis C management.

State investment in public health and health promotion activities has significantly increased in recent years, yet expenditure on public health constituted only 2.24% of total government expenditure on health in 2015 (73).

Workforce

Smooth functioning of the health system depends on an effective financing mechanism, reliable data for policy-making, a well-trained and adequately paid workforce, well-maintained facilities, logistics for delivering medicines and technologies, and strong laws.

The number of physicians in Georgia has been increasing since 2006 and is notably higher than the averages for the WHO European Region or the Commonwealth of Independent States (CIS). In contrast, the number of nurses is very low. The imbalance of doctors and nurses has reached a low level of 1:0.67. The shortage of nurses and surplus of doctors, lack of qualified personnel and their unequal geographical distribution remain important barriers for high-quality medical services in Georgia.

The Health System Barometer, IXth Wave, a study conducted by the Curatio International Foundation in 2017 (71), also emphasized the fact that Georgia employs more health system personnel with higher salaries (i.e. doctors instead of nurses) and, thus, significantly increasing the costs of health-care services, which is a high financial burden for the population. This imbalance

is aggravated by the fact that there are medical specialties which are underrepresented or not present in the country (e.g. neonatologists and anaesthesiologists).

The insufficient quality of health services as well as the absence of continuous medical education programmes are considered core challenges in the health system in Georgia. The government abolished continuous professional development in medicine in 2004. As a result, regular upgrading of professional qualifications and knowledge is not mandatory for practising doctors. In the absence of government-funded continuous professional development opportunities, usually doctors themselves, their employers or, in most cases, pharmaceutical companies bear the costs of attendance at short courses, conferences and so on.

Medicines

The pharmaceutical market in Georgia is steadily growing, with exports increasing by more than 40% since 2012. At the same time, the country's own demand for pharmaceutical products encourages imports. This growing trend is expected to continue in coming years. There are currently more than 70 manufacturers of pharmaceutical products and companies that import pharmaceuticals in Georgia (74).

The regulations and standards in this business sector are defined and controlled by the Agency for State Regulation of Medical Activities and by the Law on Medicines and Pharmaceutical Activity of Georgia. The Agency is responsible for issuing licences for pharmaceutical companies as well as for monitoring production and trade.

The high cost of medications remains a heavy burden on the population. The costs have been increasing since the late 2000s and currently constitute almost half of the population's expenditure on health care and about two thirds of OOP payments (19).

The average OOP spending on inpatient care has halved since the launching of the UHCP, but average OOP spending on outpatient pharmaceuticals has almost doubled. This does not relate to changes in coverage but mostly to the high cost of pharmaceuticals in Georgia, the fact that generics are not always available and the reliance on imports, which makes pharmaceutical prices vulnerable to economic shocks such as the depreciation of the Georgian lari (GEL) in 2015. The burden falls particularly hard on households with the lowest incomes. For 90% of those in the poorest quintile the cost of medicines has become catastrophic, pushing most of these families into poverty, while for the richest quintile this was 21% of expenditure (9). Georgia is a leader among European countries in total pharmaceuticals expenditure as a percentage of total health expenditure (38% in 2017) (73). With respect to annual health-care expenditure distribution, households spent the highest share (69%) on medicine. One reason for this increase is the costs of medicines. Almost 27.8% of households (up from 26.4% in 2015) reported buying medicine to be their main problem. Average expenditures on medication increased significantly across consumption quintiles (58).

All pharmaceuticals prescribed as part of outpatient care are purchased by patients at full cost unless they are covered by health insurance or under the UHCP. Since 2017, pharmaceutical coverage under the UHCP has been extended to patients with chronic conditions and registered as living below the poverty line. Access to affordable, effective, quality medicines is another major component of UHC and is of great concern in Georgia. Improving access requires multidimensional interventions, with comprehensive national policies together with supportive legal and regulatory frameworks and efficient supply chains.



As discussed under SDG 3.b (provide access to affordable essential medicines and vaccines), Georgia launched an electronic prescription system for medications in 2014 to enhance the safety and quality of prescription of medicines by doctors and to address the issue of irrational consumption of pharmaceuticals. The MoLHSA plans to gradually make electronic prescriptions mandatory across the country by 2020 (9).

NCDs including mental health

As discussed above, the major challenges related to overall mortality and morbidity in Georgia are associated with NCDs. The burden from NCDs is high for the population and for the health-care system. NCDs such as cardiovascular diseases, cancer, diabetes and chronic respiratory diseases have common risk factors: tobacco use/passive smoking; high intake of unhealthy fats, salt and sugar; low physical activity; and excessive use of alcohol (9).

The trend since the late 2000s indicates that 10% and 13% fewer premature deaths could be attributed to ischaemic heart disease and cerebrovascular disease, respectively, while 100% and 50% more premature deaths could be attributed to hypertensive heart disease and diabetes, which occupy fifth and seventh place, respectively, among the diseases that cause premature death. Fewer premature deaths linked to ischaemic heart disease could be associated with the improved availability of and access to invasive cardiac interventions in the country. The substantial increase in recorded deaths from hypertensive heart disease could be explained both by procedural factors (e.g. improved registration of cases through increased access to services) and by health-related factors (e.g. suboptimal management in PHC) (52).

The recently established national population-based Cancer Registry has significantly improved the epidemiological surveillance of cancer. Following the launching of the registry, 10 931 new cases of malignant neoplasms (including non-melanoma skin cancers and cancers in situ) were registered in 2015 (293.4 per 100 000 population). In 2016 and 2017, there were 10 444 and 9485 registered cases, respectively (incidence per 100 000 population of 280.2 and 254.4, respectively) (21,69).

