



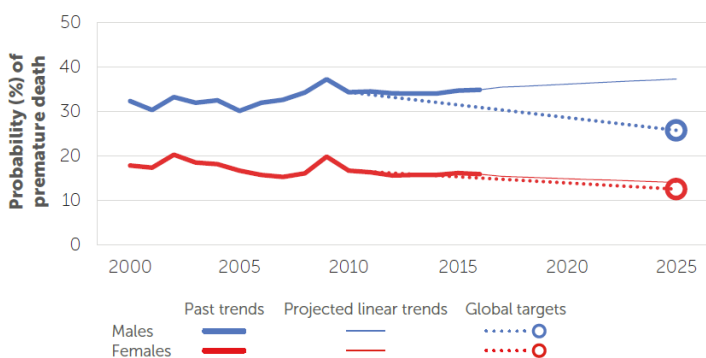
## GEORGIA Brief 2020

# GENDER AND NONCOMMUNICABLE DISEASES IN GEORGIA

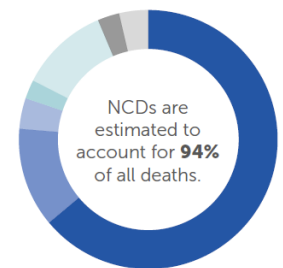
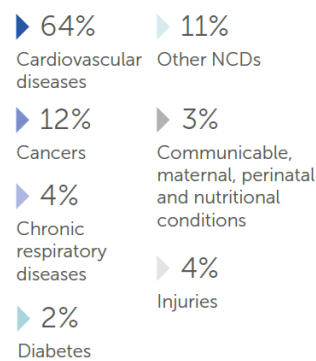
## Analysis of STEPS data

NCDs make the greatest proportion of the total burden of disease and injuries in Georgia affecting the most productive years of life. According to WHO 2018 Health Report, NCDs account for 97% of all deaths, among them 64% due to CVDs, 12.2% - cancer, 2.2% - diabetes, 4% - chronic respiratory diseases; they make influence not only on health but also on sustainable development of the country. Among CVDs the biggest share in terms of mortality and morbidity falls on Hypertension and tobacco.

### RISK OF PREMATURE DEATH DUE TO NCDs (%)\*



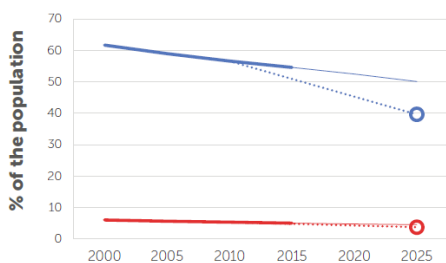
### PROPORTIONAL MORTALITY\*



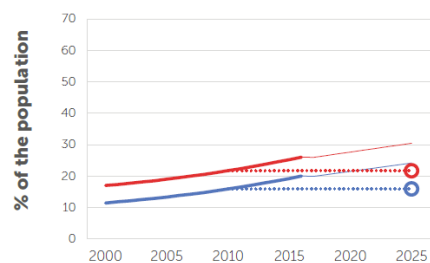
For the effective prevention and control of NCDs it is essential to have timely access to precise and reliable information, to monitor and interpret health indicators, to monitor and evaluate the impact of interventions. And for the effective NCD surveillance Georgia implemented The STEPwise approach that is giving us the unique possibility to compare the data not only with other countries but to monitor and evaluate patterns and trends of NCDs and risk-factors in Georgia.

Data on NCD risk-factors are important and thus with the assistance of the WHO and other international organizations we are using all possibilities to obtain the information on NCDs and their risk-factors through other surveys as well such as GYTS, RHS, Migrant Health Survey, HBSC, COSI, National Iodine Survey; we try to establish sentinel surveillance systems, registries such as cancer registry, birth registry, and etc.

