

**SOCIAL AND HEALTH ASSESSMENT OF RESIDENTS, REFUGEES  
AND INTERNALLY DISPLACED PERSONS IN AZERBAIJAN**

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## ACRONYMS AND FOREIGN TERMS

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ADRA	Adventist Development Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BCG	Bacille Calmette-Guerin
CDC	Centers for Disease Control
CIDA	Canadian International Development Agency
CIF	Curatio International Foundation
DPT	Diphtheria-Pertussis-Tetanus Immunization or Vaccine
EPI	Expanded Program on Immunization
FSA	Freedom Support Act
FSU	Former Soviet Union
GOA	Government of Azerbaijan
GDP	Gross Domestic Product
GNP	Gross National Product
HFA	Health For All
HIS	Health Information System
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
ICD-10	International Classification of Disease, Version 10
IDD	Iodine Deficiency Disorders
IDP and IDPs	Internally Displaced Person and Internally Displaced Persons
IEC	Information, Education, Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
IMR	Infant Mortality Rate
KAP	Knowledge, Attitudes, and Practice
MCH	Maternal and Child Health
MDR-TB	Multi-Drug Resistant-Tuberculosis
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MSF	Medecins Sans Frontiere
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts/Solution
PHC	Primary Health Care
PVO	Private Voluntary Organizations
RFA/RFP	Request for Abstract/Request for Proposal
RHS	Reproductive Health Survey
SES	Sanitary-Epidemiological Service
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	The World Bank
WHO	World Health Organization

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## EXECUTIVE SUMMARY

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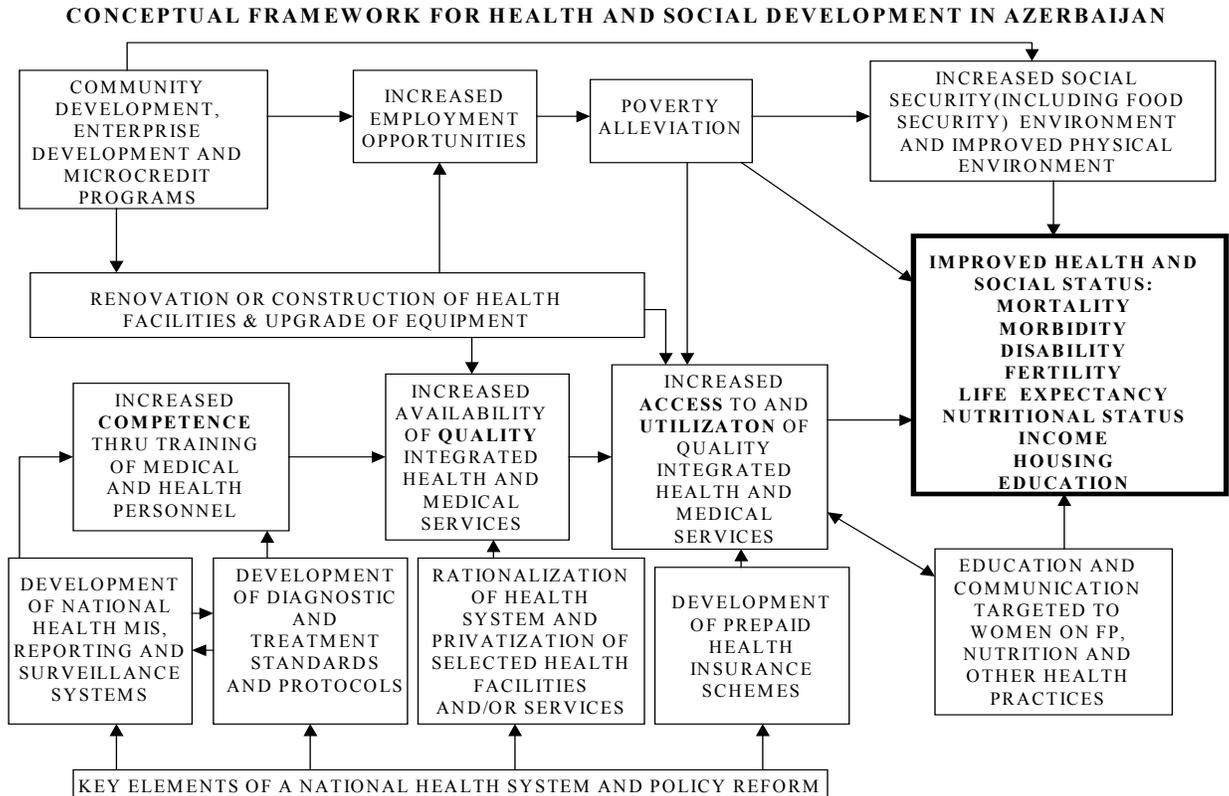
The people and Government of Azerbaijan (GOA) currently face multiple transitions that are having serious effects on social, health and economic development. After the dissolution of the Soviet Union and independence in 1991, the economy crashed but is now transitioning to a free market economy. The conflict with Armenia created new economic challenges, took 20 percent of Azerbaijan's territory, and uprooted 800,000 refugees/internally displaced persons (IDPs), the assistance for whom is transitioning from humanitarian to development. The population is in an epidemiological transition that creates a double burden of disease and need for services, while the under-financed health system struggles as it transitions from a single-provider to a pluralistic system. Health policy and system reform are inevitable. Such challenging transitions create refreshing opportunities for socioeconomic and health development.

Given this context and the recent repeal of Section 907 of the Freedom Support Act (FSA) that enables USAID to engage the GOA in substantive strategic planning as a basis for future bilateral development assistance, the team took a broad, comprehensive approach to assess the social and health situation, identify the determinants of health and the population groups at highest risk, conceptualize a framework for strategic planning, and make strategic recommendations for consideration by USAID and the GOA.

Most health, social and economic indices have deteriorated during the past decade: some have recently improved, others continue to worsen, and new challenges loom (TB, HIV/AIDS). While the health system has a surplus of doctors, nurses and other personnel, it is financially starved; many facilities are poorly maintained, equipped and supplied; quality of care falls while costs to consumers rise, so utilization declines. Health data of varied quality are rarely used for management. The dominant approach to health development is medical, not preventive; uni-sectoral, not multi-sectoral.

The determinants of ill health in Azerbaijan are related to economics (low family income, high unemployment, few opportunities); social and food security (low quality food, malnutrition, pensions); physical environment (pollutants; inadequate sanitation and housing; unreliable supplies of water, fuel, electricity); health education (inadequate health knowledge and practices); and health services (inadequate health promotion, disease prevention). While health system and policy reform are crucial, sustainable improvements in social and health status can be achieved through a synergistic, integrated, and multi-sector development strategy. The strategic approaches and program options recommended below are submitted to USAID for strategic planning purposes, but the team suggests that they be seriously considered by the MOH/GOA in an iterative process with USAID to develop a shared vision, strategic plan, and the essential partnerships for synergistic development.

**Five strategic approaches are recommended:** 1) develop multi-sector integrated development initiatives in areas where residents/IDPs are at highest risk in order to build synergism for rapid and sustainable social, health, and microeconomic status improvements; 2) improve family income, social and food security, and the health-related physical environment (water, sanitation, housing, fuel, electricity, etc.) through microcredit, enterprise development, and community development initiatives; 3) strengthen health system facilities, performance, and financing mechanisms; 4) strengthen health system management, the quality of health data, and the quality of services; and 5) strengthen health promotion, knowledge, practices and behavior.