As in the rest of the WHO European Region, rates of diabetes have increased in Georgia in recent years. The 2014 rate in Georgia (2.2%) was similar to the average for the CIS (2.3%) but lower than that for the WHO European Region (3.8% in 2013) (29). Diabetes is one of the major public health concerns in Georgia. According to the NCDC, prevalence of diabetes is increasing: in 2017, 90 599 per 100 000 population had type 1 or 2 diabetes and the incidence was 21 822 in 2017 for type 1 and 2 diabetes (21).

In 2016 chronic obstructive pulmonary disease contributed 73.8% of all registered cases of lower respiratory disease, with a prevalence of 213 per 100 000 population in 2017 (NCDC data). Bronchitis is the most common chronic obstructive pulmonary disease diagnosed in Georgia's PHC facilities. WHO estimates that mortality rates for diseases of the respiratory system in Georgia are almost three times lower than for the WHO European Region, the EU and the CIS countries (26). Presumably, such a big difference reflects incomplete registration in Georgia.

According to the STEPs NCD risk factor survey in 2010, only 4.5% of respondents did not have any risk factors for a NCD, and about 40% had three or more risk factors for NCDs (1).

Mental health

Georgia recognizes that good mental health is a fundamental component of human health and is an indispensable condition for the well-being of society. Protection of the rights of people with mental disorders is an obligation of the State, and Georgia defines the legal and institutional basis for psychiatric care. The Law on Mental Health Assistance was adopted in 1995 and was replaced by the Law on Mental Health Care in 2006. The 2006 Law clearly marks progress in this field, although further improvements are needed to fully correspond with WHO directives and regional standards of human rights.

The MoLHSA elaborated the Mental Health Strategy and Action Plan for 2015–2020 in 2014 (41). This reflects the vision of mental health improvement in the country over this five-year period. It defines the values and principles that form the basis for the design of the mental health system and outlines the needs to be addressed by the system.

The priority directions set forward by the Strategy are to increase geographical and financial accessibility of the population to mental health care and to establish a system of mental health care based on balanced, integrated and consistent care principles.

As declared by the Strategy, the State has the responsibility to support, protect and ensure the realization of equal rights and basic freedoms for people with disabilities, including those with mental health problems, as well as to ensure respect for their intrinsic personal dignity (61). The mental health system should be flexible and sustainable, focusing on the reduction of stigmatization, concentrating on needs and results, ensuring high standards of care and treatment and allowing rightful distribution of financial burden (41).

Several stages can be distinguished in the process of reforming the Georgian mental health-care services. The doubling of the State budget for mental health since 2004 has allowed the MoLHSA to gradually scale up mental health services, including the improvement of the quality of treatment, renovation of some of the main psychiatric institutions, the improvement of living conditions for patients undergoing forensic treatment, and the launch of a psychosocial rehabilitation programme. In addition to the Strategy and the Action Plan, the MoLHSA has approved 10 guidelines and protocols in the field of mental health.

The most important component of the new reform, deinstitutionalization, took place in summer 2011. One of the priorities of the reform has been professional development of the mental health workforce. The Strategy and the Action Plan stresses the importance of mental health care and of ensuring a balance between providing community-based and hospital-based mental health services (41).

Georgia spends quite a considerable portion of the budget allocated for mental care (71.8%) on provision of inpatient mental care. The other 28.2% is allocated for non-hospital services or for care services for children and adults. Inpatient expenditure has changed little since the late 2000s, although non-hospital expenditure has been regularly increasing since 2014. This ratio of spending on inpatient and non-hospital services greatly differs from the ratio in other European countries, where just 9–31% is spent on inpatient care and a much bigger share is provided for non-hospital services (75). The Strategy and the Action Plan targets this ratio of inpatient to non-hospital care and intends there to be an even 50%–50% split by 2020.



Youth

The Georgian National Youth Policy defines youth as those aged 14 to 29 years (76). It is a conceptual document developed by the Ministry of Sports and Youth Affairs, UNFPA and UNICEF to act as a reference for all relevant State organizations, self-government, NGOs, international organizations active in Georgia and academia. The Policy recognizes and commits to meet young people's needs for education, SRH services, employment and participation in decision-making, alongside provision of age-appropriate information about gender equality, SRH and rights, HIV prevention and family planning, using both formal and informal channels, such as through peer education programmes. The Policy was followed by the Georgian Action Plan for Development of the State's Youth Policy 2015–2020 (77), which covered all specific programmes, projects and activities to ensure effective implementation of the Youth Policy.

Young people's SRH is a sensitive and rather a taboo issue in Georgia; consequently, it is essential that the Government takes action for creating the moral space needed to make improvements in this field (78). The lack of understanding of young people's knowledge, attitudes and behaviour, as well as their information and service needs, is a substantial impediment for developing needs-oriented policies and programmes. Moral and practical support from the Government is particularly needed in the process of introducing school-based Healthy Lifestyles Education 4, which was launched in 2014. An assessment of the possibilities for creating special youth-friendly SRH services revealed that the conditions are not yet favourable (unpublished report). Therefore, one of the strategic priorities of Georgia Maternal and Newborn Health Strategy 2017–2030 (28) is to strengthen the stewardship role of the Government of Georgia in improving SRH of young people, through supporting their training and creating an enabling environment for the integration of youth-friendly SRH services.

Equity issues and regional disparities

The Government of Georgia has demonstrated its commitment to equal access to health care over many years, as declared in Health 2020 (3). Notable progress has been made in improving the health status of the entire population and in addressing major risk factors and threats to health. Georgia's progress towards the Health 2020 targets has been significant but so far not consistent (29). The introduction of the UHCP in Georgia has improved overall level of equity, as many households near the poverty line could then access necessary health services. However, geographical variation in outpatient contacts indicates that there may be serious inequalities in access to care across the country, with huge discrepancies between rural areas and Tbilisi (9,68,79).

