Non-communicable Diseases National Targets and Indicators Framework

NATIONAL INDICATORS FOR MONITORING NCD TARGETS IN GEORGIA

Area / target / Indicator	Definition / Unit of measurement	Data Source	Frequency of data dissemination	Lead/Line Ministry/Agency
MORTALITY & MORBIDITY				
Area 1. Premature mortality from non-communicable diseases				
Target 1. A 25% relative reduction in the overall mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases				
1. Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	Unconditional probability of dying between the exact ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases. Deaths from these four causes will be based on the following ICD codes: I00-I99, C00-C97, E10-E14, and J30-J98 Age-Specific death rates are based on data on deaths by age, sex and cause of death. Deaths per 100 000 population. For a better understanding, the indicator could be expressed in percentage.	Civil registration, verbal autopsy	Annual	Ministry of Labour, Health and Social Affairs / NCDC
2. Cancer incidence, by type of cancer, per 100,000 population	Number of new cancers of a specific site/type occurring in the population per year, usually expressed as the number of new cancers per 100,000 population. This may include multiple primary cancers occurring in one patient. The primary site reported is the site of origin and not the metastatic site. In general, the incidence rate would not include recurrences. Rate	NCDC Cancer registry	Annual	Ministry of Labour, Health and Social Affairs / NCDC
BEHAVIOURAL RISK FACTORS				
Area 2. Harmful use of alcohol				
Target 2. At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context				
3. Total (recorded and unrecorded) alcohol per capita (APC) consumption in the population,aged 18-69 years old within a calendar year in litres of pure alcohol	The total (sum of recorded and unrecorded) APC is the amount of alcohol consumed per population, aged 18-69 years within a calendar year, in litres of pure alcohol. Litres of pure alcohol per person per year; Litres of pure alcohol per adult (18-69) per year.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC

4. Age-standardized prevalence of heavy episodic drinking among the population, aged 18-69 years	Heavy episodic drinking among adults is defined as those who report drinking 6 (60 grams) or more standard drinks in a single drinking occasion. A consumption of 60 g of pure alcohol corresponds approximately to 6 standard alcoholic drinks. Numerator: the (appropriately weighted) number of respondents (18-69 years), who reported drinking 60 g or more of pure alcohol on at least one occasion weekly. Denominator: the total number of participants (18-69 years) responding to the corresponding question(s) in the survey plus abstainers. Percentage	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
5. Alcohol-related hospital morbidity and mortality among adolescents and adults, as appropriate, within the national context	Alcohol-related morbidity and mortality among adolescents and adults (monitored by alcohol use disorders). Adults (15+ years) who suffer from disorders attributable to the consumption of alcohol (according to ICD-10: F10.1 Harmful use of alcohol; F10.2 Alcohol dependence) during a given calendar year. Rate.	Civil registration, verbal autopsy	Annual	Ministry of Labour, Health and Social Affairs / NCDC
Area 3. Physical inactivity				
Target 3. A 10% relative reduction in prevalence of insufficient physical activity				
6. Prevalence of insufficiently physically active adolescents, aged 11, 13, 15 years, defined as less than 60 minutes of moderate to vigorous intensity activity daily	Percentage of adolescents, aged 11, 13, 15 years, participating in less than 60 minutes of moderate to vigorous intensity physical activity daily. Percentage.	"Health behavior in school-aged children" Survey (HBSC)	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
7. Age-standardized prevalence of insufficiently physically active persons aged 18-69 years	Percentage of adults aged 18-69 years not meeting any of the following criteria: – 150 minutes of moderate-intensity physical activity per week – 75 minutes of vigorous-intensity physical activity per week – an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 MET-minutes* per week. Minutes of physical activity can be accumulated over the course of a week but must be of a duration of at least 10 minutes.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC

	Percentage.			
Area 4. Salt/sodium intake				
Target 4. A 30% relative reduction in mean population intake of salt/sodium				
8. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18-69 years	Numerator: Sum of sodium excretion in urine samples from all respondents aged 18-69 years. The gold standard for estimating salt intake is through 24-hour urine collection, however other methods such as spot urines and food frequency surveys may be more feasible to administer at the population level. Denominator: All respondents of the survey aged 18-69 years Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
Area 5. Tobacco use				
Target 5. A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years				
9. Prevalence of current tobacco use among adolescents aged 13-15 and 16 years	The indicator is measured using the standard questionnaire during a health interview of a representative sample of the population aged 13-15 years (GYTS) and aged 16 years (ESPAD). Prevalence of current tobacco use among adolescents can be obtained from the Global Youth Tobacco Survey (GYTS) or from the results of the European School Survey Project on Alcohol and Other Drugs (ESPAD). "Tobacco use" includes cigarettes, cigars, pipes or any other oral tobacco and snuff products. "Current use" includes both daily and non-daily or occasional smoking. Percentage	GYTS ESPAD	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
10. Age-standardized prevalence of current tobacco use among persons aged 18-69 years	The indicator is measured using the standard questionnaire during a health interview of a representative sample of the population aged 18-69 years "Tobacco use" includes cigarettes, cigars, pipes or any other tobacco products. "Current use" includes both daily and non-daily or occasional use. Percentage	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
BIOLOGICAL RISK FACTORS				
Area 6. Raised blood pressure				
Target 6. A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances				

11. Age-standardized prevalence of raised blood pressure among persons aged 18-69 years (defined as systolic blood pressure ≥140 mmHg and/or diastolic blood pressure ≥90 mmHg) and mean systolic blood pressure.	Systolic blood pressure ≥140 and/or diastolic blood pressure ≥90 among persons aged 18-69 years. Numerator: Number of respondents with systolic blood pressure ≥140mmHg or diastolic blood pressure ≥90mmHg. Ideally three blood pressure measurements should be taken and the average systolic and diastolic readings of the second and third measures should be used in this calculation. Denominator: All respondents of the survey aged 18-69 years. Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
Area 7. Diabetes and obesity				
Target 7. Halt the rise in diabetes & obesity				
12. Age-standardized prevalence of raised blood glucose/ diabetes among persons aged 18-69 years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose)	Fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose among adults aged 18-69 years. Numerator: Number of respondents aged 18-69 years with fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose. Fasting blood glucose must be measured, not self-reported, and measurements must be taken after the person has fasted for at least eight hours. Denominator: All respondents of the survey aged 18-69 years. Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
13. Prevalence of overweight and obesity in adolescents aged 11, 13, 15 years.	According to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex. Body mass index (BMI) is calculated by dividing weight in kilograms by height in meters squared. Overweight is ≥ 1SD BMI for age and sex. Obese is ≥ 2SD BMI for age and sex. Percentage.	HBSC	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
14. Age-standardized prevalence of overweight and obesity in persons aged 18-69 years.	Body mass index ≥25 kg/m² for overweight and body mass index ≥ 30 kg/m² for obesity in adults aged 18-69 years. Body mass index (BMI) is calculated by dividing weight in kilograms by height in meters squared. Overweight is defined as having a BMI ≥25 kg/m² and obesity is defined as having a BMI ≥ 30 kg/m².	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC

	Percentage.			
15. Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18-69 years.	Mean proportion of total energy intake from saturated fatty acids in persons aged 18-69 years. Sum of proportion of SFA of total energy intake from all participants aged 18-69 years. For each participant, divide the saturated fatty acid intake by the total energy intake to get the proportion of total energy from SFA. Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
16. Age-standardized prevalence of persons (aged 18-69 years) consuming less than five total servings (400 grams) of fruit and vegetables per day.	Percentage of population aged 18-69 years who eat less than five servings of fruit and/or vegetables on average per day. A serving of fruit and vegetables is equivalent to 80 grams. Number of respondents aged 18-69 years eating less than 5 servings of fruit and/or vegetables per day. The average number of servings of fruit and/or vegetables is calculated for each participant as follows: 1) Calculate the average number of vegetable servings per week: total number of vegetable servings per day multiplied by number of days per week vegetables are eaten divided by 7. 2) Calculate the average number of fruit servings per week: total number of fruit servings per day multiplied by number of days per week fruit are eaten divided by 7. 3) Sum the average number of vegetable and fruit servings per week. If this total is less than 5, then the participant is counted in the numerator of the equation as eating less than 5 servings of fruit and/or vegetables per day. Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
17. Age-standardized prevalence of raised total cholesterol among persons aged 18-69 years (defined as total cholesterol ≥5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration.	Total cholesterol ≥5.0 mmol/L (190 mg/dl). Mean total cholesterol. There are two main blood chemistry screening methodology – dry and wet chemistry. Dry chemistry uses capillary blood taken from a finger and used in a rapid diagnostic test. Wet chemistry uses a venous blood sample with a laboratory based test. Either method is acceptable. Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
NATIONAL SYSTEMS RESPONSE				
Area 8. Drug therapy to prevent heart attacks and strokes				

