Georgia Advocacy Agenda of People Living with NCDs

OUR
VIEWS,
OUR
VOICES

An initiative by the NCD Alliance
and people living with NCDs

NCD Alliance

Acknowledgements

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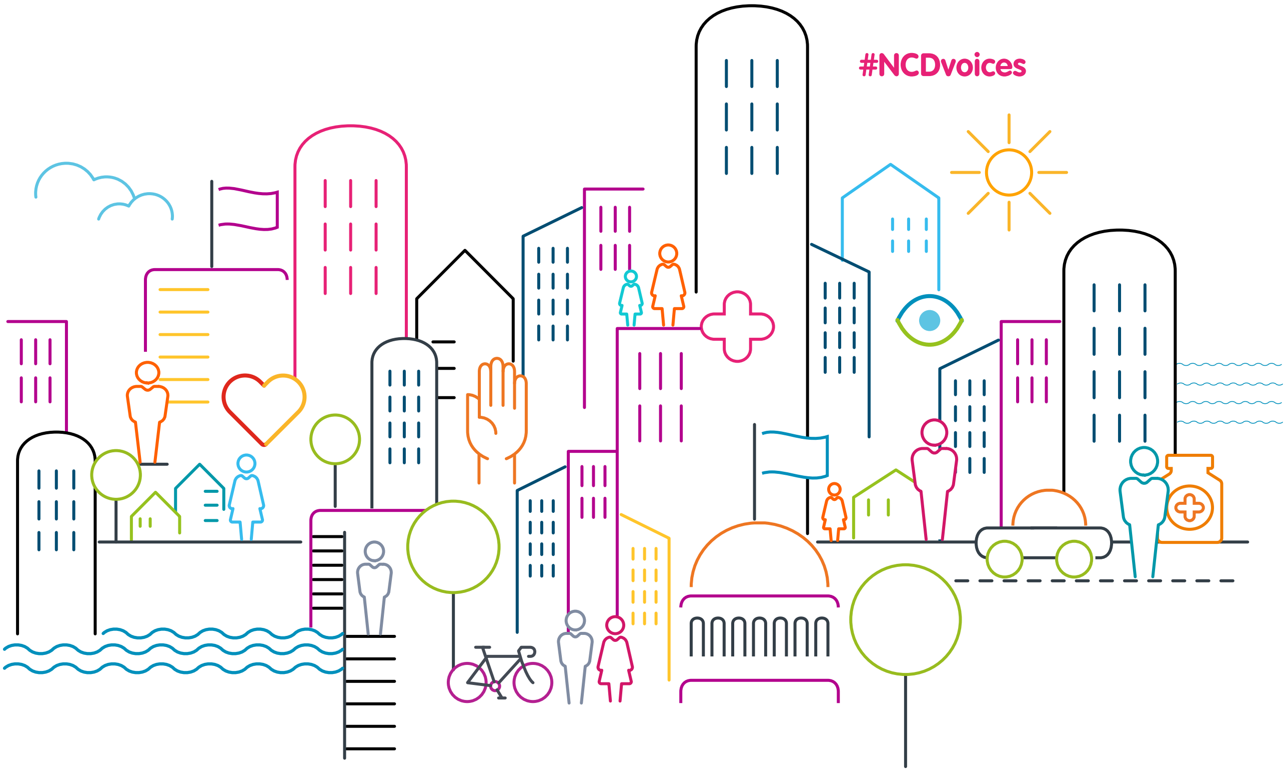


Executive summary

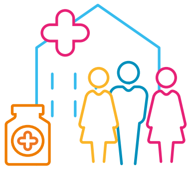
Noncommunicable diseases (NCDs) account for an overwhelming majority of deaths in Georgia – 93% of all annual mortality – indicating a profound public health challenge (WHO, 2022).

These include cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and mental health and neurological conditions, which together impose heavy social and economic burdens. This **Georgia National Advocacy Agenda** was developed to elevate the voices and rights of people living with NCDs and to outline a clear set of policy and advocacy priorities. **A mixed-methods approach was applied**, including a nationwide survey of 197 people living with NCDs and caregivers, five focus group discussions (FGDs) with 55 participants, and multi-stakeholder workshops. The agenda identifies critical gaps and recommends actions across four key pillars: **Human Rights and Social Justice; Treatment, Care and Support; Prevention; and Meaningful Involvement of People Living with NCDs.**

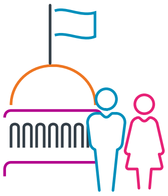
Key findings from the survey and FGDs underscored urgent needs: a majority of respondents reported difficulties accessing timely and affordable care, especially in rural areas, and instances of stigma or discrimination in healthcare settings remain common. Only a small fraction (approximately 8%) of people living with NCDs have been consulted in health policy decisions, yet over 70% express willingness to engage in advocacy if given the opportunity. Many are unaware of existing NCD prevention programs, reflecting weak public awareness raising and education. Caregivers face substantial burdens with minimal formal support and two-thirds of people living with NCDs said they were never offered any psychological or peer support as part of their care.

Human Rights
and Social Justice

Prevention



Treatment, Care,
and Support



Meaningful
Involvement

This Advocacy Agenda, aligned with the WHO Global NCD Action Plan and the NCD Alliance's global Advocacy Agenda of People Living with NCDs, provides a roadmap for addressing these gaps (WHO, 2013; NCD Alliance, 2017). It calls on Georgian authorities, civil society, and international partners to take coordinated action. Across the four pillars, the **Agenda's recommendations** can be summarised as follows:

Human Rights and Social Justice

Strengthen legal protections and anti-discrimination measures for people living with NCDs, ensure equitable access to services for vulnerable groups, and promote social justice in health. This includes enforcing patient rights laws, combating stigma through public education, and integrating a rights-based approach into health policies and medical training.

Treatment, Care and Support

Improve the continuity and quality of NCD care by investing in primary healthcare and community-based services. Key actions include expanding Universal Health Coverage (UHC) to cover essential NCD medicines, integrating mental health and palliative care, supporting caregivers, and establishing multidisciplinary care teams so that no person's needs fall through the cracks.

Prevention

Prioritise prevention and health promotion by addressing common risk factors (tobacco use, alcohol, unhealthy diets, physical inactivity) and strengthening public health programs. The agenda urges Georgia to implement "Best Buy" interventions – such as tobacco and sugar taxation, marketing restrictions, and nationwide awareness campaigns – and to reorient the healthcare system toward prevention and early detection. Schools, workplaces, and municipalities should be engaged to build a culture of health from the ground up.

Meaningful Involvement

Ensure that people living with NCDs are meaningfully involved in decision-making processes that affect their lives. This entails creating formal roles for lived experience representatives in NCD policy committees, funding advocacy and leadership training for people living with NCDs, and establishing platforms for the lived experience voice. By treating people with lived experience as equal partners in policy and program design, Georgia can craft more responsive and sustainable NCD solutions.