The UHCP has become the fastest growing social programme. However, the service delivery structure is skewed towards the costly hospital and emergency services because of fragmentation of the PHC system and misplaced incentives for the providers. The fragmented PHC system offers little value for money for patients relative to specialist or hospital care. Moreover, PHC providers are paid a fixed rate per patient, which creates incentives for the doctors to push higher-risk patients towards hospital care. Hospitals are paid based on activity, which creates incentives to pull patients towards ambulance and inpatient care, and towards emergency care in particular.

According to the Health Utilization and Expenditure Survey in 2017 (unpublished data), health service use has increased, particularly in rural areas and among the poorest households,

narrowing the gap between rich and poor. In 2017 almost 82% of the population sought care if ill in the six months preceding the survey compared with 79% in 2014. Most notable improvements in access were observed among the poor. Within the poorest quintile, those seeking care when ill rose from 70.9% in 2014 to 77.8% in 2017. The difference between the poorest and the richest quintile in seeking health care has also narrowed substantially: 12.8 percentage points in 2014 to 6.6 percentage points in 2017. The average number of consultations per person increased from 0.9 in 2014 to 1.5 in 2017 (0.9 to 1.2 outpatient consultations, respectively). The number of consultations per person in 2014 and 2017 among the poorest quintile increased from 0.9 to 1.3 and among the richest quintile from 1.3 to 1.6. Yet a large percentage of the population continued to seek outpatient care directly from hospitals (almost 32% in 2017 compared with 31% in 2014) rather than through PHC.

Limited coverage of outpatient medicines by the public sector means that patients have little choice but to pay OOP for drugs at pharmacies. This increase the risk of impoverishment from OOP costs, creates barriers for accessing timely preventive care services and is associated with an overreliance on costly hospital and emergency care services where medicines are fully covered under the UHCP. The current reimbursement and purchasing mechanisms further contribute to inefficient spending (10).

Based on Health Utilization and Expenditure 2017 survey data, chronic diseases are slightly more prevalent in rural areas, affecting 37.3% of the rural population and 36.6% of the urban population. Meanwhile, the incidence of acute illnesses seems to have increased slightly in urban areas and decreased in rural areas. In urban areas, the proportion of the population reporting at least one acute illness in the previous 30 days rose from 8.9% in 2014 to 10.5% in 2017, while in rural areas it fell from 8.2% to 7.1%.

Across Georgia, the decrease in rural population (a fall of 23.38% between 2002 and 2014) has been much more pronounced than that of the urban population (a fall of 6.3%) and, as a result, the urban/rural pattern of population settlement in Georgia has changed significantly, with the urban population now accounting for 57.4% of the total (79). However, while the policy changes improved access to care for rural residents, it also led to inequity between rural and urban communities: a recent study has revealed that access to PHC providers was higher and self-treatment practices were lower among rural residents compared with the urban population.

The Rural Development Strategy of Georgia 2017–2020 defines the poor access to health care as one of the main problems along with the weak economic diversification, migration, extreme poverty and poor infrastructure (12).

In fact, more than 48% of the country's total added value is created in Tbilisi, which is where urbanization of Georgia's economy is concentrated. In order to address this imbalance, the Rural Development Strategy aims to ensure the constant improvement of the quality of life and the social conditions of the rural population, based on a combination of increased economic opportunities, more accessible social benefits, richer cultural life, environmental protection and the sustainable management of natural resources.

Although there are a large number of trained doctors in the country, they are mostly concentrated in big cities. In Tbilisi proper there are approximately three times as many doctors as in the regions of the country (9,12).



The gender gap still determines a range of health outcomes. The gender gap in life expectancy has been decreasing since the late 2000s but the difference in life expectancy between men and women is still almost 10 years (see Fig. 2).

More studies are needed to evaluate the overall picture of health equity in Georgia, including the distribution of health outcomes between the rich and the poor, the privileged and the marginalized, and the urban and rural populations. Addressing the social determinants of health is a challenging task for the Government. Health and well-being goals for all can be supported by reducing inequalities in income, wealth, education, health-care services and access to power. All sectors have to work together to address the factors that influence health, including employment, housing, education, health care, public safety and food access.

Formulation of health and well-being accelerators for sustainable development is a very important issue for the country, with the most important health and well-being needs identified for selecting accelerators and drivers and bottlenecks identified. Based on the analyses in this report, several accelerators were identified for Georgian health-care system:

- strengthening health systems for UHC, including enhancement of PHC;
- improving health financing and finance allocation;
- strengthening national health information systems and digital health;
- identifying and removing barriers and bottlenecks to policy implementation; and
- addressing health determinants by promoting multi- and intersectoral policies, social inclusion and gender equity, and leaving no one behind.

The commitment to leave no one behind underlies all the SDGs not only SDG 3.

All these complex challenges requiring action across sectors. Better synergy and calibration of interventions from a health and well-being perspective are needed to effectively address determinants of health. Evidence-informed interventions with known multiplier effects, as well as particular combinations (baskets) of interventions, can also accelerate progress.

5. Key bottlenecks and problems in implementation

Several general bottlenecks were identified for Georgia during the MAPS mission in May 2019:

- need for evidence-informed policy-making, planning, implementation, monitoring and evaluation;
- limited progress in implementation of national policies/strategies/plans (e.g.the Youth Policy Action Plan);
- need for better intersectoral coordination between government agencies and other stakeholders; and
- constrained human resources (capacities), finance.