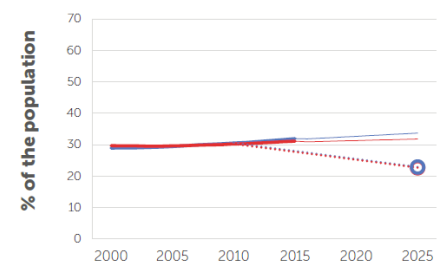
### CURRENT TOBACCO SMOKING



### OBESITY



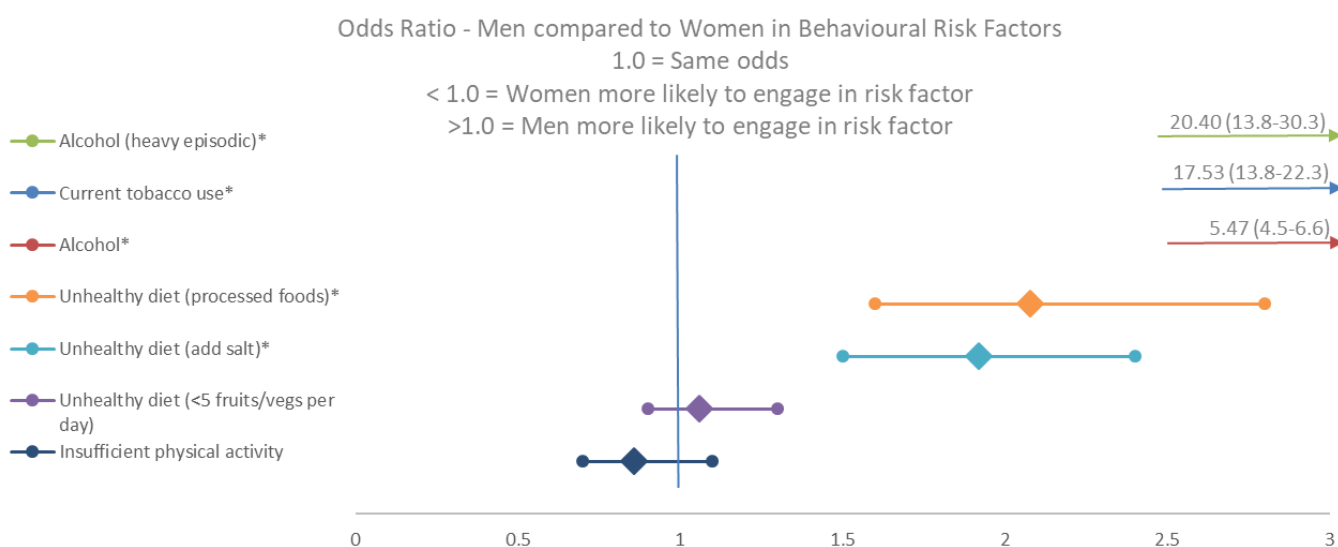
### RAISED BLOOD PRESSURE



Based on the information provided by the STEPS surveys the multisectoral state council on NCDs prevention and control was established in 2015; National Strategy of NCDs Prevention and Control and 4-year AP has been endorsed in 2017; and etc. Based on the STEPS and other survey data and according the strategy and AP the essential drugs for major NCDs for Georgia – IHD and stroke, asthma and COPD, Diabetes type 2 and etc. for the most vulnerable populations are arranged into the Universal Healthcare Program that is operational during the last 5 years and covers basic benefit package services and some medications at the primary healthcare level.

Gender analysis of NCD risk factor data for adults in Georgia makes an important contribution to, and serves as an evidence base for, enabling achievement of the SDGs, women’s and men’s health strategies, the European Action Plan for the Prevention and Control of Noncommunicable Diseases and other international commitments on NCDs, and promoting improved use of disaggregated data for better health outcomes, gender equality and human rights. It is also an important tool in accelerating action towards reducing the NCD burden and ensuring universal health coverage by unpacking inequalities by sociodemographic determinants in NCD risk factors and health system response, and contributes to raising awareness and building capacity among country-based researchers and policy-makers on the rationale for applying a gender analysis to health data.

Significantly higher percentages of men than women engage in all but one (insufficient physical activity) of the behavioural risk factors in most age groups, and significantly higher percentages of women than men are found with most of the biological risk factors in the older age groups. The percentage of men and women with multiple risk factors increases with each age group, but the increase for women is more drastic, causing the difference in percentage between men and women to lessen with each ascending age group. While the percentage of men nearly doubles from the 18–29 age group to the 60–69 group, the increase in the percentage of women is more than six times greater between comparable age groups. High prevalence of behavioural and biological risk factors for both men and women is concerning, but the greater prevalence for women in the older age groups, despite lower prevalence in behavioural risk factors, demands attention.



Differences between men and women in behavioural and biological risk factors overall and over the life-course are similar in migrant and general populations. Migrant women increase in risk with each ascending age group more than women in the general population, and migrant men increase in risk more dramatically than women through the 45–59 age group before decreasing to levels comparable to the STEPS surveys in the 60+ age group. The percentage of migrant women with multiple risk factors is nearly 10 times greater from the youngest to the oldest age group.

Men and women not only engage differently in behavioural risk factors, but also have different risk factor trajectories for both behavioural and biological risk factors over the life-course. Most notably, higher prevalence in biological risk factors is observed among women in the older age groups than men, while there is generally lower prevalence in the younger age groups among women than men. Higher levels of male premature mortality could also contribute to lower prevalence of risk factors among male survivors at older ages, but additional causes of difference in risk factors between men and women should also be explored. The importance of disaggregation by sex and age becomes apparent when significant differences are found to be hiding in the aggregated percentages of risk factors for men and women.