Within the contexts of the conceptual framework and these five strategic approaches, the team recommends the following strategic and program options:

- Support proven or new innovative microcredit and enterprise development initiatives with the potential for alleviating poverty, increasing food security, and improving the health-related environment (water, sanitation, housing, fuel, electricity, etc.) at family and community levels.
- Support proven or new innovative community development programs that are directed towards improving food security and family income, alleviating poverty, and/or improving the health-related physical environment of households and communities.

- Support the development of prepaid health insurance schemes and revolving drug funds.
- Support the regulated privatization of selected facilities and/or services in areas of need.
- Support the training of master trainers, health leaders, medical directors, and managers in health care financing, financial management, revolving drug funds, and health insurance.
- Support the development of a management information system (MIS), the strengthening of the health information system (HIS), and development of a national disease surveillance system.
- Support development of diagnostic and treatment protocols, and produce clinical guidelines.
- Support training of medical and health personnel in key clinical and public health subjects.
- Support the development of a national health information, education and communication (IEC) capacity through the development of an IEC Training Unit with master trainers, the training of district-level personnel, and implementation of selected district-level IEC activities.



## I. BACKGROUND

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Many key indicators of social, health, and economic development in Azerbaijan deteriorated rather dramatically after Azerbaijan regained its independence in 1991 with the dissolution of the former Soviet Union (FSU). Adding insult to socioeconomic injury, the 1988-1994 conflict with Armenia resulted in Azerbaijan losing productive use of some 20 percent of its territory to occupying Armenian troops, while gaining some 220,000 refugees from Armenia and 570,000 internally displaced persons from Nagorno-Karabakh who moved into other areas of Azerbaijan. These 790,000 refugees/IDPs represented over 10 percent of the total population of Azerbaijan at that time. The number of refugees/IDPs in Azerbaijan has declined in recent years: United Nations Development Program (UNDP) estimated that in 1999 there were 576,000 registered refugees/IDPs, and the United Nations High Commission on Refugees (UNHCR) estimated that in January 2000 the number of registered refugees/IDPs in Azerbaijan had fallen to 550,000. The decline can be attributed to assimilation, death, and perhaps some migration, driven in part by harsh conditions and the need to seek income.

Since 1993, USAID has provided substantial humanitarian assistance for refugees/IDPs in Azerbaijan within the framework of the provisions of FSA, Section 907 which states that *“United States assistance under this or any other Act may not be provided to the Government of Azerbaijan until the President determines, and so reports to Congress, that the Government of Azerbaijan is taking demonstrable steps to cease all blockades and other offensive use of force against Armenia and Nagorno-Karabakh.”* In FY 1999, six types of assistance were exempted from the provisions of FSA, Section 907, including humanitarian assistance.

In 2001, USAID/Azerbaijan sought to conduct a social and health assessment of the IDP/refugee situation in Azerbaijan. Initially scheduled for September-October, the assessment was rescheduled to February 2002 following the terrorist attacks of September 11. While the original Scope of Work (SOW) called for a six-person team to spend three weeks in country, the slightly revised SOW provided for a three-person team to spend 14 workdays in country for the assessment. A fourth team member from USAID spent nine workdays in country assigned to this assessment.



## II. OBJECTIVES AND SCOPE OF ASSESSMENT

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The original objectives of the assessment were to provide USAID/Azerbaijan with:

- A synthesis of the social and health status of refugees/IDPs currently living in Azerbaijan;
- Options and recommendations for a set of activities that are technically, economically, socially, and politically sound;
- Suggestions for the future direction of USAID-funded activities in the social/health sector in Azerbaijan for the next three years.

Shortly before the team's arrival in Baku, the FSA, Section 907 restrictions were repealed. Thus, during the team's initial in-country briefing, USAID/Azerbaijan instructed the team to:

- Broaden the scope of the original Terms of Reference (TR) for the Social/Health Assessment of Refugees/IDPs in Azerbaijan to include all population groups in Azerbaijan;
- Make site visits to selected facilities in various areas of Azerbaijan that serve non-displaced residents (approximately  $\frac{3}{4}$  of site visits) and refugees/IDPs (approximately  $\frac{1}{4}$  of site visits);
- Make recommendations that serve the national social and health development needs of residents, as well as the humanitarian assistance needs of refugees/IDPs; and
- Make recommendations of particular strategic and conceptual value to USAID, rather than recommendations on specific projects or other specific program interventions.



### **III. ASSESSMENT METHODOLOGY AND ACTIVITIES UNDERTAKEN**

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The methodology of this assessment involved:

- Studying a broad collection of key documents (see Annex B);
- Conducting consultations with key informants (see Annex C);
- Collecting secondary data and information on demographics, social and health status, the health system, the availability of and access to health services (see Section IV and Annex D);
- Assessing various determinants of health, risk factors, and social indicators (employment/income, housing, education, and so forth), in order to define and characterize the most vulnerable population groups at highest risk (see Section V); and
- Conducting site visits to various areas in the country in order to assess health facilities and projects, and meet with health officials, physicians and other health workers, NGO leaders, and community representatives (see Section IV and Annex C).

Site visits were made to Sabiribad, Saatly, Shaki, Masally, Sigdash Village, Salyan, Shamakhi, Goychay, Gabala, Gusar, Khizi, Sumgait, two IDP camps at Barda and Bahramtapa, and the Republican (Mirkasimov) Hospital in Baku. Consultations were conducted with the district head doctors and other health officials at the district level, physicians and other health workers at a wide range of health and medical facilities, PVO/NGO leaders, community leaders, and representatives of Executive Committees and Village Councils. Consultations were also conducted with leaders of various PVOs/NGOs, and international organizations in Baku. Significantly, on February 14, a USAID delegation (led by Bill McKinney, USAID Country Coordinator) and the team leader briefed Minister Ali Insanov, First Minister of the MOH, about the assessment, and then a debriefing was provided to Professor Alexander Umnyashkin, Adviser to the First Minister of Health by the entire team and a USAID delegation on February 26. Both interactions with the MOH were useful to the team and appreciated by the Ministry. Mr. McKinney promised Minister Insanov a copy of the Executive Summary when the final report is received by USAID Azerbaijan.

Highlights of the team's observations, analyses, and key findings are presented below (Section IV) under topics on the quality of data and principal sources, demographic overview, environmental and socioeconomic overview, health system analysis, and health

status and current health challenges. Section V presents an analysis of the key determinants of health, inequities in health and health care, and the vulnerable population groups at greatest risk. Based on these findings and subsequent deliberations, the team formulated a conceptual framework for strategic planning of a health and social development assistance program for Azerbaijan (Section VI). The team's strategic recommendations are presented in Section VII; the recommended next immediate steps are presented in Section VIII; and the report concludes with a positive note on prospects for productive partnerships to advance social, health and microeconomic development for all Azerbaijanis.

## **IV. HIGHLIGHTS OF OBSERVATIONS, ANALYSES, AND KEY FINDINGS**

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### **A. QUALITY OF DATA AND PRINCIPAL SOURCES**

The most pervasive problem that was identified early in the assessment team's work is the difficulty of finding high quality data and reliable statistical information from administrative sources in Azerbaijan, which are the principal sources of data reported to and used by international organizations and bilateral development assistance agencies. The statement that "Some of the data from administrative sources are reliable, while others are decidedly unreliable" generously sums up the problem.<sup>1</sup>

The problem is well known to the assessment team leader who had previously undertaken an assignment for the World Health Organization (WHO) to assess the completeness, accuracy and timeliness of reporting from hospitals, clinics and district health facilities, which are the primary sources of health data in Azerbaijan. Beyond the problem of incomplete and inaccurate reporting at the local level, there are methodological problems created, for example, by the use of outdated definitions of stillbirth and infant death, and by not using the 10th International Classification of Disease (ICD-10) and the international usage of classifications of the causes of death and morbidity. Also, there is often faulty communication between local and central authorities for a variety of reasons, such as the use of various "norms" (e.g., the number of hospital beds) for determining budgetary allocations.