A range of health-related targets as well as bottlenecks and problems require to be specifically addressed.

Maternal and neonatal health

There has been a significant progress in maternal and child health since the end of the 1990s in Georgia largely achieved through streamlined actions, among them the regionalization of perinatal health services and the implementation of the Georgian Birth Registry. Nevertheless, several important challenges need to be met to achieve international targets in the field of maternal and neonatal health.

The ongoing programmes and the financial resources allocated for their implementation are mostly defined by a case-planning system. In addition, there are no surveys that assess the services provided or patients' satisfaction with medical facilities. An integrated system for monitoring and evaluation of the State programmes needs to be elaborated and enforced.

The State Regulation Agency for Medical Activities under the MoLHSA has the task of protecting patients rights in terms of the quality of health-care services. The Agency is formally responsible for issuing and controlling the licences and permits for health-care facilities and for regulating medical professionals and pharmaceuticals. However, a regular analysis of the legislative environment and patients' needs is required to address identified gaps and implement more effective response mechanisms.

Although antenatal care coverage with four full visits is relatively high (84.6%) in Georgia, this has now been extended to up to eight visits. There are discrepancies between rural and urban residents in the initiation of the first visit before 12 weeks of pregnancy (86% in rural areas compared with 93% in urban areas). This may reflect the low level of awareness of the population about the importance of antenatal care and there may be a correlation between this variable and the socioeconomic condition, age and education of mothers. At the same time, preconception and postpartum care in Georgia is largely nonexistent and gynaecological routine health-care visits (outside pregnancy) are rare. Postnatal care services are integrated under the UHCP. Despite the national antenatal care protocol requiring a postnatal care consultation within three days of discharge from a maternity care facility, women use it rarely. According to the Reproductive Health Survey 2010, only 23% of women received postnatal care and only 31% of women who received postnatal care made a postpartum visit within one week after birth, as recommended



by WHO. Although the coverage of institutional deliveries increased from 92% in 1999 to 99% in 2010, some obstetric care facilities have fewer than 500 births a year. Mechanisms are being implemented for timely detection of high-risk pregnant women and newborns and for proper referral to the appropriate levels of care or information sharing and feedback between the different levels of care (PHC, women's consultation centre, maternity hospital, referral maternity hospital). Often, maternity hospitals, particularly in rural areas that lack capacity to deal with obstetric and neonatal emergencies (e.g. shortage of personnel, medicines, equipment or blood bank), either do not perform referral to the higher-level facility or make referrals but with substantial delays. A well-organized and centrally coordinated transportation system is an essential part of an effective referral system, but this is not sufficiently developed in the country as yet (28).

Another important issue is a lack of professional or financial incentives for health-care providers, which results in a high staff turnover and, eventually, shortages, particularly in rural areas. This creates unacceptable barriers to access adequate health care.

Ensuring quality of care requires specific, evidence-informed standards of care and a process to ensure implementation of these standards. Currently such standards are either missing or not operational. The use of national guidelines and protocols by health-care providers in routine practice is quite limited, which greatly affects the quality of provided care.

Communicable diseases

HIV/AIDS

Georgia has achieved significant progress in several directions in the fight against HIV/AIDS, especially in treatment outcomes, but a number of challenges remain.

Timely detection and inclusion in treatment. The significant gap in the diagnosis stage undermines accomplishments in treatment provision. On a population level, only 35% of PLHIV achieve viral suppression, which is insufficient for maximum individual and public health benefits of ART. Despite efforts, coverage with preventive services and uptake of tests remain serious issues for HIV/AIDS national response in Georgia. Stigma and discrimination associated with HIV and HIV-associated specific behaviours also impact on uptake of testing and treatment.

Data collection and disaggregation. Routine statistical reporting, monitoring and evaluation systems for HIV are integrated into the national reporting systems but challenges remain in the standardization of data collection and disaggregation.

Financing. With decreasing financial support from the Global Fund, it is vital that the Georgian Government gradually takes financial responsibility to cover activities previously funded by the Global Fund (80). The primary challenge is that all outpatient care and support activities are entirely supported by donor funding, which include adherence promotion and support services, home-based palliative care for chronically ill people and community-based self-support services. The change in funding provision will also require close collaboration with NGOs that have been implementing activities since the late 1990s. HIV-related research, including second-generation studies (population size estimation studies, bio-behavioural surveillance among key affected populations), are also donor funded and advocacy work

should be in place during the transition period to ensure that the Government of Georgia incrementally increases funding for surveillance studies.

TB

Despite the important positive developments achieved in TB control, Georgia continues to face a number of serious challenges.

Epidemiological change. First and foremost, the high burden of drug-resistant TB threatens to reverse the recent positive trends and further increase the overall economic and social burden of the disease. The very high rates of treatment interruption are attributed not only to the difficulties patients face in completing the lengthy (up to two years) course of therapy through social and economic circumstances but also to insufficient adherence support and failures by health-care providers to manage complications of treatment related to comorbid conditions and adverse drug reactions.

Poor outcomes of treatment for drug-resistant TB. Novel treatment approaches are required that revise current treatment regimens (including scaling up the use of new drugs) and that also strengthen the use of patient-centred approaches with appropriate patient support to ensure compliance with treatment. Patient support includes not just provision of incentives but also a broader set of adherence determinants.

TB/HIV coinfection. The burden and impact of TB/HIV coinfection in Georgia has been underestimated and needs to be addressed through strengthened collaborative activities between the two national programmes, including more active involvement of civil society, particularly in addressing the needs of the most-at-risk population groups.