The Agenda's vision is to achieve a people-centered, rights-based health system in Georgia where prevention is paramount, treatment is accessible and high-quality, and those most affected by NCDs have a seat at the table. Moving forward, the document outlines specific actions ("What Georgia Must Do") under each pillar and practical steps for government agencies, civil society, and communities. With political will and multi-sector collaboration, these recommendations will translate into reduced preventable deaths, improved quality of life for people living with NCDs and their families, and fulfillment of Georgia's commitments to global NCD targets and human rights standards.

In summary, the Georgia National Advocacy Agenda of People Living with NCDs is both a **call to action** and a **strategic guide**. It presents evidence-based recommendations, drawn from the lived realities of Georgians, to drive policy change and social transformation. By implementing this Agenda, Georgia can make significant strides toward a future where no one is left behind in the fight against NCDs.

Introduction

Despite notable policy efforts in recent years – including **progressive tobacco control legislation** (Law on Tobacco Control, 2017; WHO, 2018) and active participation in **global NCD initiatives** – Georgia continues to face widespread challenges in preventing and controlling NCDs.

NCDs such as heart disease, cancer, chronic respiratory diseases, diabetes, and mental health and neurological conditions now cause approximately 93% of all deaths in the country (WHO, 2022), a proportion even higher than the European regional average (WHO/Euro, 2024). Many of these deaths are premature and avoidable with proper interventions. The burden of NCDs weighs most heavily on the poor, older people, and rural populations, exacerbating health inequities. Risk factor prevalence remains high: for example, over a quarter of Georgian adults smoke tobacco daily and over a third are living with hypertension or obesity, according to nationally representative surveys (STEPS 2010, 2016). These underlying risk factors drive increased NCD incidence and complications.

Crucially, the human impact of NCDs in Georgia goes beyond statistics. People living with NCDs often encounter **stigma and discrimination,** particularly those with visible conditions or mental illness.

Many feel excluded from health policy decision-making – historically, policies have been designed “for” people living with NCDs, not “with” them. Georgia has made commitments in its national strategies (Parliament of Georgia, 2017) to prioritise NCDs, yet gaps persist between policy and practice. Access to quality treatment and continuity of care are inconsistent; preventive services and early detection programs are under-resourced and lived experience voices are still underrepresented in governance. It is in this context that the **Georgia Advocacy Agenda for People Living with NCDs** was developed.

Creating this Advocacy Agenda

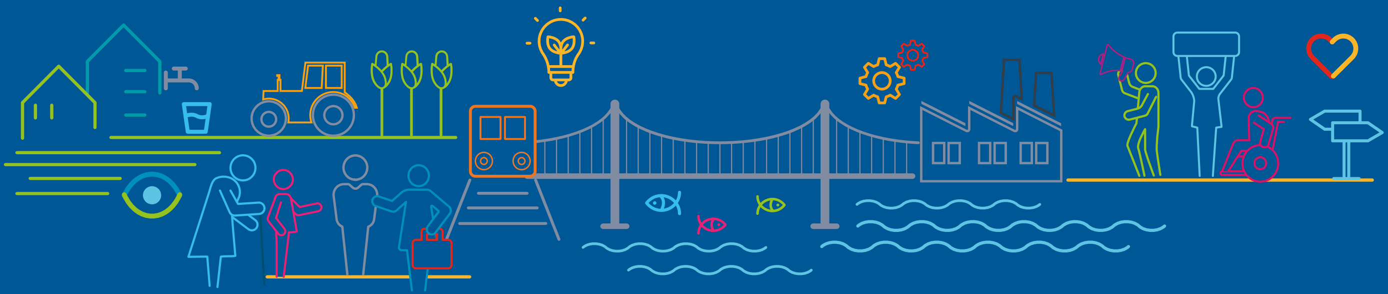
This document was crafted through an inclusive, evidence-informed process led by NCD Alliance of Georgia from late 2024 to early 2025. Drawing from the **WHO Global NCD Action Plan** and the **NCD Alliance's Advocacy Agenda of People Living with Non-Communicable Diseases** (WHO, 2013; NCD Alliance, 2017), as well as a national study on the needs of people living with NCDs, it aims to bridge the gaps between Georgia's high-level commitments and the realities on the ground.

The process included:

- A **national survey** of 197 individuals living with NCDs from across Georgia, capturing their experiences with healthcare, discrimination, support systems, and ideas for change.
- A series of **focus group discussions (FGDs)** with 55 participants (people living with NCDs and caregivers) in Tbilisi and regional areas, providing qualitative insights into daily challenges.
- **Stakeholder consultations and workshops** involving people living with NCDs, caregivers, health professionals, policymakers (including representatives from the Ministry of Health, Public Defender's Office and Parliament), non-governmental organisations (NGOs), and international partners (e.g. WHO). These multisector discussions helped prioritise issues and refine recommendations.

The result of this process is a comprehensive Advocacy Agenda organised around four pillars, mirroring the Global Advocacy Agenda: 1) Human Rights and Social Justice, 2) Treatment, Care and Support, 3) Prevention, and 4) Meaningful Involvement of people living with NCDs. Each pillar section presents below: survey and FGD Findings that highlight the current situation and challenges; the key issues identified; actionable recommendations; and specific tasks under "What Georgia Must Do" to implement those recommendations.

By addressing these four interrelated areas, the Agenda seeks to ensure a rights-based, equitable approach to NCDs in Georgia. It emphasises reorienting the health system toward primary care and prevention, while also safeguarding the dignity and participation of those affected. This Agenda is both a roadmap for change and a tool for advocacy to be used by civil society and lived experience advocates when engaging government leaders, and to hold stakeholders accountable for progress.



The Georgia Advocacy Agenda of People Living with NCDs

The highest attainable standard of health is a fundamental human right for every individual in Georgia, regardless of their culture, religion, political belief, or socioeconomic status. For people living with NCDs, this includes the right to inclusive, accessible, acceptable, and quality health services, as well as the freedom to choose treatment, equality of opportunity, and freedom from stigma and discrimination. A core principle of this human right is the meaningful involvement of people living with NCDs in all decision-making processes affecting their health and well-being.

Raising awareness of human rights is critical to advancing the NCD agenda in Georgia. People living with NCDs often experience stigma and discrimination, both in the community and within healthcare settings. Misconceptions surrounding chronic illnesses—such as diabetes, cardiovascular disease or cancer—can lead to marginalization, especially among vulnerable groups.

In Georgia, the right to health must guarantee universal access to services, essential medicines, education, and information, allowing individuals to make informed health decisions and effectively manage their conditions. We advocate for a multi-sectoral, whole-of-society approach, involving all relevant government sectors, civil society, communities, and people living with NCDs. We also call for the recognition and support of care partners, who shoulder a substantial part of the NCD burden and deserve to have their voices heard in all relevant policy discussions.