A costly and hopefully temporary solution to the problems of unavailable data or unreliable data from administrative sources is to conduct sample surveys. However, sample surveys can also produce unreliable data because survey methodology is complex with respect to sampling, questionnaire design, interviewer training and control, analysis and reporting. The assessment team found six surveys to be particularly useful for the purposes of this assessment:

- Health and Nutrition Survey of Internally Displaced and Resident Population of Azerbaijan – April 1996, USAID, WHO, and UNICEF;
- Azerbaijan Poverty Assessment, Vol. I and Vol. II, 1997, the World Bank;
- Azerbaijan – Multiple Indicator Cluster Survey, December 2000, UNICEF (unpublished);
- Population Health Needs and Health Service Utilization in Southern Azerbaijan, November 2000, IMC/CIF/USAID;

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<sup>1</sup> "Children and Women in Azerbaijan: A Situation Analysis," UNICEF, 1999.

- Primary Health Care Network Survey for Southern Azerbaijan, November 2000, IMC/CIF/USAID; and
- Reproductive Health Survey, Azerbaijan, 2001, Center for Disease Control (CDC)/Adventist Development Relief Agency (ADRA).

The problem of the paucity of high quality data is presented here as the team's first observation in order to: 1) alert readers to this problem as the principal reason for some inconsistencies of data taken from various sources given within this report; and, 2) prompt readers to seriously consider the importance of advocating for:

- a. A strengthened health information system (HIS) at the district level, which is the primary source of data, along with other data reported by the Sanitary and Epidemiological Service (SES), used by the MOH Statistics Department and by the Bureau of Statistics;
- b. The design, testing and development of a national disease surveillance system; and
- c. A district-oriented management information system (MIS), as high quality data is critically needed for planning, implementing, and managing primary health care and social services at the district level, and for assessing the effectiveness and efficiency of the health system at both the district and central levels.

At such time that the MOH undertakes a comprehensive health system and policy reform initiative, the various health data record keeping, reporting, and information systems should be consolidated into a single National Health Management Information System, but this will require substantial organizational, policy, and regulatory changes within and outside the health sector.

## **B. DEMOGRAPHIC OVERVIEW**

The United Nations Statistic Division estimates that in 2002 there are approximately 7.84 million people residing in Azerbaijan, 27 percent of which are under 14 years of age. Males constitute 51 percent and females 49 percent of the population. Population growth for the last several years has averaged near or less than one percent per year. Consistent with this slow growth, the estimated total fertility rate is 2.1 (CDC, 2002) and the net migration rate is  $-5.67/1000$  (CIA, 2002). Of the total population of Azerbaijan, more than one-half (57 percent) live in urban areas and one-third live in Baku, the nation's capital, and the surrounding areas.

Ninety percent of the total population is ethnically homogenous Azeri (SCS, 2001); three percent are Russian, two percent are Armenian, and about six percent are other ethnic groups (UNFPA, 1996). Like the other 14 republics of the former Soviet Union (FSU), life expectancy in Azerbaijan decreased during the mid-1990s, but began to rise later in that decade. In 1996, life expectancy was 70.0 years, but then rose to 71.5 years in 1999 (WDID, 2001). Of course, national averages can mask broad differences between various sub-population groups and geographical regions.

The Azerbaijan population is in the midst of an epidemiological transition, moving from a predominance of infectious and nutritional diseases, generally characteristic of Third World countries, to a preponderance of chronic and degenerative diseases characteristic of industrialized countries. During the transition, the population faces a “double burden of disease.” It is experiencing increasing rates of chronic degenerative diseases (cancer, diabetes, and cardiovascular disease, especially heart disease and stroke), while the population continues to suffer from health problems of the poor countries (malaria and other infectious diseases, malnutrition, anemia, iodine deficiency disorders, and poor reproductive health). The double burden of disease not only challenges the population, it also challenges and strains the health system.

### **C. ENVIRONMENTAL AND SOCIOECONOMIC OVERVIEW**

#### **Why Consider Conditions Outside the Health Sector?**

Health development, social development, and economic development are inextricably linked in a complex but mutually dependent relationship. While the health and social benefits of economic development, particularly environmental and infrastructure developments (agriculture, water, sanitation, roads, housing, electrification, and so forth) have been long recognized, it is only in the past 20-25 years that investments in “human capital” and improvements in health and social status have been recognized to have powerful positive benefits to the quality and rate of economic development. Investments in social and health development and the subsequent improvements in health status and performance are now recognized as crucially important for improving productivity. Higher levels of productivity generally lead to higher income; higher income leads to increased quality of life and greater levels of disposable income that, in turn, can be spent on health, preferably health promotion and disease prevention, rather than curative care alone. Of the principal determinants of health (see Section V), the education of women, even informal education, has the strongest positive effect on improving health status at the family level. Poverty reduction also has a powerful influence on improving health status. For these reasons, a social and health assessment must consider environmental, socioeconomic, and other conditions outside the health sector that have a positive or negative impact on health status.

#### **Physical Environment: Housing, Water, Sanitation, Electricity, Fuel**

Numerous improvements in the physical environment are needed and the situation could worsen. Although most Azerbaijanis do not consider their housing situation to be a serious problem now, this situation could change because of reduced family income and the relative inability to make repairs and provide maintenance. Currently, most complaints with regard to housing relate to utilities. Water is cited as the most problematic service because of irregular supply and poor water quality (World Bank, 1997). The links between poor quality water supply and poor sanitation with diarrheal disease and other gastrointestinal infections are well understood, and these are common problems in Azerbaijan. Similarly, the links between irregular electrical power, perishable food and gastrointestinal disease is well understood. The links between irregular electrical power, interruption of the vaccine “cold chain,” and the occurrence of

immunizable diseases among immunized children, which is happening in Azerbaijan, is also understood. Surveys reveal that 90 percent of the population has electricity, and six percent have no electrical service in their community. Significantly, groups in all areas reported frequent interruptions in the supply.

The more serious energy problem is related to gas supplies in areas outside of Baku. In the winter of 1995-1996, most areas outside Baku had no gas supplies, which led to the use of wood to heat homes.<sup>2</sup> In homes without adequate ventilation, wood burning in homes led to increased rates of respiratory infections and asthmatic distress. While the winter of 1995-96 was dramatic, this situation still occurs in most rural areas. Most homes and many health facilities, some of which are very cold in winter, have a wood stove in the room to provide some heat when the gas supply is interrupted, which happens frequently.

The situation for refugees/IDPs in many areas deserves attention: while many IDPs have assimilated into host communities, the majority of IDPs have inadequate shelter, poor access to clean water and sanitary services, and severely limited supplies in proportions higher than the general population.<sup>3</sup>

### **Poverty and Unemployment**

Poverty is a major contributor to most of the numerous health issues in Azerbaijan. Although annual GDP growth in recent years has been quite high (10 percent in 1999), the per capita GDP is just \$537, and per capita GNP remains low at only \$550 in 1999 (World Bank, 2001). And these figures are misleading in terms of the real situation at the family level, which is severe, because national figures are buoyed by foreign investment, little of which reaches to the purse of the average family.