Incorporation of TB care into wider health sector developments. The National TB Programme requires strengthened governance and management and adjusted financing and allocation arrangements. Proper attention should be given to the development of the required human and infrastructural resources for providing essential TB services to the entire population as part of work towards provision of UHC.

Financing. Georgia is currently dependent on external support (primarily from the Global Fund) in financing key TB control activities, including procurement of drugs and laboratory equipment and supplies, adherence support and support for essential functions such as training and supervision. In view of the fact that external funding support is decreasing with time (80), there is a stringent need to ensure a substantial and rapid increase in the Government financing of these components, particularly those related to complex and costly drug-resistant TB management interventions.

Hepatitis C

The main challenges of the national Strategic Plan for Elimination of Hepatitis C in Georgia relate to the effectiveness of awareness-raising activities; coverage of harm-reduction services for PWID due to the strict drug policy and the stigma related to drug use; inadequate infection control measures in health-care facilities; and declining rates of linking those who test as positive for hepatitis C with the care and treatment services.



NCDs

Based on surveillance of NCDs and related risk factors, there is a need to reorientate primary and secondary prevention, disease screening and management mechanisms. It will be critical to establish and maintain sustainable surveillance through continuing the STEPS surveys every three to five years to assess and estimate tendencies; provide baseline data for further in-depth analysis and identification of potential solutions; and to inform government and nongovernment stakeholders in view of increasing capacities/coverage offered by the State Health Insurance Policy with regards to NCD management and treatment. Further research would also be valuable to inform policy-makers and other partners/donors on needs (e.g. intervention research examining NCD prevention measures and evaluation of the impact of health insurance/allowance for NCD drugs on treatment compliance). The need for capacity-building in PHC with an emphasis on NCDs and health promotion is evident. In addition, information, education and communication materials are required to ensure provision of good health-related information for the population as well for specific groups.

Road safety

Georgia is making progress in road safety, but current efforts are insufficient to achieve the desired progress. The key road safety problems need to be measured and reported transparently, the level of improvement targeted and progress monitored. Addressing these will involve improving all components of the road traffic system (planning, design, construction and use of roads, mandatory periodic roadworthiness tests for motor vehicles, vehicle safety standards and compliance, driver and rider licensing standards, user compliance with key road safety rules, and the emergency medical system and trauma care).

SRH

While many national policies recognize the need to address challenges associated with the limited access to family planning services and information, by and large, they lack detailed accounts as to how this should be done. Overall, the Government so far has failed to provide an adequate, supportive environment for effective family planning services, largely because family planning services are not integrated into the PHC system and funds are not allocated for provision of modern methods of contraception. Other challenges include the low level of use of contraceptive methods, which reflects inadequate knowledge of the use of the range of contraceptive methods and their affordability, as contraceptives are not funded by the State's health programmes. In Georgia, there is no official essential medicines list where contraceptives could be added. A core human rights requirement under the right to health is to ensure that contraceptives, including emergency contraception, are included in a country's essential medicines list, which ensures availability and accessibility, including affordability, of these medicines for all. There is a shortage of information on the full range of modern contraceptives available on the market. In addition, while emergency contraception should be available without a prescription, practice seems to be inconsistent, with provision sometimes without a prescription while at other times requiring a prescription, leading to an unacceptable delay. The low use of contraceptives is also attributed to misconceptions among the population about possible side effects (e.g. that contraceptives are harmful to health, hormonal contraceptives cause cancer, and the pills may result in infertility). Lack of affordability, together with the lack of overall accurate information on effectiveness of modern contraceptive methods, contributes to their low use. Full access to

accurate contraceptive information is essential for informed consumption for all, including for adolescents and youth, yet there is a lack of comprehensive youth friendly services (78).

Health workforce

Human resources is one of the most important components determining performance of a public health system. The problems with quality assurance in medical education in Georgia have been repeatedly admitted. The Ministry of Education has already developed proper standards based on the Bologna requirements, and the National Centre for Educational Quality Enhancement is responsible for controlling and monitoring those standards. Moreover, most Georgian medical training centres are part of the International Association for Medical Education, with Tbilisi State Medical University acting as focal point since 2019. The accreditation of faculty programmes needs to be strengthened and high-quality standards set to ensure progress in this area.

However, numbers of qualified personnel are not simply insufficient overall, there is the problem that they are also concentrated in the capital. This uneven geographical distribution is one of the greatest obstacles for access to quality medical services in the country.

There is no specialization, licensing or continuous medical education opportunities for nurses in Georgia and no degrees beyond the undergraduate level. Overall, nursing education lacks standardization; there is no accreditation for nursing schools, and minimum training requirements vary widely (9).

UHC

UHC was discussed above as an accelerator for health systems strengthening. Currently, the UHCP in Georgia has key challenges including:

- limited administrative capacity in the Social Service Agency;
- lack of financial resources for PHC (per capita cost rate does not reflect real service costs);
- low use of preventive services;
- lack of monitoring and evaluation of the Programme; and
- overspending of the Programme's budget (52).

People-centred integrated health services with quality and accessible PHC are fundamental to advancing UHC. For example, the immunization programme is implemented within PHC and some of the specific challenges for this programme are sustainability in view of gradual reduction of donor support, development and introduction of a performance-based payment mechanism; and institutionalization of the best vaccine management practices.

Pollution

The current regulatory framework for ambient air protection is considered ineffective in regulating emissions from transport and other economic sectors. The national limits for most common pollutants are not in line with EU standards. In addition, the lack of statistical data that can allow emission inventory and the identification of pollution sources hinders effective planning.



The current chemicals management system in Georgia is rather weak. An incomplete legal basis (except for the legislation related to pesticides and agrochemicals) and a lack of data are among the major challenges hindering the introduction of the European practice of chemicals management in Georgia. Information necessary for the management of chemicals is also lacking.