Given that many NCDs are lifelong conditions, it is essential that the right to health is placed at the center of the national response. Everyone deserves to live in a safe and supportive environment that enables health, dignity, and well-being.

Human rights and social justice

Ensuring that the rights of people living with NCDs are respected and that social justice principles guide the NCD response in Georgia.

Survey and FGD findings

Access barriers

61% of people with lived experience surveyed reported difficulties in accessing timely and affordable healthcare services, with **70% of rural respondents** citing distance and lack of local services as a major barrier. These figures reflect a significant urban-rural divide in health access.

Perceived legal protection

Only **12% of respondents** believe that people living with NCDs are adequately protected under existing anti-discrimination laws. Many participants shared anecdotes of facing stigma at work or in their communities due to their health conditions.

Social support gaps

Qualitative inputs indicated that people living with NCDs often feel isolated and lack social support. Communities and employers are not fully aware of the needs of people living with NCDs, leading to instances of exclusion or unfair treatment (e.g. being denied certain job opportunities or social activities).

Key issues

Geographic and financial disparities in care

People in remote or economically disadvantaged communities struggle to obtain essential NCD services. Travel costs, limited transportation, and out-of-pocket expenses create inequalities in outcomes.

Stigma and discrimination

Deep-rooted stigma surrounds certain NCDs (especially mental health conditions, obesity, and cancer), leading to social exclusion. Many people do not realise that most NCDs are long-term conditions that can be treated, which leads to stigma and discrimination.

Gaps in legal protection

Georgia's anti-discrimination framework does not explicitly or effectively cover health status in areas such as employment and education. Enforcement mechanisms for the rights of people living with NCDs (such as the right to confidentiality, informed consent, and respectful treatment) are weak. As a result, people living with NCDs have little recourse when their rights are violated.

70%

of **RURAL RESPONDENTS** cite distance and lack of local services as a **MAJOR BARRIER.**

Calls to action

Strengthen legal safeguards

Amend and enforce anti-discrimination laws to explicitly include health status and disability caused by NCDs (WHO, 2021). Ensure **monitoring mechanisms** (e.g. through the Public Defender's Office) to uphold the rights of people living with NCDs (UN, 1948).

Integrate rights-based approaches in healthcare

Incorporate human rights and health equity training into medical and nursing curricula and continuous education (Hunt, 2006). Health workers should be sensitised to the rights and needs of people living with NCDs, including issues of informed consent and nondiscrimination (Gruskin et al., 2013).

Public awareness and stigma reduction

Launch a nationwide media and education campaign to **reduce stigma** around NCDs (Corrigan, 2004). This could feature testimonials of people living with various NCDs, emphasising their abilities and contributions to society, and awareness raising on NCDs and the challenges faced by people who live with them (for example, increase public and caregiver awareness on how to support people living with NCDs and show greater empathy). Such a campaign should engage professionals/community leaders and leverage TV, radio, and social media (Link&Phelan, 2001).

Legal aid and counseling

Establish free legal advisory services (e.g. a 24/7 hotline or helpdesk) for people living with NCDs and their families. This would help individuals understand and claim their rights in healthcare, employment, and social services. In parallel, provide counseling and peer support programs for those facing discrimination or psychosocial challenges (WHO, 2013).

Government accountability on rights

Advocate for parliamentary hearings or an oversight committee focused on the human rights of people living with NCDs. The existing Consultative Council on disease prevention and health promotion could host regular sessions to review cases of rights violations, recommend policy changes, and keep the issue visible at the national level.

What Georgia must do

Conduct equity audits

Carry out regular "health equity audits" to identify which populations (e.g. rural poor, ethnic minorities, older persons, etc.) are being left behind in NCD outcomes. Use these findings to guide resource allocation (such as deploying mobile clinics or community health workers to underserved areas).

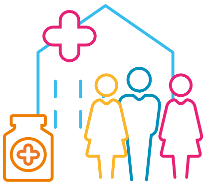
Improve access in underserved areas

Increase state funding for decentralised, community-based NCD services, including screening and follow-up care in rural primary healthcare centers. This may involve opening new clinics or expanding telemedicine programs to reach remote populations.

Civil society partnerships

Collaborate with civil society and patient organisations to **document and address rights violations**. The Ministry of Health and Public Defender's Office, for instance, can partner with NGOs to create a report or index on the state of the rights of people living with NCDs annually, and jointly implement interventions (such as workplace policy reforms or anti-stigma trainings in communities).

Treatment, care and support



Ensuring that people living with NCDs have access to quality treatment, continuous care, and the support services they need to manage their conditions and maintain a good quality of life.

Survey and FGD findings

Education gaps among people with NCDs

38% of people living with NCDs surveyed were **unaware of their recommended treatment guidelines or care plan**, indicating poor patient education and provider communication. Many people do not receive clear instructions about managing their condition.

Lack of psychosocial support

66% reported that medical personnel did not offer any psychological counseling or peer support options alongside medical treatment. This highlights a biomedical focus on care without attention to mental health or support groups.

Medication access and affordability

Access to essential NCD medications is inconsistent – **43% of respondents** cited trouble obtaining or affording their prescribed medicines. In interviews, people living with NCDs mentioned high out-of-pocket costs for newer drugs and having to travel to big cities for specialty medicines.

Caregiver burden

The FGDs underscored the heavy burden on family caregivers. Participants shared that caregivers often have to stop working to care for a sick relative, receive little training on providing care, and experience burnout. Yet there are almost no formal respite services or financial support for caregivers. In our survey, **57% of respondents** felt that the government does not pay adequate attention to caregiver support needs.

43%

of respondents have **TROUBLE OBTAINING OR AFFORDING** their prescribed **MEDICINES.**

Key issues

Inconsistent quality of care

The quality of NCD care varies widely across facilities. While some urban clinics follow updated clinical guidelines and provide comprehensive care, many providers lack training in chronic disease management. People living with NCDs report that follow-up is haphazard – for instance, someone with diabetes might not get guidance on foot care or nutrition in one clinic, whereas another clinic might offer more guidance to manage their condition.

Lack of multidisciplinary approach

There is an **absence of multidisciplinary care teams** for NCDs. People diagnosed with an NCD should have coordinated input from various health professionals – for example, someone with diabetes should have access to doctors, nurses, nutritionists, and perhaps a psychologist. In Georgia, such integration is rare. Mental health and palliative care services are not well integrated into NCD care pathways, leaving important aspects regarding the wellbeing of people living with NCDs unaddressed.