Unemployment is approximately 20 percent.<sup>4</sup> Twenty-four percent of the population is classified as very poor and 68 percent is classified as living below the national poverty line.<sup>5</sup> No reliable estimates are available for either of these estimates from the GOA. The government records only the number of people who have registered as unemployed, which amounts to just one percent of the labor force.<sup>6</sup> Within this limited number of registered unemployed persons, women account for 60 percent. And most women who are employed are typically in the lower paying professions. Unofficial labor markets where people are hired on a daily basis at low rates now exist in most large settlements throughout the country. The emergence of these markets is a clear signal that a large number of people are desperately searching for work. A substantial number of people have migrated to other countries during the last decade seeking employment. Some of these people have returned periodically and imported new health problems, such as HIV/AIDS.

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<sup>2</sup> World Bank, 1997.

<sup>3</sup> United Nations Development Program (UNDP), 1999.

<sup>4</sup> Center for Disease Control (CDC), 2002.

<sup>5</sup> World Bank (WB), 2001.

<sup>6</sup> UNDP, 1999.

Poverty and unemployment have changed patterns of household spending and consumption. In 1997, 70 percent of the average family income was spent for food. Even with that high proportion, the quality of food purchased and consumed diminished well below what is needed for adequate growth and nutrition (such as meat, fish, and dairy products).<sup>7</sup> When families are forced to concentrate their expenditures on basic food products, their ability to pay for other categories of products and services, such as health care, is diminished for most and non-existent for many. To say that economic issues, poverty and unemployment are having a negative effect on health status and on access to health care in Azerbaijan would be a vast understatement.

### **Social Status of Women**

In Azerbaijan, like most other regions in the world, the status of women is closely linked to issues of health. Women are typically the primary caretakers in families and their educational and social status will determine to a great extent their own health and their family member's health. In Azerbaijan, women and men possess equal rights and liberties under the constitution, and the country's labor law explicitly prohibits wage discrimination based on gender. However, a greater percentage of women than men remain unemployed and those employed are in lower paying professions. One important area where Azerbaijan has achieved near gender equality is educational enrollment.<sup>8</sup> However, significant asymmetries are noteworthy: women comprise only 10 percent of people with D.Sc. degrees, Azerbaijani's highest scientific degree, and only 30 percent of people with Ph.D. degrees.

### **Social Status of Children**

The social status of children and how it links with their health is also important. In the World Bank's 1997 poverty assessment, focus groups stated that it had become increasingly common for children as young as six years of age to work in the informal labor market, despite the fact that Azerbaijan law forbids the employment of children less than 16 years of age.<sup>9</sup> The overall level of child labor is difficult to estimate, as school records do not give good estimates of dropout and truancy rates. However, estimates of the number of school age children who had dropped out of school or were spending a substantial amount of school time working have ranged between 10 and 25 percent with that number increasing dramatically once children reached 10 to 12 years of age. This figure also has regional variation: informal child labor was much more common in urban areas. The main reason given for the increase in child labor was low family income.

### **Food Security**

While malnutrition is a problem for the general population, food security is especially difficult for the IDP population. Food security is defined here as "having the quantity,

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<sup>7</sup> United Nations Development Program (UNDP), 1999.

<sup>8</sup> *Ibid.*

<sup>9</sup> United Nations Children's Fund (UNICEF), 1999.

quality and diversity of food needed at all times to lead a healthy and productive life” (CARE, 1994). By 1996, 90 percent of IDPs indicated that they had no more assets to sell (WHO, 1996). Based on general income and food security parameters, WHO in its 1996 survey found that IDPS were substantially worse off than the resident population. It is important to note, though, that the poor among the resident population also suffer from food insecurity. Female-headed households, particularly those with many children, can have severe food insecurity. On a national scale, regardless of displacement status, female-headed households with many children comprise a highly vulnerable population group at high risk.

#### **D. HEALTH SYSTEM ANALYSIS**

The health system in Azerbaijan, which has been deteriorating for most of the past decade, can be generally and succinctly characterized as follows:

- Declines in real public spending on health;
- Reliance on historic “norms” based methods of resource allocation;
- Inefficiency and inequity of health resources allocation;
- Over emphasis on secondary hospital care at the expense of primary care;
- Long lengths of hospital stay (17-18 days), the longest lengths of stay among all FSU countries;
- Low hospital occupancy rates (42 percent), among the lowest in the FSU countries;
- Over provision of hospital beds and infrastructure;
- Aged and often non-functional medical equipment, and few if any medical supplies or drugs;
- Reduction in the quality of care;
- Over provision of doctors and medical staff; all staff underpaid;
- Unofficial informal payments for services; new privatization and user fees policy accepted;
- Up to 70 percent of the population is experiencing a reduction in access to health care;
- A lack of public confidence in the health system; and

- Low utilization of the health system.

### **Availability of Health Personnel, Facilities, Equipment and Supplies**

Azerbaijan employs nearly four doctors per 1,000 population, twice the number employed in the United Kingdom (1.6) and Canada (2.1). Even with the over-supply of doctors, their distribution within the country is very uneven, as most of them are specialists and they prefer to work in large hospitals at the expense of the primary care facilities. Nurse-to-population ratios in Azerbaijan are also far higher than in the health care systems in the industrialized countries of Europe and North America. Earning salaries that are well below subsistence levels, medical and health personnel in Azerbaijan must seek other means of earning an adequate income.

In rural areas, the feldsher-midwife posts, called Feldsher-Accousherski Punkt (FAP) provide basic primary care to population groups of 600-3,000. In other areas, the FAPs, the rural polyclinics and small rural hospitals are being replaced by a number of outpatient health centers serving populations of about 10,000. Large hospitals are found in every district, some of which are reference hospitals serving several districts; and the largest tertiary care hospitals are located in Baku.

The number of hospital beds per 1,000 population has gradually declined from 10.5 in 1992 to 8.4 in 1998, but remains much higher than the average for Europe (7.8), Sweden (6.4) and the United Kingdom (5). Except for the large reference hospitals and tertiary hospitals, most facilities in Azerbaijan have a serious lack of medical equipment, drugs, and supplies. This is particularly true at rural facilities, but the worst situations were observed at some of the IDP/refugee settlements.

### **Accessibility to and Utilization of Health Services**

Given the over-provision of physicians, medical staff, and hospitals beds, it is not surprising that there is an over emphasis on secondary hospital care at the expense of primary care. Most clients go directly to the hospital for primary care, in stark contrast to the practice in Europe and North America where 80-90 percent of clients receive care at primary care facilities.

Despite high levels of available health facilities and personnel, these resources are underutilized. Azerbaijan has the dubious distinction, for example, of having the second lowest hospital occupancy rate within the FSU countries at a very low 41.5 percent nationwide average, and the longest hospital stays among all the FSU countries at 17.9 days in 1994 and 17.1 days in 1998.

The principal reasons for such low and inappropriate use of hospitals and other medical facilities are: low quality of care related to the relative unavailability of equipment, supplies, and drugs; the outdated resource allocation methods used; the informal costs of medical consultations which are unaffordable to large segments of the population; and worsening levels of poverty in Azerbaijan.

## **Health Care Financing, Privatization, Equity, and Monitoring Inequities**

Reliable data on government health expenditures are difficult to obtain. According to the MOH, government spending on health was \$9.92 per capita in 1998 and slipped to \$7.58 in 1999; however, another source (Azerbaijan Economic Trends) indicates that these figures should be \$4.41 and \$5.25, respectively. As most of these expenditures are allocated to personnel costs, little remains for other costs associated with quality health and medical services (diagnostic and therapeutic equipment, supplies, and drugs), seriously compromising the quality of services. Given low-quality services, the increasing costs to patients of “informal” fees-for-service, and the low affordability of these services because of increasing levels of poverty, utilization can be expected to remain low until new methods for the financing of health services can be found.