Drug abuse policy

The country has developed and operates a number of laws and legal regulations that regulate illegal narcotic drugs and/or psychotropic substances and rotation of legitimate drugs. Current drug legislation is focused only on punitive measures. According to the order of the President of Georgia, the Interagency Coordinating Council for Combating Drug Addiction was created in 2011. The Coordinating Council includes representatives from a number of ministries (Ministry of Education; Ministry of Finance; Ministry of Internal Affairs; Ministry of Justice; Ministry of Labour, Health and Social Affairs; Ministry of Sport and Youth Affairs; and MoLHSA), the Prosecutor's Office, the Supreme Court and the Parliament of Georgia.

The main objectives of the Coordinating Council were to define policy built on the principles of prevention of drug abuse and protection of human rights and to elaborate a State strategy on combating drug addiction and the relevant action plans.

The 2013 State Strategy on Drug Abuse was approved by the Parliament of Georgia. The Coordination Council then approved the Action Plan for 2014–2015 and the Action Plan for 2016–2018, which included measures for preparation of legislative amendments, reduction of risk and modification of drug policy (prevention, treatment and rehabilitation).

Strict drug policy complicates the implementation of treatment/rehabilitation and prevention programmes. This adds to the country's inadequate efforts in prevention and treatment/rehabilitation. Additionally, the socioeconomic condition of drug-addicted people and their families is aggravated by fines imposed by the State, plea bargains and so on.

In order to solve such problems, existing drug policy needs to change. In 2017 drug policy reform was proposed by the Georgian National Narcotic National Platform and initiated by members of the Parliament. This included decriminalization of drug use, liberalization of sanctions for drug offences, fair definitions for narcotic drugs and improved rights for those convicted of drug offences.

Provision of data to support evidence-informed policy-making

Indicators for monitoring and evaluation provide an opportunity to alter programmes based on evidence. Up to now, in the most cases, such indicators have not been included in the health-care programmes of the MoLHSA. State programmes do contain an administration/inspection component, but this does not ensure their full evaluation. The financing component does not include an indicator that would support improvement of quality services. To ensure better functioning of the system, it is necessary and desirable that all State health-care programmes include a monitoring and evaluation framework and indicators.

The collection of data for many indicators is difficult and costly. The results are hard to interpret and often do not meet basic quality criteria of relevance, reliability and validity. It is a major challenge for the MoLHSA to collect information and to make evidence-informed decisions.

The national population surveys produce nationally representative and internationally comparable estimates of demographic, health and social indicators. These surveys are the most appropriate, if not the only, data source for monitoring health trends in the population, including nonmedical determinants of health such as exposure to risk factors for chronic disease, knowledge about disease transmission and treatment, self-reported health and prevalence of symptoms, and coverage of services. Consequently, it is vital to conduct population-based surveys and evaluate progress towards the most important health-care objectives. Both quantitative and qualitative health data need to be user friendly at national and local levels.

Overall, the country has only a weak concept of the type of information needed for what type of decisions (strategic, operational); where this information should come from (e.g. routine data collection or surveys including population ones); who should process information and generate evidence; and, finally, who must use this information to assess the success of policies and programmes. The health information system needs to be strengthened and standards and best practices should be used for data sources. Improving information flow is critical to making the monitoring and evaluation system more efficient. Population-based surveys are an invaluable source of health information. Policy-makers need data for wise, evidence-informed decision-making and information-driven policy. Bridging the gap between data collection, research and policy-making remains a major challenge for Georgia.



6. Recommendations for the future work

Based on the analysis of the information provided in this report, the following recommendations can be considered for improving the state of implementation of the SDGs in the health sector.

Strengthen the health system in Georgia for UHC. This will help to achieve better health outcomes and enhance equitable access, quality and safe health care.

Strengthen PHC. PHC is a core component to ensure the delivery of high-quality and integrated health-care services that meet the needs of the population, particularly in view of the growing burden of NCDs. A patient-centred health-care approach at the PHC level will support moves towards UHC.

Support health financing. Mobilization of domestic resources and improved public investment mechanisms in the health and social sectors are required in order to deliver quality prevention, treatment, care and support services. Ensuring the health and well-being of population is an essential step towards sustainable development.

Address health determinants through multi- and intersectoral policies. Investing in health promotion and health prevention can be cost-effective and can contribute to wider sustainability by generating economic, social and environmental benefits. It includes investing in interventions that address the environmental and social determinants of health; build resilience of individuals, communities and society; and promote healthy behaviours. Intersectoral collaboration for promoting better health and health protection and strengthened cooperation on national and international levels will help to address the root causes of ill health and to respond to the challenges of NCDs, substance abuse, air pollution and other issues;

Adopting the Health in All Policies approach. Implementation of this approach requires whole-of-government and whole-of-society actions.

Enhance national health information systems and digital health. A stronger, more-accessible and sustainable evidence base is needed for health policy-making. Standards for evidence need to be elaborated, implemented and monitored in order to guarantee the consistent improvement of the quality of health care. Links between surveillance, research, policy and practice need to be enhanced.

Leave no one behind. Achieving this goal requires that issues of equity in the health sector should be assessed, measured and analysed and the results should be integrated into policy planning. Issues to consider include equity of utilization of health care; distribution of services based on the needs of the population and population subgroups; and equity in access to health services, including consideration of regional and socioeconomic disparities.

7. Conclusions

The overview of the current state of the health-care sector in Georgia in light of the implementation of the SDGs demonstrates significant achievements. However, challenges and bottlenecks remain in different areas that need further responses and sustained Government commitment.