Target 8. At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes				
18. Proportion of eligible persons (defined as aged 40 – 69 years and older with a 10-year cardiovascular risk ≥30%, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.	Percentage of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular disease (CVD) risk* ≥30%, including those with existing CVD) receiving drug therapy** and counseling*** (including glycaemic control) to prevent heart attacks and strokes. *A 10-year CVD risk of ≥30% is defined according to Age, Sex, other relevant sociodemographic stratifiers where available, blood pressure, smoking status (current smokers OR those who quit smoking less than 1 year before the assessment), total cholesterol, and diabetes (previously diagnosed OR a fasting plasma glucose concentration >7.0 mmol/l (126 mg/dl). **Drug therapy is defined as taking medication for raised blood glucose/diabetes, raised total cholesterol, or raised blood pressure, or taking aspirin or statins to prevent or treat heart disease. ***Counseling is defined as receiving advice from a doctor or other health worker to quit using tobacco or not start, reduce salt in diet, eat at least five servings of fruit and/or vegetables per day, reduce fat in diet, start or do more physical activity, maintain a healthy body weight or lose weight. Percentage.	STEPS	Based on Survey completion	Ministry of Labour, Health and Social Affairs / NCDC
Area 9. Essential non communicable disease medicines and basic technologies to treat major non communicable diseases				
Target 9. An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities				
19. Availability and affordability of quality, safe and efficacious essential non-communicable disease medicines, including generics, and basic technologies in both public and private facilities	Percentage of public and private primary health care facilities who have all of the following available: Medicines - at least aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long acting calcium channel blocker, a beta-blocker, metformin, insulin, a bronchodilator and a steroid inhalant. Technologies - at least a blood pressure measurement device, a weighing scale, blood sugar and blood cholesterol measurement devices with strips and urine strips for albumin assay. Percentage.	Nationally-representative health facility assessment	At least every 5 years	Ministry of Labour, Health and Social Affairs
20. Access to palliative care assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer	Consumption of morphine-equivalent strong opioid analgesics (excluding methadone) per death from cancer. Morphine- equivalent is a method of standardizing and combining volumes of opioids with differing potencies and is used as a measure of opioid consumption, which is used as the indicator for access to pain and palliation.	Consumption of opioids from International Narcotics Control Board annual	Annual	Ministry of Labour, Health and Social Affairs