Current trends towards the privatization of health services and fee-for-service charges can, if not properly regulated, introduce new inequities in access to health services, particularly where people are already spending 70 percent of their income on food, leaving little or nothing for health care. The introduction of privatization and the application of user fees are doomed if family income cannot support these new costs; hence, the introduction of microcredit, enterprise development, and other potential income-producing initiatives should be given a priority and precede the introduction of privatization and user-fees in poor areas. Low-cost health insurance schemes, whereby health care costs are spread out over large populations might be feasible if large numbers of families participate and especially where the population covered includes people with varying incomes, and where multi-rate premiums are scaled according to the families’ ability to pay.

Poverty is a multi-dimensional phenomenon characterized by a denial of the choices and opportunities necessary for gainful employment or other means of generating family income, accessing health care when needed, and improving one’s health and social status. Moving out of a state of multi-dimensional poverty is reflected by improvements in health status indicators, especially those of children. And conversely, the introduction of new inequities in access to health care that might be introduced by privatization and user fees can be detected among children before being seen in adults. Therefore, monitoring the health of children of poor families is one means of detecting inequities experienced by poor families when introducing privatization and user fees.

## **E. HEALTH STATUS AND CURRENT HEALTH CHALLENGES**

### **Mortality, Morbidity, Longevity**

Determining an accurate picture of population health status in Azerbaijan is very difficult, as there are serious problems with the reliability of official statistics; and population-based data available from scientifically sound sample surveys and special studies are relatively scarce. Nevertheless, it is clear that many indicators of health status in Azerbaijan worsened dramatically in the period of economic transition that started after independence in 1992, as happened in most FSU countries.

The infant mortality rate (IMR) increased in the years immediately following independence and reached a peak in 1993, but it has since fallen to below the 1990 level (WHO, HFA Database, 2000). The official IMR for 2000 is 13 deaths per 1000 live births (Health Statistics of Azerbaijan Republic, [www.mednet.az](http://www.mednet.az)). However, the estimated IMR derived from more reliable surveys is 79-80 deaths per 1000 live births.<sup>10</sup>

While the official maternal mortality ratio (MMR) for 2000 is reported as 37.6 maternal deaths per 100,000 live births,<sup>11</sup> the more reliable population-based estimate of the MMR for 2000 is 79 per 100,000 live births.<sup>12</sup>

The overall mortality rate increased between 1990 and 1995, but has since diminished to its pre-independence level. Correspondingly, there was a significant decrease in life expectancy, more pronounced among men, which has since increased to 1990 levels.

Disability-adjusted life expectancy in Azerbaijan is presently 65 years: 66.7 for women and 63.7 for men, (World Health Report, 2000). However, the quality of government reported statistics is of uncertain reliability, so the indicators given above might not reflect the real situation.

According to “official” statistics, the three leading causes of mortality in Azerbaijan are: 1) cardiovascular disorders, 2) cancer, and 3) injuries. And, according to the same source, the highest occurrences (incidence/prevalence) of disease are reported as: 1) diseases of the nervous system and sensory organs, 2) cardiovascular disorders, 3) infectious and parasitic disease, 4) mental disorders, 5) genitourinary diseases, and 6) gastrointestinal diseases (Health Statistics of Azerbaijan Republic, [www.mednet.az](http://www.mednet.az)). However, it must be emphasized that these classifications of disease are not in accordance with the ICD-10.

### **Nutritional Status and Micronutrient Deficiency Disorders**

#### Growth indices

The Azerbaijan Multiple Indicator Cluster Survey 2000 (unpublished) revealed poor nutritional status among children under the age of five years: eight percent of children have acute malnutrition (weight-for-height Z score <-2), 20 percent of children have chronic malnutrition (height-for-age Z score <-2), and seven percent of children were severely stunted. Children whose mothers have at least a college or vocational school education are the least likely to be wasted or stunted compared to children of mothers with less education. There were regional disparities: more than 12 percent of children under five in Nakhchivan and the west and southwest regions were severely stunted, compared to the national average of seven percent (Azerbaijan MICS, 2000). According to the results of the 1996 Health and Nutrition Survey, chronic energy deficiency (Body Mass Index < 18.5) was found in 12 percent of elderly people.

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<sup>10</sup> RHS Azerbaijan 2000; Azerbaijan MICS, UNICEF, 2000.

<sup>11</sup> WHO, HFA Database, 2000

<sup>12</sup> Azerbaijan MICS, UNICEF, 2000.

During 1990–1999, the average number of calories consumed per person per day decreased from 2600 to 2200 kcal. The lowest intake, 2000 kcal, was reported for 1995. Correspondingly, the proportion of total energy available from proteins decreased from 14.5 percent to 12 percent during this period. The lowest proportion, 11.5 percent, was reported for 1997. In 1996, around 12 percent of households reported a lack of food security, which was defined as those who: 1) ate no meat in the last week, 2) skipped at least one meal because of insufficient food in the last week, and 3) have no access to a garden.<sup>13</sup>

### Anemia

The 1996 Health and Nutrition Survey revealed very high rates of anemia among IDPs and residents in Azerbaijan: 44 percent of children 12-59 months of age (Hgb <11.0 g/dl); 36 percent of non-pregnant women (Hgb <12.0 g/dl); 26 percent of men (Hgb <13.6 g/dl). Anemia was highly prevalent among both rural and urban populations, the rural populations had higher prevalence compared to their urban counterparts (49.8 percent vs. 40.0 percent in children, 39.6 percent vs. 33.5 percent in women, and 31.9 percent vs. 21.2 percent in men).

The anemia levels found in the Reproductive Health Survey 2001 (blood samples collected from women with children under five) were in a similar range: 41 percent of non-pregnant women with at least one child under five years of age were anemic (i.e., had hemoglobin levels under 12.0 g/dl). Seventy-six percent of all anemic women had mild anemia (Hgb 10.0-11.9 g/dl) and less than one percent had severe anemia (Hgb <7.0 g/dl). The continuing high and apparently increasing rates of anemia among women, children and unusually, men in Azerbaijan should be studied further to determine the clear causes of this widespread problem. Is it related to the deteriorating nutritional patterns resulting from the worsening economic situation at the family and community levels? Once the causes are understood, intervention programs can be created and targeted to women of childbearing age and children.

### Iodine deficiency disorders

Azerbaijan has a very serious problem concerning highly endemic Iodine Deficiency Disorders (IDD): 23 of a total of 59 districts have endemic IDD. UNICEF reports that up to 80 percent of schoolchildren in these highly endemic districts suffer from IDD, and half of them have already developed goiter.<sup>14</sup> As IDD among infants and young children arrests brain development, producing cretins and children of low intelligence, this situation constitutes a public health emergency with grave long-term consequences.

As revealed by the 1996 Health and Nutrition Survey, an estimated 11 percent of the adult population in Azerbaijan suffers from goiter (enlarged thyroid glands detected by clinical examination). The prevalence is higher among IDPs than the resident population

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<sup>13</sup> “Health and Nutrition Survey of IDPs and Residents,” USAID, UNICEF, WHO, 1996.