Fragmentation between primary healthcare (PHC) and specialised care

PHC is underutilized for NCD management – many people bypass clinics and go straight to hospitals or specialists, leading to fragmented care, because they have less trust in PHC specialists and their qualifications compared to doctors working in hospitals. Communication and referral systems between family doctors and specialists are weak. This results in duplication of tests, loss of patient information, and interrupted care continuity (for example, after discharge from a hospital, there may be no systematic follow-up in the community).

Insufficient support for caregivers and home-based services

Family members shoulder much of the care (medication management, assisting with daily activities, etc.) for people living with NCDs at home, but they receive **little training or respite**. Home-based services (like visiting nurses, physiotherapy at home, or hospice care) are limited, meaning people with limited mobility or severe illness struggle to get needed services at home.

Calls to action

Updating and implementing clinical protocols

Mandate the implementation of updated national clinical guidelines for major NCDs, such as hypertension, diabetes, cancer, and COPD(National Institute for Health and Care Excellence [NICE], 2018). All providers should follow evidence-based protocols. The Ministry of Health, with professional associations, should disseminate these guidelines and monitor adherence (Grimshaw et al., 2004). This also involves regular training on new protocols and treatment modalities.

Expanding essential medicines coverage

Broaden the list of subsidised medications for NCDs under Georgia's UHC program. Essential medicines (including insulin, hypertension drugs, cancer treatments, and smoking cessation aids) should be affordable and available in all regions (Cameron et al., 2009). The government should negotiate better pricing or use pooled procurement to lower costs. In addition, ensure these medicines are regularly stocked at local pharmacies and clinics.

Person-centered care training

Invest in training health workers on person-centered chronic care models (Mead and Bower, 2000). This means going beyond treating acute symptoms – providers should be trained in communicating with people living with NCDs, setting joint treatment goals, and basic counseling (for lifestyle changes, medication adherence, etc.). For example, every person with diabetes should get guidance on diet and mental health support as part of routine care (Glasgow et al., 2003).

Integrating mental health and palliative care

Incorporate mental health professionals into NCD care teams and include psycho-social support as a standard part of managing NCDs (e.g. depression screening for people with cardiac disorders, psycho-oncology services for people with cancer) (WHO, 2008). Likewise, develop palliative care services for people with advanced NCDs (like stage IV cancers or end-stage organ failure) and support for their families. Palliative care and pain management should feature in future health system reforms and training (Sepulveda et al., 2002).

Support for caregivers

Recognise caregivers as an integral part of the care team (Schulz&Sherwood, 2008). Provide training workshops or educational materials for caregivers on how to care for people living with NCDs (e.g. managing medications, preventing bedsores, providing psychosocial support). Central governments of local municipalities should set up respite care programs – for instance, community centers or NGOs could offer a few hours of care for people with advanced NCDs, so that caregivers can rest. Encourage employers to adopt flexible work or leave policies for those caring for relatives with advanced NCDs.

Strengthening PHC and referral systems

Enhance the role of primary care clinics as the "medical home" for people living with NCDs (Starfield, 1998). This involves improving referral pathways (so that when a person living with an NCD is referred to a specialist, the family doctor is informed of the outcome and continues follow-up). It also means equipping PHC facilities with basic diagnostics and nurses trained in NCD case management. PHC teams should conduct proactive outreach – e.g. calling people living with NCDs for check-ups or to monitor chronic conditions – to improve continuity.

What Georgia must do

Pilot integrated care models

Launch **integrated NCD care pilot programs** in three to five regions. For example, establish a "one-stop" NCD care service within an existing primary healthcare facility or clinic, where people can access a general practitioner, pharmacist, and nutritionist in a single visit—or develop a regional NCD center that coordinates care among multiple providers. Use these pilots to demonstrate the benefits (better outcomes, cost-effectiveness) and then scale up successful models.

Continuous professional development

Institute **regular continuing education** requirements for general practitioners and nurses in NCD care. This could include annual courses or certification updates in areas like diabetes management, cardiovascular risk reduction, palliative care, smoking cessation, etc. By keeping the frontline workforce uptodate, the system can ensure consistent quality of care nationwide.

Community-based support groups

Help establish **peer support groups** for various NCDs in partnership with NGOs and patient associations. For instance, a diabetes club, a cancer survivors' network, or a mental health peer group can provide education and psychosocial support. Georgia currently lacks such peer support groups, and their introduction could significantly improve the motivation and mental health of people living with NCDs.

Leverage technology for care continuity

Expand telemedicine, e-health and m-health tools so that specialists in urban centers can **support primary care providers** remotely. Teleconsultations for patients in remote areas, electronic medical records accessible across facilities, and mobile health apps for self-management are all ways to improve care connectivity and support.

A majority (62%) highlighted insufficient information, training and support for caregivers, while 57% called for better access to respite care (temporary relief services for caregivers). About 42% stressed the need for formal leave policies to protect the jobs of those who must care for chronically ill family members, and 29% pointed to inadequate transportation and accessibility in public spaces for people with disabilities. These findings underscore the broad range of support systems that need strengthening to aid both people living with NCDs and their caregivers (Figure 1).

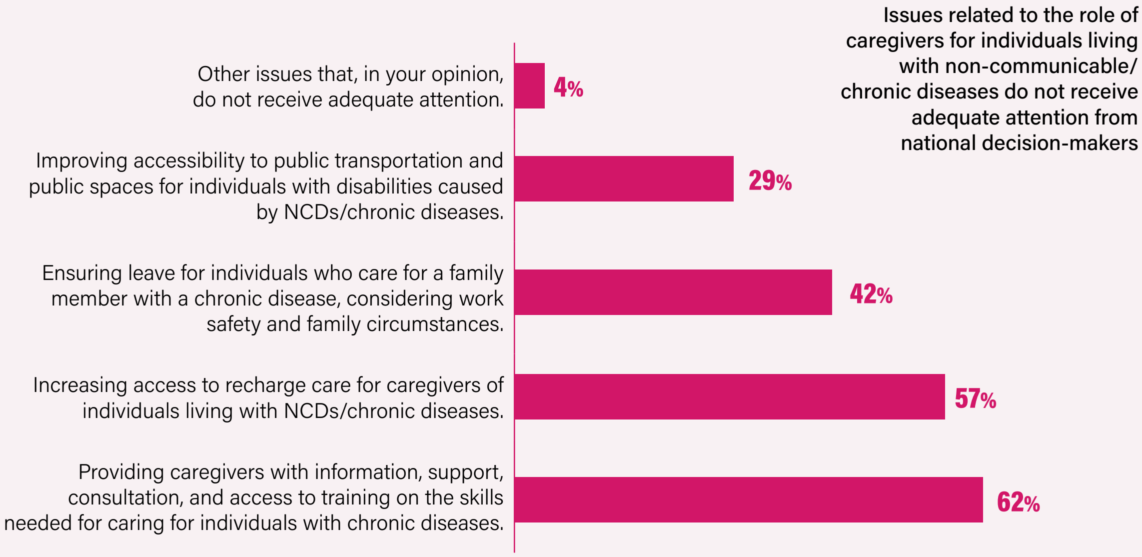


Figure 1. Survey results on caregiver support issues which do not receive adequate attention from national decision-makers.