	Population-level consumption of morphine-equivalent strong opioid analgesics for a given time period. Levels of consumption of opioid medicines in kilograms or grams (for Fentanyl) are calculated by the INCB on the basis of statistics on manufacture and trade provided by Governments. Consumed quantities include those distributed by wholesalers or manufacturers to retailers (mainly pharmacies and hospitals) plus quantities imported directly by retailers. The average reported consumption for the previous three-year period in many cases provides a more accurate estimate of actual consumption since volumes procured in one year may be consumed in the following year. Morphine-equivalent volumes are calculated as: (1*morphine)+(83.3*fentanyl)+(5*hydromorphone)+(1.33*oxycodone)+ (0.25*pethidine). Denominator: Number of cancers deaths occurring in the population over the same time period. Ratio.	reports for narcotics consumption / Civil registration / Cancer registry		
21. Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programs.	Adoption of a policy to limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply. Country can respond "yes" to the question “Is your country implementing any national policies that limit saturated fatty acids and virtually eliminate industrially produced trans fats (i.e. partially hydrogenated vegetable oils) in the food supply?”	WHO NCD Country Capacity Survey	Every 2 years	Ministry of Labour, Health and Social Affairs / NCDC
22. Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programs and policies	Availability of HPV vaccines as part of a national immunization schedule. Country can indicate that they have added HPV vaccine to their national immunization program, as reflected in their responses to the WHO-UNICEF Joint Reporting Form.	WHO-UNICEF Joint Reporting Form (JRF)	Annual	Ministry of Labour, Health and Social Affairs / NCDC
23. Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt	Existence of a policy to reduce the impact on children of marketing of foods and nonalcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt. Country can respond "yes" to the question “Is your country implementing any policies to reduce the impact on children of	WHO NCD Country Capacity Survey	Every 2 years	Ministry of Labour, Health and Social Affairs / NCDC

	marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt"?			
24. Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants	Percentage of one-year-olds who have received three doses of hepatitis B vaccine in a given year. Numerator: Total number of hepatitis B vaccinations given to children taken from reports of vaccinations performed by service providers (e.g. district health centres, vaccination teams, physicians). Denominator: Number of children in target population. Percentage.	Service/facility reporting system /administrative data	Annual	Ministry of Labour, Health and Social Affairs / NCDC
25. Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programs or policies	Proportion of women aged 30 - 49 who report they were screened for cervical cancer using any of the following methods: Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test.	Facility based data / STEPS State program	At least every 5 years / Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC

NATIONAL INDICATORS FOR MONITORING NCD RELATED HEALTH 2020 POLICY TARGETS IN GEORGIA

Area / target / Indicator	Definition / Unit of measurement	Data Source	Frequency of data dissemination	Lead/Line Ministry/Agency
1. Burden of disease and risk factors				
Reduce premature mortality in Europe by 2020				
(1) 1.1.a. Age-standardized overall premature mortality rate (from 30 to under 70 years) for four major non-communicable diseases (cardiovascular diseases (ICD-10a codes I00–I99), cancer (ICD-10 codes C00–C97), diabetes mellitus (ICD-10 codes E10–E14) and chronic respiratory diseases (ICD-10 codes J40–47)) disaggregated by sex; diseases of the digestive system (ICD- 10 codes K00–K93) also suggested but to be reported separately.	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population Deaths per 100 000 population	Civil registration, verbal autopsy	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(1) 1.1.a. Standardized mortality rate from all causes, disaggregated by age, sex and cause of death (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population Deaths per 100 000 population	Civil registration, verbal autopsy	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(2) 1.1.b. Age-standardized prevalence of current (includes both daily and nondaily or occasional) tobacco use among people aged 18-69 years.	The indicator is measured using the standard questionnaire during a health interview of a representative sample of the population aged 18-69 years. “Tobacco use” includes cigarettes, cigars, pipes or any other tobacco products. “Current use” includes both daily and non-daily or occasional use. Percentage	STEPS	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC
(2) 1.1.b. Prevalence of weekly tobacco use among adolescents, aged 13-15, 16 years (additional indicator).	Prevalence of current tobacco use among adolescents (13-15, 16 age groups) can be obtained from the Global Youth Tobacco Survey (GYTS) or from the results of the latest adolescent tobacco-use survey (or a	GYTS ESPAD	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC