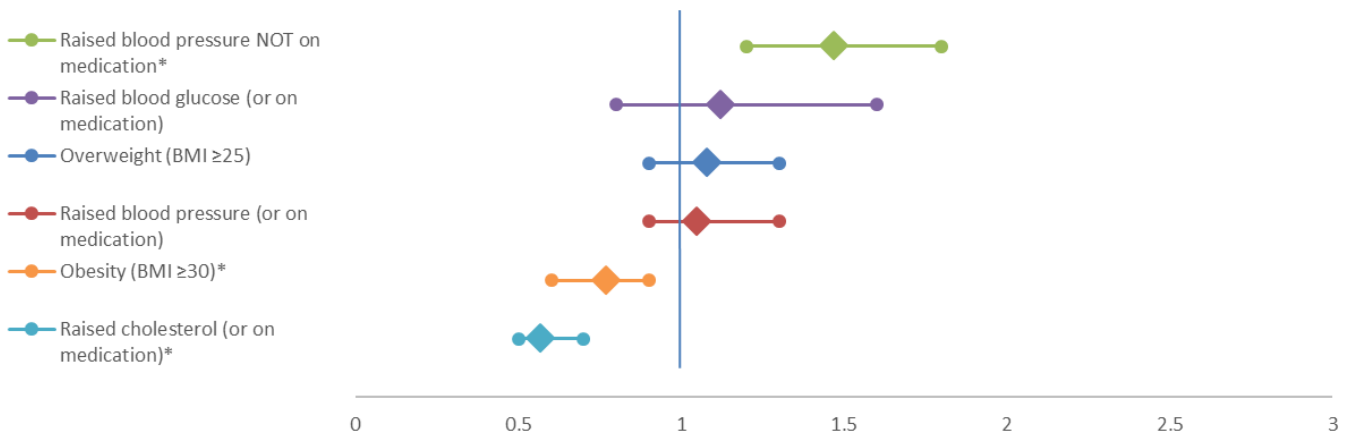
Higher prevalence for behavioural risk factors is generally found in urban areas, but there is variance. For example, higher prevalence of insufficient physical activity is found in urban areas for men and women, but while tobacco use is higher for women in urban areas, eating fewer than five servings of fruit and vegetables per day is higher for men. The prevalence of obesity for women is significantly higher in rural areas, while there is no significant difference for men. The prevalence of overweight is significantly higher in urban areas for men but significantly higher in rural areas for women.

### Odds Ratio - Men compared to Women in Biological Risk Factors

1.0 = Same odds

< 1.0 = Women more likely to engage in risk factor

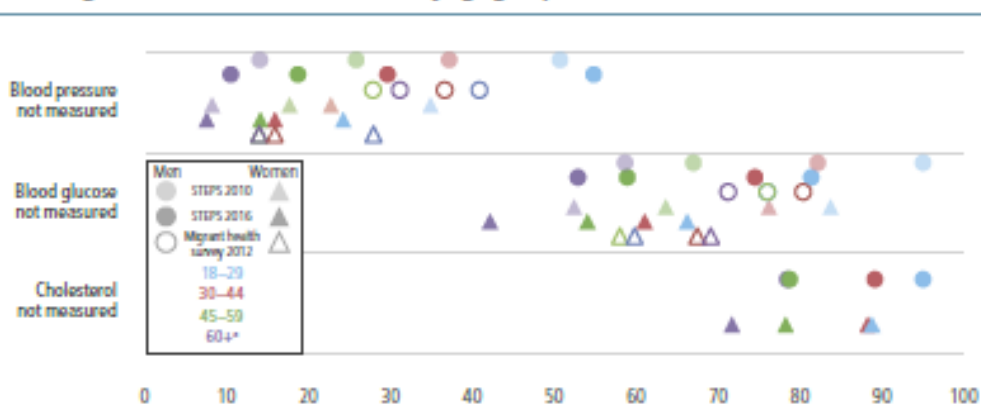
>1.0 = Men more likely to engage in risk factor



With biological risk factors, higher prevalence tends to be found in the low education level for women but in the high education level for men. There is less variance with employment status than geographic location or education, but a trend of those risk factors that reveal differences indicates more employed men and women engage in behavioural risk factors, while higher prevalence of biological risk factors is found among those who are unemployed or not in the labour force, especially for women.