Prevention

Prioritising the prevention of NCDs and the promotion of healthy lifestyles through public policy, education, and community initiatives, so that fewer Georgians develop diseases or face complications.

Survey and FGD findings

Many people delay seeking medical help until severe complications arise, often due to lack of awareness or financial constraints.

Preventive screenings (e.g., glucose monitoring, cardiovascular check-ups) **are not easily accessible**, leading to undiagnosed or poorly managed conditions. Many people are unaware of the importance of early prevention, leading to late-stage diagnoses and worsening conditions. Public health campaigns promoting early detection and lifestyle changes are needed.

Barriers to healthy living, such as the high cost of healthy food and fitness services prevents many from making lifestyle changes.

Policy implementation gaps

Participants pointed out that while some laws exist (for example, bans on tobacco advertising or restrictions on public smoking), gaps remain. Children and teenagers are still frequently exposed to alcohol and junk food marketing, and community-level prevention activities (like exercise programs or screenings) are rare outside major cities.

Key issues

Public unawareness of risk factors

Large segments of the Georgian population do not fully understand how lifestyle factors contribute to NCDs. Misconceptions are common (e.g. that e-cigarettes are safe, or that exclusively traditional diets are always healthy). Without awareness, people have little motivation to change behaviours or utilise preventive services.

Weak enforcement of regulations

Georgia has passed certain preventive regulations – such as bans on tobacco and alcohol advertising, and partial regulations on trans fats – but **enforcement is insufficient**. There is no comprehensive policy on sugar or salt reduction yet, and existing rules (like those on trans fats) are not well monitored.

Limited local (municipal) initiatives

Prevention is not yet a priority at the local government level.

Municipalities often **lack funding or expertise** for health promotion. This results in few community exercise programs, health screenings, or healthy city initiatives. In rural areas especially, prevention efforts are minimal.

Youth and high-risk groups left out

There is a lack of **targeted interventions for youth** (aside from basic school curriculum) and other high-risk groups such as low-income communities or ethnic minorities. Health promotion campaigns are often one-size-fits-all and may not resonate with these audiences. Additionally, unhealthy products remain easily accessible and affordable to young people.

Call to action

Behaviour change campaigns

Implement sustained, evidence-based behaviour change communication campaigns focusing on key risk factors: **smoking cessation, healthy diet, physical activity, and responsible alcohol use** (Wakefield et al., 2010). These campaigns should use modern marketing techniques and be culturally sensitive – e.g. using popular influencers on social media for youth, and community leaders for older populations. WHO's recommended "best buy" interventions include mass media campaigns for tobacco and diet (WHO, 2017; Galea et al., 2025). Georgia should invest in such outreach, emphasising positive messaging (e.g. the benefits of quitting smoking) and providing practical tips.

Strengthening regulation enforcement

Rigorously enforce existing public health laws (Chaloupka et al., 2002) such as increasing funding for inspectorates or involving civil society in monitoring of smoke-free environments, alcohol restrictions, food quality control, trans fat regulations, gambling regulations, etc. For example, ensure that bans on tobacco advertising and sponsorship are upheld (no ads in shops or at events), and that any violations carry penalties. Expand regulations where gaps exist: introduce comprehensive **alcohol control legislation in particular** (limiting sales hours, raising taxes, requiring health warnings, etc.), as Georgia currently lacks a strong alcohol policy (Anderson et al., 2009). Also, finalise and implement pending strategies such as the **Physical Activity Strategy** and an updated **National Nutrition Strategy**.

Embedding health in education

Mainstream health education into both formal and non-formal education systems (Nutbeam, 2000). This means updating school curricula to include **age-appropriate, skills-based health education** from primary through secondary levels (covering nutrition, exercise, mental health, substance abuse, etc.), and training teachers to deliver it. In universities and vocational schools, incorporate modules on wellness and prevention. Additionally, support "health-promoting schools" that integrate physical activity and healthy eating into the school environment (e.g. healthy school meals, daily exercise breaks) (WHO, 1998).

Municipal health promotion

Encourage and fund **municipal health promotion plans** (Kickbusch, 2003). The national government should support municipalities (through grants or technical assistance) to run local prevention programs. Examples include city-wide fitness events, local quit smoking contests and support lines, mobile clinics for screening (blood pressure, glucose, cancer screenings) in villages, and healthy cooking workshops led by nutritionists. By making prevention visible at the community level, people are more likely to participate.

Multi-sector collaboration

Prevention of NCDs is not just a health sector responsibility (Beaglehole et al., 2011). Establish cross-sector initiatives – for instance, working with the Ministry of Education on school programs, the Ministry of Finance on health taxes for unhealthy products, and the Ministry of Regional Development on creating parks and bike lanes for physical activity. Engage media outlets to increase coverage of health topics and responsible reporting. Public-private partnerships can also be explored for workplace wellness programs or sports promotion.

Digital health literacy

Utilise the fact that many young people rely on social media for health information by **improving digital health literacy** and providing quality content online (Norman and Skinner, 2006). Partner with popular Georgian social media personalities, doctors, or lived experience advocates to disseminate accurate information on NCD prevention (combating any misinformation). To address the needs of elderly groups, who may require additional support, ensure the platform offers user-friendly interfaces, large font sizes, and audio/visual aids. Consider incorporating remote assistance features like telehealth consultations and step-by-step guides. Partnering with community centers and senior organisations can help promote digital literacy and provide in-person support for navigating e-health/m-health resources.

What Georgia must do

Reorient the health system toward prevention

At the policy level, redefine the goals of the healthcare system so that prevention and health promotion are top priorities. For example, **mandate that at least 5% of healthcare spending is dedicated to public health and prevention programs** (up from the current percentage of 0.02%). Launch a major reform of primary healthcare where family doctors are incentivised and trained to focus on prevention, risk factor counseling, and community outreach rather than just referrals.

Introduce fiscal and policy measures for risk factors

Introduce **taxes on sugar-sweetened beverages, highly salted products, and ultra-processed snacks** as a deterrent and to fund health promotion. Simultaneously, implement policies such as reformulating foods to contain less salt/sugar and mandating clear front-of-pack nutrition labels to help consumers make healthier choices.

Engage communities and train local actors

Train teachers and community leaders as health promoters. For instance, equip schoolteachers to run after-school sports or anti-smoking clubs, and train religious leaders or village elders to incorporate health messages into their gatherings. Community ownership of prevention can greatly enhance impact. Also, involve municipalities by establishing local health promotion committees that include civil society and lived experience representatives, to plan targeted interventions for their context.