<sup>14</sup> “Master Plan of Operations 2000-2004,” UNICEF, 1999

(23.0 percent vs. 9.8 percent) and is higher among women than men (13.3 percent vs. 5.8 percent). The higher prevalence in women was consistently found regardless of geographic location or resident status. [Note: Although this difference was statistically significant, it might not be reflective of a true difference in iodine deficiency between women and men, as men have muscular necks that can hide goiter.] Goiter was found to be more prevalent in urban areas than in rural areas (15.1 percent vs. 6.1 percent), and this difference applied to both IDP and resident populations. On a positive note, the MOH has launched an IDD control program in endemic districts where iodinated oil is given to children by mouth and iodized salt is available in the marketplace.

### **Infectious and Communicable Diseases**

Infectious and communicable diseases remain a widespread problem. Among children, acute respiratory infections and diarrheal diseases are very prevalent. Acute respiratory infections, particularly pneumonia, are leading causes of child deaths in Azerbaijan as elsewhere.<sup>15</sup> Dehydration caused by diarrhea is a major cause of mortality among Azerbaijani children. In the 2000 Multiple Indicator Cluster Survey (unpublished), seven percent of children under five years of age had diarrhea in the two weeks preceding the survey. Only one out of ten children received ORS, though, a larger percentage received some form of a recommended liquid (breast milk, gruel, soup, or other food-based oral rehydration solutions) during a diarrheal episode.

The prevalence of malaria, endemic in southern Azerbaijan, increased in the years following the breakup of the Soviet Union. In 1967, there were only three recorded cases of malaria in Azerbaijan, but after the dissolution of the Soviet Union the number of malaria cases increased to 667 in 1994. By 1996, there were more than 13,000 cases. In response, the MOH worked with both private and public organizations to conduct a malaria eradication campaign and reduce the number of malaria cases. Activities included training medical personnel, providing treatment, and reducing the population of mosquitoes. By 1999, less than 2,000 cases were reported. But 1999 was a dry year with a low mosquito population and decreased transmission. The malaria situation deserves vigilant monitoring.

Tuberculosis is a continuing problem. In 2000, the case notification rate was 64.45/100,000 (5,187 cases), which is average for the region but contrasts with countries in Western Europe, such as Italy, which has a rate of 7/100,000 (WHO, 2002). Currently, the treatment success rate approximates 80 percent, but this may change as multi-drug resistant tuberculosis (MDR-TB) becomes more prevalent. There is little to no information regarding MDR-TB in Azerbaijan at the present time, but given the emergence of MDR-TB in other countries of the FSU it can be reasonably expected that Azerbaijan will soon face similar problems.

The number of HIV infections in Azerbaijan is relatively low compared to other countries in the region, but it is clearly increasing. By April 2000, there were a total of 193

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<sup>15</sup> UNICEF, 2000.

registered people with HIV/AIDS;<sup>16</sup> however, this number is probably underestimated by a factor of two- to ten-fold. Most reported cases have been in Baku (65 percent); the remaining cases being registered in 21 districts. A main source of transmission is intravenous drug use, but several other factors could contribute to a future epidemic: a large displaced population, growing sexual activity among youth, a highly mobile rural male population, an increase in commercial sex workers, and a highly medical, rather than a public health, approach to the disease. The official Sexually Transmitted Infection (STI) rate has increased three-fold since 1991, which can facilitate the transmission of HIV, and is further cause for concern about the future of HIV/AIDS in the country.

## **Chronic and Degenerative Diseases**

### Atherosclerosis, Heart Disease, and Stroke

Atherosclerosis, coronary heart disease, and stroke combine to form the greatest disease burden for the overall population in Azerbaijan.<sup>17</sup> The population's poor cardiovascular health is likely to worsen because of high and often increasing prevalence of hypertension (Health Statistics of Azerbaijan), obesity, smoking,<sup>18</sup> the escalating socioeconomic hardships and poverty,<sup>19</sup> the very limited access to and low utilization of health services, and the low quality of care.<sup>20</sup>

### Cancer

In 1990-2000, Azerbaijan reported a decreasing trend in cancer incidence and prevalence, which can probably be attributed to under-reporting of cases, as one should expect to see cancer morbidity and mortality rising given the serious environmental hazards (e.g., industrial pollution, oil refinery by-products, low quality petrol, chemical fertilizers) and the concentration of the population in large cities.<sup>21</sup>

Among men, the incidence of cancer is highest for tracheal, bronchial, lung and stomach cancers. Among women, the incidence of cancer is highest for breast, cervical and uterine cancers (Health Statistics of Azerbaijan Republic). Of great concern is the fact that less than 30 percent of sexually experienced women of childbearing age have ever heard about breast self-examination techniques and only 10 percent have ever done self-examination. Only two percent of sexually experienced women have ever had a cervical cancer screening (Pap test) service and less than one percent had received a Pap test within the past three years.<sup>22</sup>

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<sup>16</sup> UNAIDS, 2001.

<sup>17</sup> "World Health Report (Rapport sur la Santé dans le Monde) (WHR), 2000.

<sup>18</sup> Health for All (HFA) Database, WHO, 2000.

<sup>19</sup> WB Poverty Assessment, 1997.

<sup>20</sup> Reproductive Health Survey (RHS), 2000; Health and Nutrition Survey, 1996; "Population Health Needs and Health Service Utilization," International Medical Corps (IMC), 2000.

<sup>21</sup> "Azerbaijan Human Development Report," UNDP, 1997.

<sup>22</sup> RHS, 2000.

The increasing use of tobacco products contributes to the high morbidity and mortality of cardiovascular disease and cancer, as well as to the development of many chronic diseases. Twenty-seven percent of the adult population (age 15+ years) are regular smokers with over 1000 cigarettes consumed per person/year.<sup>23</sup>

### **Women's Reproductive Health**

There are approximately two million women of reproductive age in Azerbaijan. Although there are few reliable statistics on reproductive health indicators from official sources, survey data shows that reproductive health status remains low and in many areas women's reproductive health is declining. For example, there has been a doubling of maternal mortality and morbidity from vaccine-preventable diseases.<sup>24</sup> While the official estimate of the maternal mortality ratio for 2000 is reported to be 37.6 per 100,000 births, this ratio does not contain any deaths caused by unsafe abortions performed outside of the medical establishment and is acknowledged to be underestimated. While the MMR in 2000 is almost four times higher than that of the 1991 level of 10.4 deaths per 100,000 live births. A more accurate, population-based estimate of the MMR for 2000 is 79 per 100,000 live births, which is more than double the officially reported MMR of 37.6 for 2000.<sup>25</sup>

Many pregnant women have shifted from delivering in government hospitals, assisted by government-employed physicians, to delivering at home, assisted by local midwives, apparently because of costs. The 1996 National Health and Nutrition Survey found that as many as one-third of all children under one year of age had been born at home. Regional household cluster surveys of women with children under five years of age conducted in Northwest Azerbaijan in 1997 and 1999 documented that 25 percent of women had no prenatal care visits and the proportion of newborns born at home increased from 37 percent in 1997 to 44 percent in 1999. According to the Azerbaijan MOH, the number of deliveries recorded in "obstetrical establishments" decreased dramatically by 48 percent (from 168,605 to 87,357) between 1988 and 2000. Caesarean deliveries increased from 15.1 per 1,000 labors to 34.5 per 1,000 over the same period.

Three-fourths of sexually active women have had at least one induced abortion in their lifetime, according to a small area survey conducted by Relief International.<sup>26</sup> Although the abortion rates reported by the MOH (calculated from reports of abortions conducted in governmental facilities) have declined from over 25 abortions per 1,000 women of reproductive age in 1988 to 7.7 per 1,000 in 2000, abortion continues to be the most common birth control practice in Azerbaijan and remains a very serious problem due to the high rate of post-abortion complications.