Prevalence of some behavioural risk factors for men and women decreased from 2010 to 2016. Prevalence nevertheless is observed to increase with many biological risk factors, especially for groups more at risk, such as older age groups, urban men and rural women, low-education women and high-education men, and men and women who are unemployed or not in the labour force. While there are similarities between the migrant and general populations, risk factors tend to be higher with the migrant population and more variance is seen by demographic groupings such as education level, especially for men. There is also an opposite association by education level for overweight and obesity risk factors for migrant women than is observed for women in the general population.

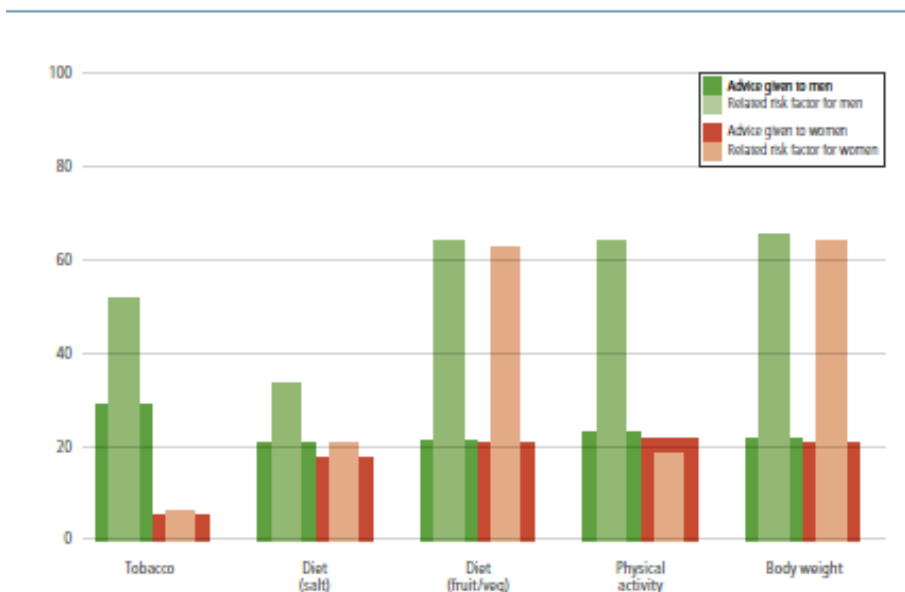
### Percentage not measured for risk factors by age group



Important differences between men and women are also observed in accessing services. A significantly higher percentage of men are not being measured for biological risk factors, while a significantly higher percentage of women than men are being given lifestyle advice on most behavioural risk factors. Despite accessing services more, the prevalence of biological risk factors as measured during the STEPS survey is still higher for women than men, or they are not significantly different. This may in part be due to the differences in accessing services among subgroups of men and women as observed through disaggregation by age, geographic location, education and employment status, among other reasons. Men and women also vary in accessing services by geographic location. Fewer men and women in rural areas than in urban have been measured for risk factors, though an increase has been seen from 2010 to 2016 in the percentage of rural men and women who have been measured.

Higher percentages of both women and men in the low and medium education levels than the high level have not been measured for risk factors.

The percentages of men and women who have reportedly received lifestyle advice are not significantly different. Most primary health-care protocols and guidelines are for both men and women, and this could in part explain the lack of difference between men and women receiving lifestyle advice, apart from tobacco use. A higher frequency of interaction of women with health-care services and a higher proportion of women with biological risk factors, especially in the older age groups, nevertheless indicate that lifestyle advice may not be given as frequently to women as men.



There is a need to identify gender-specific norms and barriers to access and exposure to risk. Barriers are both gender- and disease-specific, with men and women experiencing them differently depending on the risk factor and sociodemographic characteristic. These barriers can be identified and explored through studies that engage specific sociodemographic groups through quantitative and qualitative approaches. Such approaches could also explore possible influences, such as the presence of implicit bias in provider counselling, the sex of the health-care professional and social norms regarding social interactions between men and women. Gender-sensitive and culturally appropriate responses would then facilitate behavioural change, access and use of services. An analysis of the impact of gender inequalities requires further quantitative and qualitative information that cannot be retrieved from the STEPS data.

Findings highlight the importance of an in-depth gender analysis of existing sex-disaggregated data together with other variables in identifying NCD risk-factor differences not only between men and women, but also among men and among women. The analysis will further reveal specific needs and opportunities in prevention and management of NCDs among different population groups that can then be addressed through tailored interventions.

In addressing the areas identified, cost-effective interventions like best-buy and other interventions recommended by WHO should be prioritized and tailored to the country-specific context to ensure uptake and efficiency. This would greatly contribute to the achievement of universal health coverage and the health-related Sustainable Development Goals.



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