Strengthen monitoring and accountability

Regularly **monitor the enforcement of public health regulations** (tobacco, alcohol, food safety, etc.) with the involvement of NGOs. Publish annual reports on compliance (e.g., rates of violations found in restaurants for smokefree law, or proportion of schools implementing new health education curriculum). Use innovative tools like mobile apps for the public to report violations (for example, an app to report illegal tobacco advertising/promotion or smoking in prohibited areas). By making enforcement data public, authorities can be held accountable and motivated to improve.

Pursue bold endgame goals

Position Georgia as a regional leader by adopting bold targets – for instance, a **"Tobacco Endgame" goal of reducing smoking prevalence to below 5% by 2040** and becoming **trans-fat free** by enforcing bans on trans-fats in all foods. Develop a roadmap to reach these targets, learning from countries that have made similar commitments. Ambitious goals can drive innovation and rally public support for strong preventive measures.

Meaningful Involvement of people living with NCDs

Ensuring that people living with NCDs are not just beneficiaries of policies but active participants and leaders in the NCD response – from shaping policies to implementing and monitoring them.

Survey and FGD findings

According to the respondents' views, people living with NCDs feel excluded from decision-making. They report feeling **left out of healthcare decisions,** with policies being made without consulting those directly affected. Unlike in other countries, Georgia **lacks advocacy networks** where individuals living with NCDs can share their experiences and support each other.

Lack of platforms

Focus group discussions revealed that formal **advocacy platforms are virtually nonexistent.** Some disease-specific patient organisations do exist (notably for cancer, diabetes, and mental health), but they have limited reach and resources, and there are notable gaps (e.g. very few patient groups for cardiovascular or chronic respiratory diseases in Georgia). There is no umbrella forum where patients from different conditions come together with policymakers.

Internalised stigma and capacity needs

Many people living with NCDs have internalised stigma – some feel that their health issues make them "burdens" and thus hesitate to speak up. The survey indicated that a significant number of people lack confidence or knowledge to engage in advocacy (for example, not knowing their rights or the channels to provide input). This points to a need for destigmatisation and capacity-building.

Key issues

Absence of formal engagement mechanisms

The health governance structure in Georgia does not systematically include lived experience representatives. Technical working groups are typically composed of doctors and policymakers only. The lack of formal mechanisms mean that lived experience input is ad hoc at best.

Tokenism in involvement

On the rare occasions when people living with NCDs are invited to discussions, it may be **tokenistic** – e.g. having one person living with NCDs give a testimony at a conference, but not actually involving them in planning or decision-making. This undermines the credibility and impact of the lived experience voice.

Capacity gaps for civil society

Patient organisations and NCD-focused NGOs in Georgia are relatively young and face funding and capacity constraints. They often lack training in advocacy, leadership, fundraising, and media engagement. Without stronger capacity, these groups struggle to influence policy. Additionally certain NCD areas like heart disease or chronic obstructive pulmonary disease (COPD) lack organised groups entirely.

Sustainability of involvement

Even when health advocates are active, their involvement is often project-based or short-term (e.g. tied to a donor-funded activity). There is no sustainable platform or funding stream to ensure continuous engagement of people living with NCDs over the long term.

Call to action

Institutionalising representation of people living with NCDs

Formally include **lived experience representatives in national health decision-making bodies** (Stewart et al., 2008). For example, create seats for advocates representing people living with NCDs on the national NCD multi-sectoral committee or task forces developing NCD-related strategies. At the regional level, involve lived experience representatives in regional health council meetings. Representation should be diverse (covering different diseases, genders, ages) and the representatives should have a mandate to consult with and bring input from the broader community of people living with NCDs.

Capacity-building for advocacy

Establish programs to **train people living with NCDs in advocacy and leadership skills** (Laverack, 2006). This could be done through workshops or an "Advocacy Academy" where people living with NCDs learn about health policy, communication skills, rights literacy, and how to engage media or policy dialogues. Equipping individuals with lived experience to confidently tell their stories and propose solutions will amplify the lived experience voice.

Media and storytelling

Support **people living with NCDs in creating and disseminating their stories.** Produce video testimonials, blogs, or social media content that highlight experiences of people living with NCDs and successes in navigating NCDs. Humanising NCD issues through real stories can reduce stigma and influence public and political audiences. Media training for lived experience advocates will help in crafting compelling narratives and handling public speaking or interviews (Deacon&Stanyer, 2014).

Lived experience-led monitoring and watchdogs:

Encourage the development of **lived experience-led "watchdog" groups** to monitor the implementation of NCD policies and services (Callahan, 2003). For instance, a group of trained advocates living with NCDs could track whether commitments (like providing essential medicines or promoting utilisation of cancer screening programs) are being met and publish user-friendly scorecards or reports. Such watchdog activities can hold the system accountable from a citizen's perspective.

Small grants for patient initiatives

Set up a funding mechanism (possibly a state fund or via donor support) to provide **small grants to patient organisations** (Anheier&Toepler, 1999). These grants could support activities like support group meetings, patient-organised awareness campaigns, or the development of information materials for them. By resourcing patient groups, their reach and sustainability will grow.

A national platform of people living with NCDs

Facilitate the creation of a **national platform or network of people living with NCDs.** This could start as a coalition of existing organisations and interested individuals, with support from NCDA Georgia. The platform would serve as a unified voice, coordinate advocacy agendas annually, and facilitate dialogue with government bodies. The experience of other countries (e.g., the Healthy Philippines Alliance convening forums for people with lived experience) can serve as a model.

What Georgia must do

Establish a National Council of People Living with NCDs

Create a **National Council of People Living with NCDs under the Ministry of Health.** This advisory council would meet regularly with health officials to provide input on policies, ensure perspectives of people living with NCDs are considered in program design, and review progress on the Advocacy Agenda. Its members should be democratically selected from amongst lived experience advocates and relevant organisations.

Provide funding and space for advocacy

Dedicate government funding (or allocate through the universal health budget or grants) for **lived experience-led advocacy and community engagement projects.** For example, fund a yearly "NCD Advocacy Week" where people living with NCDs hold events, or sponsor local advocacy initiatives targeting municipal governments. Additionally, make institutional spaces available – e.g. allow these groups to use public meeting rooms or community centers for their activities at no cost.

Partner with educational institutions

Partner with universities and public health schools to involve people living with NCDs in research, training, and advocacy skill-building. Universities could host internships or volunteer programs where students support patient associations (grant writing, social media, etc.), and in turn patient or lived experience advocates can lecture in public health courses about lived experience. Such partnerships both build capacity and normalise the inclusion of people living with NCDs in academia and policy discourse.