The fertility rate started to decline prior to 1990 but the decline during the previous decade had been at a higher rate; from 3.3 births per women in 1980, the total fertility

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<sup>23</sup> HFA Database, 2000.

<sup>24</sup> UNFPA, 1999.

<sup>25</sup> Azerbaijan Multi-Indicator Cluster Survey (MICS), UNICEF, 2000).

<sup>26</sup> Postner, SF, et. al., 2001.

rate decreased slowly to about 2.7 in the period 1981-1993 but has fallen abruptly to slightly below replacement level of two births per woman in 1998. Women typically marry and begin families at a young age. The average age at marriage for women is 20.5 years. Most women do not have pre-marital sexual relationships and births out-of-wedlock are rare (less than five percent of all births, according to the MOH). Unmarried women usually do not live on their own, no matter what their age, educational or professional status. More than 50 percent of women suffer from pelvic inflammatory diseases, endocrine disorders, miscarriage and infertility. Increased incidences of STDs and HIV/AIDS have been reported among young people as a result of increased drug addiction, alcoholism and prostitution. A National Reproductive Health Strategy has been drafted but not yet been finalized or approved.

A reproductive health survey (RHS) has recently been conducted (2001) by the Division of Reproductive Health, US Centers for Disease Control and Prevention (CDC), and the Adventist Development and Relief Agency (ADRA) in Baku. USAID (through an umbrella agreement managed by Mercy Corps), the United Nations Population Fund (UNFPA), and the United Nations High Commissioner for Refugees (UNHCR) provided funding for the survey. Key findings of the RH Survey are summarized in Annex D.

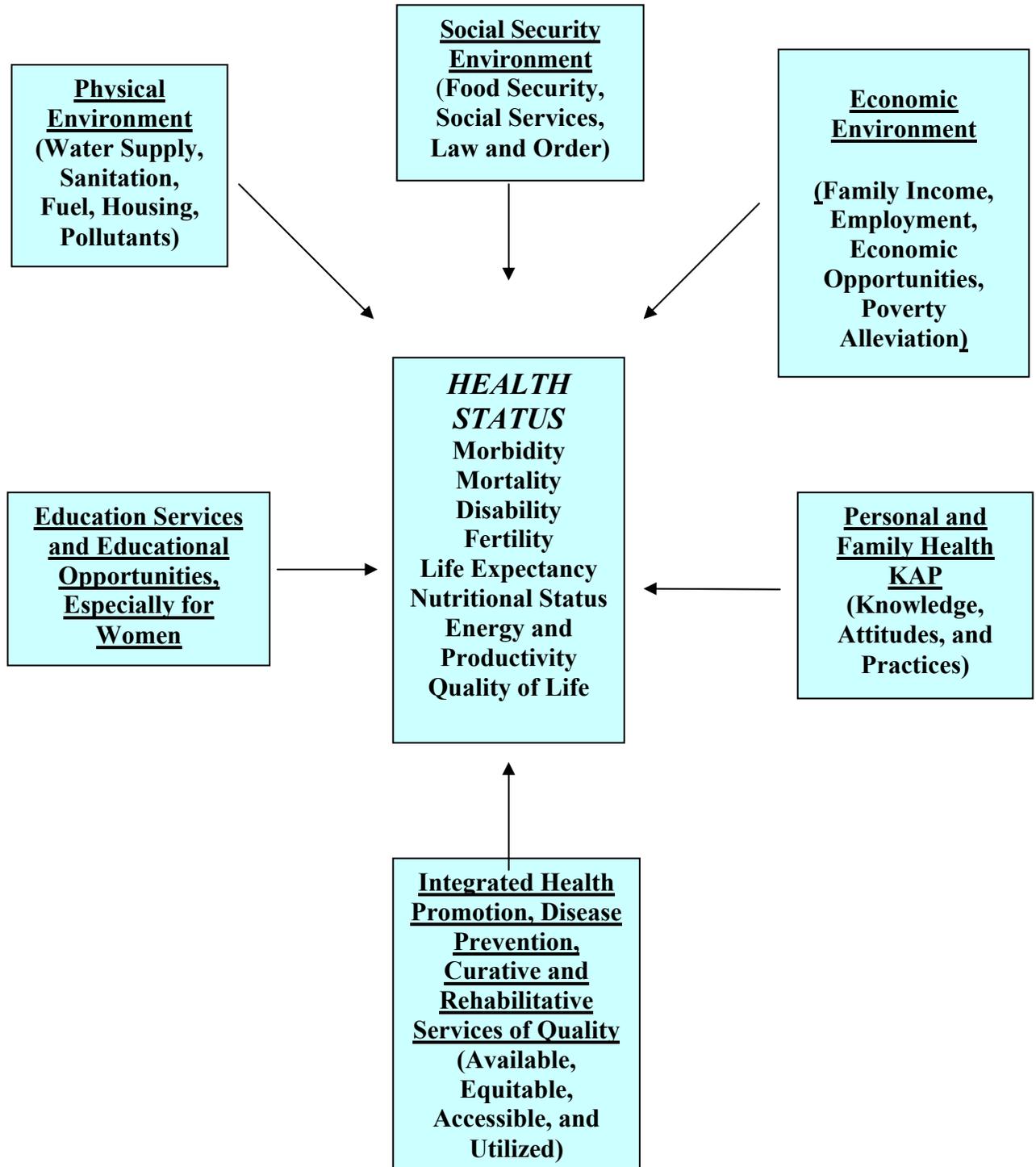
## **V. THE DETERMINANTS OF HEALTH, INEQUITIES IN HEALTH AND HEALTH CARE, AND THE VULNERABLE POPULATION GROUPS AT HIGHEST RISK**

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Given the multiple determinants of health, efforts to identify population groups at greatest risk should take a comprehensive approach. Such an approach is also useful for purposes of developing a conceptual framework for planning an effective health and social development strategy. The identification of the most vulnerable population groups at highest risk was performed by:

- Assessing the health status and current health challenges of the entire reference population, as has been summarized in a previous section;
- Assessing the principal determinants of health (and of ill health) as summarized in the following section; and
- Assessing inequities in terms of health status, health challenges, and determinants of health.

## A. THE PRINCIPAL DETERMINANTS OF HEALTH



The economic environment, especially as it influences employment and family income, is a major determinant of health status. The erosion of economic opportunities, employment, and family income in Azerbaijan over recent years has led to deteriorating health and nutritional status, micronutrient deficiencies and reduced immunity, increased incidence of many diseases, and increased mortality, especially among financially challenged residents, refugees and IDPs. Reduced family income has also made health services financially inaccessible for many people, leading to an underutilization of health services. Given the low level of government spending on health in Azerbaijan, the currently high levels of poverty among both resident and refugee/IDP population groups, and new policies promoting user fees and privatization of health services, there is an increasingly urgent need to launch innovative grassroots initiatives that can help to improve family income by providing low-interest credit and supporting enterprise development at the local level.

The physical environment has a major impact on health. The availability of environmental sanitation, clean water, vector control, fuel, and electricity services, and the quality of housing have positive effects on health status. As many of these determinants of health are seriously affecting rural poor populations and IDP/refugee populations, as well as some urban populations, assistance programs that support community development, enterprise development, and microcredit initiatives can strongly and rapidly influence health status, social status, and quality of life in a very positive way.