A priority is the delivery of high-quality health services to ensure universal access to health care, maternal and child health, SRH, and care for communicable diseases and NCDs. Furthermore, as health-care quality is strongly related to the quality of the health workforce, targeted capacity-building and education programmes need to be put in place. The quality of the Georgian health-care services would be strengthened by reforms in medical education, including improving the post-diploma education system. On the one hand, this will improve the results of preventive measures and treatment for patients and, on the other hand, it will reduce expenses for health-care facilities. The patient-centred health-care approach should be implemented fully. Inefficient use of medical services should be discouraged more actively. Health services must be accessible, available, acceptable and of good quality for everyone, on an equitable basis, where and when needed.

Noting the remarkable progress Georgia has achieved since the late 2000s, all stakeholders acknowledge the need for continued public investment in the health sector. Despite significant increases, public spending on health remains low compared with most Member States of the WHO European Region, while OOP payments are high. Strengthening leadership, governance and investment for health will help to maximize co-benefits for health and sustainable development and achieve the highest attainable standard of health and well-being for all at all ages and for future generations; There are gaps in equal and universal access to social and health services and, therefore, eliminating inequity in provision of social and health services is a big challenge for the Georgian Government. Policy decisions are needed to tackle health and social inequities across the country.

Government efforts with regard to developing strategies and action plans in the health sector are to be admired. Nevertheless, the mechanisms for their intersectoral implementation, monitoring and evaluation are limited. It is essential to sustain and enhance the implementation of existing strategies, action plans and programmes, putting in place an effective monitoring and evaluation process and ensuring intersectoral coordination.

A successful sustainable development agenda requires meaningful engagement of different sectors of society as critical stakeholders, acting in support of government-led efforts at all levels in accordance with national priorities, policies and mechanisms. Indeed, implementation of the health and well-being priorities will only be possible with the collaboration of sectors and partners outside of the public health sector, using an intersectoral approach to policy development and implementation.

Following the SDGs, the Government of Georgia continues to work on strengthening the health-care system towards achieving quality health care for all citizens of Georgia. Going forward, it remains important to closely monitor the progress and the impact of these actions on the health and well-being of the population in the country.



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Annex 1. The priorities of the Georgian health-care system defined in key strategic documents and their relevance to the SDGs

Title of the document	Institution and date of adoption/ publication	Priorities	Relevance to specific SDGs
State Concept of the Healthcare System of Georgia for Universal Health Care and Quality Control for the Protection of Patients' Rights	Ministry of Labour, Health and Social Affairs of Georgia Government of Georgia Ordinance 724, 26 December 2014	<ol style="list-style-type: none"> 1. Health in All policies: general state multisectoral approach 2. Develop the health-care sector governance 3. Improve health-care financing system 4. Develop quality medical services 5. Develop human resources in the health-care sector 6. Develop health management information systems 7. Support maternal and child health 8. Improve prevention and management of priority communicable diseases 9. Improve prevention and control of priority NCDs 10. Develop public health system 	3
Vision for Developing the Healthcare System in Georgia by 2030	Healthcare and Social Issues Committee of the Parliament of Georgia, 2017	<ol style="list-style-type: none"> 1. Preserve the geographical accessibility of health-care services and ensure their continuity, with the primary focus on the development of preventive care and PHC; steadily improve the quality of medical services through the regulation of medical infrastructure, the qualifications of staff and the development of efficient quality management systems 2. Provide the health-care system with the needed number of motivated and qualified medical staff 3. Ensure access to basic and quality pharmaceutical products through the rational policy on pharmaceutical industry 4. Improve the efficiency of the system of health-care funding considering UHC principles 5. Develop an efficient system of administration in the health-care field, improve the general electronic system of health-care provision and develop a general state multisector Health in All polices approach 	3

contd.

Title of the document	Institution and date of adoption/ publication	Priorities	Relevance to specific SDGs
Vision for Developing the Labour and Social Protection Sectors in Georgia by 2030	Healthcare and Social Issues Committee of the Parliament of Georgia, 2017	<ol style="list-style-type: none"> 1. Increase opportunities for employment and earning income 2. Elaborate a system of social protection and old age pension 3. Create a social protection system at local and central levels 4. Strengthening community-based services, the role of social workers and other social services 5. Focusing the social protection system on the child and on family strengthening 6. Inclusion of people with disabilities into society 	1, 3, 8, 10, 16
Social and Economic Development Strategy: "Georgia 2020"	Government of Georgia Government of Georgia Decree No. 400, 17 June 2014	<ol style="list-style-type: none"> 1. Private sector competitiveness <ul style="list-style-type: none"> • improve investment and business environment • support innovation and technologies • facilitate the growth of exports • develop infrastructure and fully realize the country's transit potential 2. Human capital development <ul style="list-style-type: none"> • develop the workforce to meet labour market requirements • tighten the social security net • ensure the accessible and quality of health care 3. Access to finance <ul style="list-style-type: none"> • mobilize investments • develop financial intermediation 	1-4, 7-11, 15-17
The Demographic Security Concept	Resolution of the Parliament of Georgia 5586-II, 24 June 2016	<ol style="list-style-type: none"> 1. Birth, sexual and reproductive health 2. Mortality and morbidity 3. Migration 4. Population structure and population ageing 	3, 5, 8, 10, 17
Georgia Maternal and Newborn Health Strategy 2017-2030	Ministry of Labour, Health and Social Affairs of Georgia Government of Georgia Decree No. 459, 6 October 2017	<ol style="list-style-type: none"> 1. Provide access to evidence-based preconception, antenatal, obstetric and neonatal and postpartum care that meets women's needs 2. Improve quality of maternal and neonatal health services 3. Improve awareness and knowledge of general population about the healthy behaviours, medical standards of high-quality care and rights of patients 4. Provide easily accessible family planning services for all who need them 5. Ensure the quality of family planning services meets international standards 6. Ensure young people are sufficiently educated on SRH issues and have full access to those services 	3, 5



contd.