Recognise and utilise expertise of people living with NCDs

The government and health providers should formally recognise the value of expertise of people living with NCDs. This might include hiring people living with NCDs as navigators or advisors in hospitals (to help people diagnosed with an NCD to cope, and provide feedback to staff), or engaging them as experts in guideline development processes. By treating people living with NCDs as experts in their own right, a cultural shift toward meaningful involvement will take root.

Conclusion

The Georgia Advocacy Agenda for People Living with NCDs not only presents a set of policy priorities but also a strategic blueprint for advocacy toward a more equitable and sustainable health system. A central tenet of this agenda is the urgent need to integrate NCD prevention and care into primary healthcare (PHC) and reorient Georgia's healthcare model to one that prioritises health promotion, early detection, and effective long-term care. Current fragmented health systems and hospital-centric approaches are insufficient to meet the growing NCD burden. A preventive, community-based, and person-centered model must replace the existing structure.

Advocacy efforts must emphasise strengthening primary healthcare as the frontline for NCDs – this means equipping PHC facilities to provide continuous NCD management and risk reduction and making them the first point of contact for most people living with NCDs. It also involves training PHC teams in risk factor counseling, chronic disease management, and behaviour change communication, as well as strengthening referral systems so that people move smoothly between levels of care. Such reorientation can vastly improve early diagnosis and ongoing management of NCDs.

Simultaneously, there is an urgent need to create sustainable funding streams for NCD-related initiatives. This includes funding for professional and civil society organisations working on NCD prevention, policy reform, and health education. Grassroots advocacy and public awareness campaigns require consistent support, not one-off projects. Continuous monitoring, evaluation, and community engagement activities also need dedicated resources. For example, a permanent budget line for health promotion would ensure that campaigns and community programs are not subject to political whims or donor cycles.

These shifts – toward primary care, prevention, and people-centeredness – require coordinated advocacy targeting multiple actors: the Ministries of Health and Finance, parliamentary committees, local governments, international development partners, and public health institutions. Georgia's aspirations for European Union (EU) integration and alignment with global health frameworks (including WHO's recommended "Best Buy" interventions for NCDs) provide a strong impetus for reform and opportunities for resource mobilisation. EU alignment could attract funding for health system strengthening, and global initiatives could provide technical support in implementing high-impact interventions (Table 1,2; Figure 2).

With an empowered civil society, engaged community of people living with NCDs, and evidence-driven action, Georgia can transition from isolated interventions to a resilient, integrated, and people-centric NCD response grounded in primary care and human rights. The successful implementation of this Advocacy Agenda will mean that in the coming years, fewer Georgians will suffer preventable conditions or complications (Table 1,2; Figure 2).

Those living with NCDs will have a better quality of life and more dignity; and the health system will become more equitable and efficient. Achieving these outcomes is a shared responsibility – one that requires the voices of people living with NCDs to remain at the forefront of advocacy. Georgia stands at a crossroads in its NCD journey, but by adopting the recommendations herein and upholding the principle of "nothing about us, without us," it can pave the way to a healthier and more just future for all its citizens.

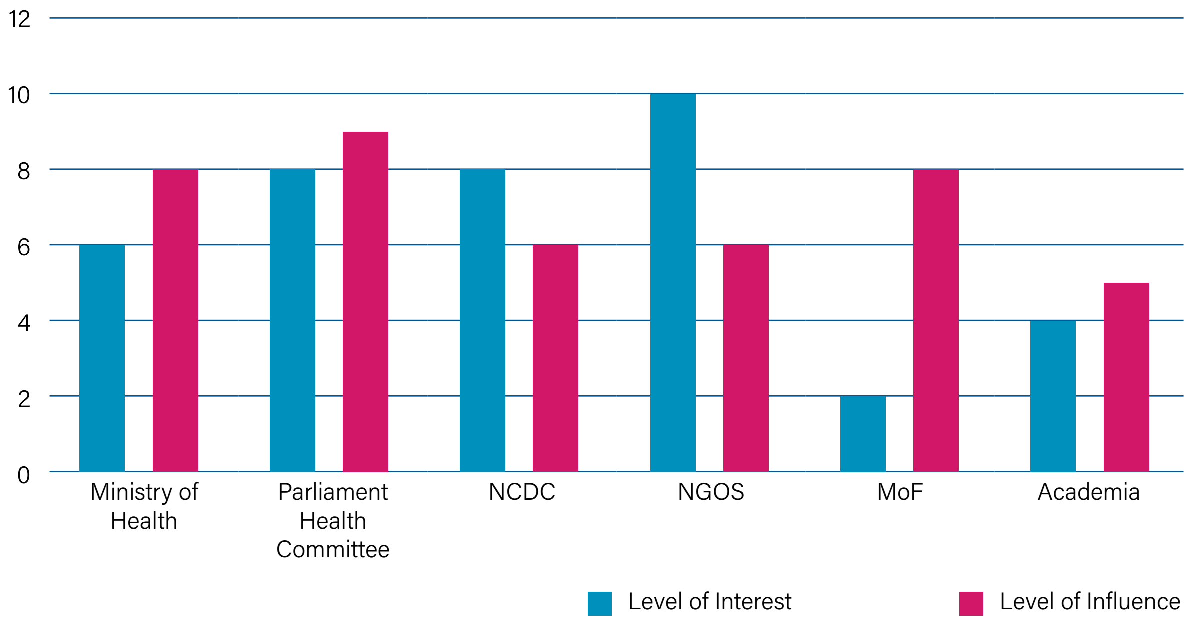
Annexes

Table 1. Intervention prioritisation matrix

Recommendation	Timeframe	Feasibility	Resources needed	Stakeholders
Launch national media campaign on prevention	Short-term (1 year)	High	Medium	National Center for Disease Control (NCDC,) NCDA Georgia, Ministry of Health (MoH), Mass Media, NGOs
Introduce sugar tax	Mid-term (2–3 years)	Moderate	High (political capital)	MoF, MoH, NCDA Georgia, Parliament
Establish lived experience working group	Short-term	High	Low	Parliament, MoH, NCDC, NCDA Georgia

This matrix will be informed by the comments received, feasibility analysis (political, technical, legal), and feedback from government and civil society.

Figure 2. Stakeholder Mapping Matrix



These stakeholders will help civil society tailor their advocacy tactics and identify "champions" within the system.

Table 2. Implementation guide, providing a structured, actionable framework for guiding NCD policy implementation in Georgia, ensuring accountability, multi-sectoral collaboration, and measurable progress.