	survey that asks tobacco-use questions) and request the following data: 1. the number of days on which the respondent smoked cigarettes or other tobacco products during the past 30 days; 2. whether or not, or the number of days on which, the respondent used any tobacco products other than cigarettes during the past 30 days. "Tobacco use" includes cigarettes, cigars, pipes or any other oral tobacco and snuff products. "Current use" includes both daily and non-daily or occasional smoking. Percentage			
(3) 1.1.c. Total (recorded and unrecorded) per capita alcohol consumption among people aged 18-69 years within a calendar year (litres of pure alcohol), reporting recorded and unrecorded consumption separately, if possible.	The total (sum of recorded and unrecorded) APC is the amount of alcohol consumed per adult (aged 18-69 years) within a calendar year, in litres of pure alcohol. Recorded APC is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits and other) Litres of pure alcohol per person per year; Litres of pure alcohol per adult (18-69 years) per year	STEPS	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC
(3) 1.1.c. Heavy episodic drinking (60 g of pure alcohol or around 6 standard alcoholic drinks on at least one occasion weekly) among Adolescents, aged 18-19 years (additional indicator).	Heavy episodic drinking among adolescents is defined as the proportion of adolescents (18-19 years) who have had at least 60 g or more of pure alcohol on at least one occasion weekly. A consumption of 60 g of pure alcohol corresponds approximately to 6 standard alcoholic drinks. Numerator: the (appropriately weighted) number of respondents (18-19 years) who reported drinking 60 g or more of pure alcohol on at least one occasion weekly. Denominator: the total number of participants (18-19 years) responding to the corresponding question(s) in the survey plus abstainers. Percentage	STEPS	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC
(4) 1.1.d. Age-standardized prevalence of overweight and obesity in people aged 18-69 years.	The prevalence refers to the percentage of defined population aged 18-69 years with overweight or obesity (defined as a BMI ≥25 kg/m2 for overweight and ≥30 kg/m2 for obesity). WHO defines overweight in adults (aged 18 years and over) as a BMI ≥25 kg/m2 and obesity as a BMI ≥30 kg/m2.	STEPS	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC

	Percentage			
(4) 1.1.d. Prevalence of overweight and obesity among adolescents aged 11, 13, 15 years (additional indicator).	The prevalence refers to the percentage of defined population with overweight or obesity, in kg/m2 (defined as a BMI-for-age value above +1 Z-score relative to the 2007 WHO growth reference median for overweight and above +2 Zscore relative to the 2007 WHO growth reference median for obesity). Percentage	HBSC	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC
(6) 1.3.a. Age-standardized mortality rates from all external causes and injuries, disaggregated by sex (ICD-10 codes V01–V99, W00–W99, X00–X99 and Y00–Y98).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA NCDC	Annual	Ministry of Labour, Health and Social Affairs / NCDC
1.3. a. Age-standardized incidence rates from all external causes and injuries, disaggregated by sex (ICD-10 codes V01–V99, W00–W99, X00–X99 and Y00–Y98) (country additional indicator).	Number of new cases occurring in the population per year per 100,000 population. Rate	NCDC	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(5) 1.3.a. Age-standardized mortality rates from motor vehicle traffic accidents (ICD-10 codes V02–V04, V09, V12–V14, V19–V79, V82–V87 and V89) (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(6) 1.3.b. Age standardized mortality rates from accidental poisoning (ICD-10 codes X40–X49) (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs / NCDC

(7) 1.3.c. Age standardized mortality rates from alcohol poisoning (ICD-10 code X45) (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(8) 1.3.d. Age-standardized mortality rates from suicides (ICD-10 codes X60–X84) (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(9) 1.3.e. Age-standardized mortality rates from accidental falls (ICD-10 codes W00–W19) (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs / NCDC
(10) 1.3.f. Age-standardized mortality rates from homicides and assaults (ICD-10 codes X85–Y09) (additional indicator).	The age-standardized mortality rate is a weighted average of the age-specific mortality rates per 100 000 people, where the weights are the proportions of people in the corresponding age groups of the WHO standard population. The age-standardized mortality rate is calculated using the direct method: it represents what the crude rate would have been if the population had the same age distribution as the standard European population / Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs
Area 3. Processes, governance and health systems				
Target 5. Universal coverage and the "right to health"				
(16) 5.1.a. Maternal deaths per 100 000 live births (ICD-10 codes O00–O99) (additional indicator).	The maternal mortality ratio is the annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes), during	Civil registration, verbal autopsy	Annual	Ministry of Labour, Health and Social Affairs / NCDC

	pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy. Deaths per 100 000 live births.			