Title of the document	Institution and date of adoption/publication	Priorities	Relevance to specific SDGs
National Tuberculosis Strategy and Operational Plan for Georgia 2019–2022	Ministry of Labour, Health and Social Affairs of Georgia (approved by the Georgian Country Coordinating Mechanism), 2018	<ol style="list-style-type: none"> 1. Provide universal access to early and quality diagnosis for all forms of TB including MDR-TB and XDR-TB 2. Provide universal access to quality treatment for all forms of TB including MDR-TB and XDR-TB with appropriate patient support 3. Enable supportive environments and systems for effective TB control 	3
National Strategic Plan on HIV/AIDS 2019–2022	Ministry of Labour, Health and Social Affairs of Georgia (approved by the Georgian Country Coordinating Mechanism), 2018	<ol style="list-style-type: none"> 1. Prevention and Detection: scale up preventive services to ensure timely detection and progression to care 2. Treatment and Care: improve HIV health outcomes through ensuring universal access to quality treatment, care and support 3. Governance and policy development: ensure sustainability of response to the epidemic through enhanced government commitment, an enabling legislative and operational environment and greater involvement of civil society 	3
Strategic Plan for Elimination of Hepatitis C in Georgia 2016–2020	Ministry of Labour, Health and Social Affairs of Georgia Government of Georgia Decree No. 1704, 18 August 2016	<ol style="list-style-type: none"> 1. Promote advocacy, awareness, education and partnerships for resource mobilization to combat hepatitis C 2. Prevent hepatitis C transmission 3. Identify people infected with hepatitis C 4. Improve laboratory diagnostics 5. Provide care and treatment 6. Improve surveillance 	3
National Strategy and Action Plan for Non-communicable Diseases Prevention and Control 2017–2020	Ministry of Health, Labour and Social Affairs of Georgia, NCDC Government of Georgia Decree No. 2, 11 January 2017	<ol style="list-style-type: none"> 1. Strengthen national and international cooperation in order to recognize the high priority of prevention and control of NCDs for the country's health care system 2. Strengthen the capacity for prevention and control of NCDs in terms of development, implementation and evaluation 3. Improve monitoring and surveillance of NCDs and associated determinants 4. Modify behavioural risk factors for NCDs through raising population awareness and improving health promotion 5. Promote screening and management for biological risk factors and NCDs 6. Improve financial access to essential medical services and medicines for NCDs 7. Improve the quality of screening and management for NCDs and their risk factors 	3

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Mental Health Strategy and Action Plan for 2015–2020	Ministry of Labour, Health and Social Affairs of Georgia Government of Georgia Decree No. 762, 31 December, 2014	<ol style="list-style-type: none"> 1. Promote the mental well-being of the population 2. Prevent mental disorders 3. Protect the rights of people with mental disorders 4. Reduce the morbidity and mortality caused by mental disorders 	3
National Strategy and Action Plan for Combating Drug Abuse	Interagency Coordination Council for Combating Drug Addiction, 2016	<ol style="list-style-type: none"> 1. Prevention and education 2. Demand/harm reduction 3. Treatment and rehabilitation 4. Supply reduction 	3
Tobacco control strategy	Ministry of Labour, Health and Social Affairs of Georgia Government of Georgia Decree No 196, 30 July 2013	<ol style="list-style-type: none"> 1. Encourage smoking cessation through development of smoking cessation services for all groups of population 2. Prevent smoking, particularly in young people 3. Reduce the affect of secondary smoke (passive smoke) by raising population awareness on smoking and passive smoking 4. Strengthen and enforce tobacco control legislation, in particular with respect to penalties, in accordance with the WHO Tobacco Control Framework Convention 5. Reduce inequalities between population groups regarding tobacco-related issues 6. Establish international cooperation with neighbouring states, countries of the WHO European Region and other regions for effective action 7. Obtain and generate scientific evidence on the cost-effectiveness of measures to reduce tobacco consumption, its economic damage and preventive measures 	3
National Road Safety Strategy and Action Plan of Georgia	Ministry of Education, Ministry of Economy and Sustainable Development, Ministry of Internal Affairs, Ministry of Regional Development and Infrastructure, MoLHSA, Tbilisi City Hall Government of Georgia Decree No. 1386, 11 July 2016	<ol style="list-style-type: none"> 1. Move towards roads and traffic that are eventually free from death and serious injury 	3, 11



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Third National Environmental Action Programme of Georgia for 2017-2021	Ministry of Environmental Protection and Agriculture of Georgia Government of Georgia Decree No.1124, 22 May 2018	<ol style="list-style-type: none"> 1. Improve the status of the environment, ensure the protection/sustainable use of natural resources and prevent/minimize risks that threaten human health and the welfare of the population 2. Increase compliance with the obligations under regional and global environmental agreements to which Georgia is a party and move to align with the EU's overall environmental policies, framework legislation and directive-specific requirements 3. Increase the capacities of administrative structures required to ensure efficient environmental management and the enforcement of environmental legislation 	3, 6, 11–13, 15
National Youth Policy Document of Georgia	Ministry of Sport and Youth Affairs of Georgia Government of Georgia Decree No. 553, approved by 2 April 2014	<ol style="list-style-type: none"> 1. Participation 2. Education, employment and mobility 3. Health 4. Special support and protection 	3–5, 8, 10, 16

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