Strategic priority	Timeline	Key Performance Indicators (KPIs)	Coordination
Form a lived experience working group under the Diseases Prevention and Health Promotion Scientific-Consultative Council, of the Healthcare Committee of the Parliament	Q4 2025	Working group formed with TOR by end of 2025	Parliament, MoH, NCDC, NCDA Georgia, WHO
Integrate NCD prevention in primary healthcare	Short (<1 year)	Number of PHC centers delivering NCD prevention; % increase in screenings	MoH, NCDC, NCDA, PHC Council
Update and enforce clinical guidelines and quality assurance mechanisms	Medium (1-3 years)	Compliance rate with updated protocols; patient satisfaction rates	Professional Associations, MoH
Establish representation of people living with NCDs in policymaking	Short (<1 year)	# of councils including people living with NCDs; frequency of consultations	CSOs, NCDA, Parliament Healthcare Committee
Adopt legislation for sustainable funding mechanisms	Long (3-5 years)	Amount of funding secured; % of NCD programs funded sustainably	MoF, MoH, Parliament, NCDA
Launch national health literacy and lifestyle campaign	Medium (1-3 years)	Reach of campaigns; changes in public awareness (survey-based)	NCDC, NCDA, MoES, Mass Media
Promote implementation of the national NCD data registry	Medium (1-3 years)	Registry completeness	NCDC, MoH, NCDA

References

Anderson, P., Chisholm, D., & Fuhr, D. C. (2009). Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *The Lancet,* 373(9682), 2234-2246.

Anheier, H. K., & Toepler, S. (1999). Private funds, public benefit: Philanthropic organizations in transatlantic perspective. VS Verlag für Sozialwissenschaften.

Beaglehole, R., Bonita, R., Horton, R., Adams, C., Alleyne, G. A., Asaria, P. & Bundred, P. (2011). Priority actions for the non-communicable disease crisis. *The Lancet,* 377(9775), 1438-1447.

Callahan, D. (2003). The role of a citizen watchdog in health care. *Health Affairs,* 22(6), 254-256.

Cameron, A., Ewen, M., Ross-Degnan, D., Ball, D., & Laing, R. (2009). Medicine prices, availability, and affordability in 36 developing and middle-income countries: a secondary analysis. *The Lancet,* 373(9669), 240-249.

Chaloupka, F. J., Straif, K., & Leon, M. E. (2002). Effectiveness of tax policies in reducing consumption of tobacco and potential implications for reducing obesity. *Health Policy,* 59(3), 627-648.

Corrigan, P. W. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Deacon, D., & Stanyer, J. (2014). Mediatization: Key concept or conceptual bandwagon?. *Media, Culture & Society, 36(6), 791-806.*

Galea, G., Ekberg, A., Ciobanu, A., Corbex, M., Farrington, J., Ferreira-Bores, C., Stuckler, d. Quick buys for prevention and control of noncommunicable diseases. *The Lancet*, 52(101281), 1-11.

Glasgow, R. E., Bayliss, E. A., Goings, L. A., & Piette, J. D. (2003). The chronic care model and self-management: what do we know?. *Diabetes Spectrum,* 16(4), 203-212.

Grimshaw, J. M., Thomas, R. E., MacLennan, G., Fraser, C., Ramsay, C. R., Vale, L. & Eccles, M. P. (2004). Electronic searching to identify guidelines: development of a sensitive search strategy. *BMC Health Services Research*, 4(1), 1-8.

Gruskin, S., Mills, E. J., & Tarantola, D. (2013). History, principles, and practice of health and human rights. *The Lancet,* 381(9865), 449–455.

Hunt, P. (2006). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. United Nations General Assembly. https://digitallibrary.un.org/record/591658?v=pdf

Kickbusch, I. S. (2003). The contribution of the World Health Organization to a new public health and health promotion. *American Journal of Public Health*, 93(3), 383-388.

Laverack, G. (2006). Using a 'domains' approach to build community empowerment. *Community Development Journal,* 41(1), 4-12.

Law on Tobacco Control, Georgia. Adopted on May 17/05/2017. Retrieved on May 12, 2025: https://matsne.gov.ge/ka/document/view/3676731?publication=4

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology,* 27(1), 363–385.

Mead, N., & Bower, P. (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine,* 51(7), 1087-1110.

NCD Alliance. (2017). Advocacy agenda of people living with NCDs. https://ncdalliance.org/resources/advocacy-agenda-of-people-living-with-ncds

National Institute for Health and Care Excellence. (2018). Developing NICE guidelines: the manual.

Norman, C. D., & Skinner, H. A. (2006). eHealth Literacy: Essential Skills for Consumer Health in a Networked World. *Journal of Medical Internet Research*, 8(2), e9.

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International,* 15(3), 259-267.

Parliament of Georgia. (2017). Vision for developing the healthcare system in Georgia by 2030. https://web-api.parliament.ge/storage/files/shares/Komitetebi/jandacva/jand-sist-2030/Health-Strategy-2030-eng.pdf

Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *American Journal of Nursing*, 108(9 Suppl), 23-27.

Sepúlveda, C., Marlin, A., Yoshida, T., Ullrich, A., & Yamey, G. (2002). Palliative care: the World Health Organization's global perspective. *Journal of Pain and Symptom Management,* 24(2), 91-96.

Starfield, B. (1998). Primary care: balancing health needs, services, and technology. Oxford University Press.

Stewart, M. A., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2008). The impact of patient-centered care on outcomes. *The Journal of Family Practice*, 45(9), 796.

UN General Assembly. (1948). Universal declaration of human rights.

Wakefield, M. A., Loken, B., & Hornik, R. C. (2010). Use of mass media campaigns to change health behaviour. *The Lancet,* 376(9748), 1261-1271.

WHO. (1998). Health-promoting schools: a healthy setting for living, learning and working. WHO Information Series on School Health: Document 1.

WHO. (2008). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. World Health Organization.

WHO. (2013). Global action plan for the prevention and control noncommunicable diseases 2013-2020. https://www.who.int/publications/i/item/9789241506236

WHO. (2017). Tackling NCDs: 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases.

WHO. (2018). New law on cigarettes and tobacco coming into effect in Georgia. https://www.who.int/europe/news/item/01-05-2018-new-law-on-cigarettes-and-tobacco-coming-into-effect-in-georgia

World Health Organization. (2021). Global action plan for the prevention and control of NCDs 2013-2030. https://www.who.int/teams/noncommunicable-diseases/governance/roadmap

WHO. (2022). Noncommunicable Diseases Progress Monitor 2022 [Global report]. World Health Organization. https://www.who.int/publications/i/item/9789240047761

WHO/Europe. (2024). Data for a healthier future: how countries can protect people from noncommunicable diseases. https://www.who.int/europe/news/item/10-09-2024-data-for-a-healthier-future--how-countries-can-protect-people-from-noncommunicable-diseases

WHO STEPS Survey results for Georgia 2010, 2016. https://ncdc.ge/#/pages/file/67a7cad9-b8e0-438c-b74c-f5303418e033

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