NATIONAL INDICATORS FOR MONITORING NCD RELATED SDG TARGETS IN GEORGIA

Georgia Adjusted Target and Indicator	Definition / Unit of measurement	Data Source	Frequency of data dissemination	Lead/Line Ministry/Agency
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being				
3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes and COPD disease. Target: decrease by one third.	Crude mortality rate due to cardiovascular disease, malignant neoplasms, diabetes and COPD. Deaths per 100 000 population.	Civil registration, verbal autopsy	Annual	Ministry of Labour, Health and Social Affairs
3.4.2: Suicide mortality rate. Target: decrease by one third.	Crude mortality rate due to suicide. Deaths per 100 000 population	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol				
3.5.2: Alcohol per capita consumption in population, aged 18-69 years). Target: decrease by 10%.	The total (sum of recorded and unrecorded) APC is the amount of alcohol consumed per adult (aged 18-69 years) within a calendar year, in litres of pure alcohol. Recorded APC is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits and other). Litres of pure alcohol per person per year; Litres of pure alcohol per adult (18-69) per year.	STEPS	Based on Survey results	All of Government of Georgia
3.6 By 2030, reduce the number of deaths and injuries from road traffic accidents in Georgia				
3.6.1: Death rate due to road traffic injuries. Target: reduce by 25-30%.	Crude mortality rate due to road traffic injuries. Deaths per 100 000 population.	Civil registration, verbal autopsy / MIA	Annual	Ministry of Labour, Health and Social Affairs / NCDC
3.8 By 2030, Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all				
3.8.2 a: Coverage of essential health services (defined as the average coverage of essential services based on NCDs tracers (hypertension treatment coverage; diabetes treatment coverage; cervical cancer screening; tobacco use) Target: 100%	Measurement of the indicator is based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population. Percentage	MoLHSA (SSA)	Annual	Ministry of Labour, Health and Social Affairs
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination				
3.9.4: Prevalence of lower chronic respiratory diseases (disaggregated by sex and age) Target: substantially reduced by 2030	Total number of registered cases of lower chronic respiratory diseases (disaggregated by sex and age) among target population. Prevalence rate per 100 000 population.	NCDC	Annual	Ministry of Labour, Health and Social Affairs / NCDC

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in Georgia, as appropriate				
3.a.1: Age-standardized prevalence of current tobacco use among persons aged 18-69. Target: 20%	The indicator is measured using the standard questionnaire during a health interview of a representative sample of the population aged 18 years and over. "Tobacco use" includes cigarettes, cigars, pipes or any other tobacco products. "Current use" includes both daily and non-daily or occasional use. Percentage	STEPS	Based on Survey results	Ministry of Labour, Health and Social Affairs / NCDC
11.6 By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management				
11.6.2: Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10). Target: in cities - PM2.5 - 20 µg/m3 and PM 10 - 40 µg/m3.	Target levels of PM in 2030: PM10 - 40 µg/m3; PM2.5 - 20 µg/m3 (According to EU standard (Directive 2008/50/EC on ambient air quality and cleaner air for Europe) the PM2.5 limit value is 25 µg/m3 and must reach 20 µg/m3 by 2020). Rate.	MOE	Annual	Ministry of Environment and Natural Resources Protection
16.1 Reduce all forms of violence and related death rates everywhere				
16.1.1: Number of victims of intentional homicide per 100,000 population, by sex and age. Target: reduce by 10-15%.	Crude mortality rate due to intentional homicide. Deaths per 100 000 population	Civil registration, verbal autopsy / MIA		Ministry of Internal Affairs / NCDC
16.1.2. Proportion of women and men subjected to physical, psychological or sexual violence in the previous 12 months.	Proportion of cases registered using appropriate ICD 10 codes in mortality structure and hospital registry, disaggregated by sex and age. Share in hospitalization %. Hospitalization per 100000 population. Deaths per 100 000 population.	Civil registration, verbal autopsy / MIA / UN Women / NCDC	Annual	Administration of Government / Inter-sectorial Commission for Gender Equality, Combatting Violence against Women and Domestic Violence