The social security environment, including food security; family; community and societal support; political and social security; freedom from war and civil disturbances; law and order; and other social services, including pensions, have a strong influence on health status. In Azerbaijan, food security improvements relate more to the quality of food than to the quantity of food, given the need to prevent specific micronutrient deficiencies, such as iodine deficiency and iron deficiency.

Education services and educational opportunities, especially for women, have a powerful impact on women's health and on the health of their families because women strongly influence health practices and health-related behavior of family members. While female literacy rates are commendably high in Azerbaijan, as is women's awareness about modern contraceptive methods, more health information, education and communications activities are needed in order to increase levels of health knowledge but also to encourage healthier practices concerning modern contraception, STI, HIV/AIDS prevention, IDD and anemia prevention, oral rehydration for prevention of death from diarrheal disease, cancer prevention, and so forth.

Personal and family health knowledge, attitudes and practices enable people to take greater responsibility for promoting and protecting their own health. Improving health-related knowledge, attitudes and practices (KAP) is one of the most cost-effective ways to improve health status (such as women's reproductive health status) prevent acute and chronic diseases, and promote healthy behavior within their family and community.

Integrated health promotion, disease prevention, and curative and rehabilitative services can influence the health status of the population of Azerbaijan much more than can be done by the current medical care model that emphasizes curative care and costly high tech diagnostic and therapeutic procedures. The impact of integrated health services on health status depends largely on the availability of these services to population groups at highest risk and equitable access to these services according to need.

The most effective efforts to improve health and social outcomes will involve consideration of each of these determinants of health, where feasible to apply an integrated development approach for greater synergy and economy, ensuring equitable access to information and education services, food, employment and other economic opportunities, and integrated health services of high quality.

## **B. EQUITY IN HEALTH AND HEALTH CARE**

Equity in health means minimizing avoidable disparities in the determinants of health and in health care services between various groups of people who have different levels of underlying social advantage.<sup>27</sup> Efforts that aim to improve health status generally apply a multi-sector strategy that aims to improve the determinants of health. The development and implementation of effective integrated development strategies and intervention programs can be facilitated by the creation of a multi-sector policy, strategy and coordinating entity with authority over the key sectors and their respective programs and resource allocation functions.

Equity in health care means equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all.<sup>28</sup> Equal access to available care for equal need means equal entitlement to the available services for everyone, a fair distribution throughout the country based on health care needs and ease of access in each geographical area, and the removal of other barriers to access. Equal utilization for equal need requires the removal of any restrictions on essential services, such as immunizations, resulting from social or economic disadvantage, including the reduction of inappropriate use or overuse of services for unnecessary treatments. The concept of equal quality of care for all means that every person has an equal opportunity of being selected for attention through a fair procedure based on need rather than social influence.<sup>29</sup>

Inequities in health and health care are evidenced by inequalities in health status, risk factors, and the utilization of health services between individuals or groups, especially when these differences are unnecessary, avoidable and unfair.<sup>30</sup> Inequities in the provision of care are often related to inequalities in socioeconomic status, geographic location, gender, and ethnicity.

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<sup>27</sup> Braveman, "Monitoring Equity in Health," WHO, 1997.

<sup>28</sup> Leenan, "Equality and Equity in Health Care," 1985.

<sup>29</sup> Whitehead, "The Concepts and Principles of Equity in Health," WHO/EURO, 1990.

<sup>30</sup> WHO, Geneva, 1997.

Observed inequities in Azerbaijan are mainly related to: 1) socioeconomic inequalities experienced by refugees, IDPs, and residents whose income levels are below the national poverty line and whose access to health care has been affected by the introduction of informal charges, which will become even more severe with privatization and the introduction of formal user fees; 2) geographic factors relating to the incidence of IDD; and to some extent 3) gender issues relating to women and the various factors that result in the high rates of abortion as a contraceptive method, placing women at higher risk than need be the case, given the availability of safer modern contraceptive methods. Such issues and concepts of equity could usefully be addressed with GOA and MOH leaders in the context of planning a synergistic social and health development strategy.

### **C. VULNERABLE POPULATION GROUPS AT HIGHEST RISK**

The team identified the following population groups to be at high risk. Within each of these groups, the most vulnerable sub-population groups are identified.

**Children under five years of age.** The health status of children relate to a number of factors, such as the equitable provision of health and education services, food security, housing, environmental safety, employment and financial security. Iodine deficiency, iron deficiency anemia, Vitamin A deficiency, and food security are of particular concern in Azerbaijan. Guidelines and practical tools to enable health workers to assess and monitor these conditions should be used regularly.

*The most vulnerable children in Azerbaijan are those who: 1) live in the IDD endemic districts, particularly those who have already developed goiter; 2) live in IDP/refugee camps; 3) live in poor households; 4) live in environmentally hazardous areas; 5) are malnourished, particularly those with acute malnutrition; 6) have not yet been fully immunized; and 7) have iron-deficiency anemia and/or other micronutrient deficiencies.*

**Women, especially during the childbearing years.** The health status of women in Azerbaijan is related to cultural factors, their social status, access to health services, employment or other income generating opportunities, and geographic location.

*The most vulnerable groups of women are those who: 1) are unemployed heads of households with no adult male in the household but with any number of children, recognizing that the greater the number of children the greater the vulnerability; 2) have insufficient knowledge of modern contraceptive practices and other measures to protect and promote women's reproductive health, including prevention of STIs and HIV/AIDS; 3) have iron-deficiency anemia; 4) have IDD, particularly with palpable goiters; 5) are below the national poverty line; and 6) have no access to health services.*

**Poverty-stricken Refugee/IDPs and Residents.** The health of poverty-stricken residents and most of the remaining 500,000 refugees/IDPs is compromised by high levels of poverty with very limited income generating and economic opportunities, and limited health and social services, food supplies, limited potable water, often inadequate housing, and limited sanitary and other environmental conditions. Any one of these factors can

place these groups at high risk, but the various combinations of these factors, which are often compounded at refugee/IDP camps, can combine to make them extremely vulnerable. NGO-government partnerships and well-coordinated multi-sector approaches are needed. Improved health and social services are also needed, but not if such services are provided on a fee-for-service basis, as this would introduce new inequities in health care.

*The most vulnerable groups of IDPs/refugees and residents living in poverty are those whose households: 1) have no one who is employed and there are no opportunities for employment or income-producing activities; 2) are headed by a woman with any number of children; 3) include one or more aged persons (over 65); 4) are situated in one of the IDD endemic districts; 5) are living in tents or sub-standard housing without adequate water, sanitation, fuel, and/or electricity; and 6) have no access or only very limited access to health and/or social services.*

**HIV/AIDS and Tuberculosis Patients.** Although these are still emerging public health problems in Azerbaijan, the global experience of these pandemics suggest that their prevention and/or control in Azerbaijan should be given a high priority because both infectious agents produce highly vulnerable population groups, and they have a synergistic effect when co-infections occur. The inequities and discriminatory treatment experienced by people with AIDS and HIV infections, and to a lesser extent tuberculosis patients, have been well documented in many countries.

*The most vulnerable HIV-infected and tuberculosis-infected people are those who: 1) have AIDS; 2) live in poverty and have very limited access to health services; 3) have poor nutritional status, micronutrient deficiencies, or poor diets; and 4) live alone without family or other social support.*

## **VI. CONCEPTUAL FRAMEWORK FOR PLANNING A SYNERGISTIC SOCIAL AND HEALTH DEVELOPMENT STRATEGY AND ASSISTANCE PROGRAM FOR AZERBAIJAN**

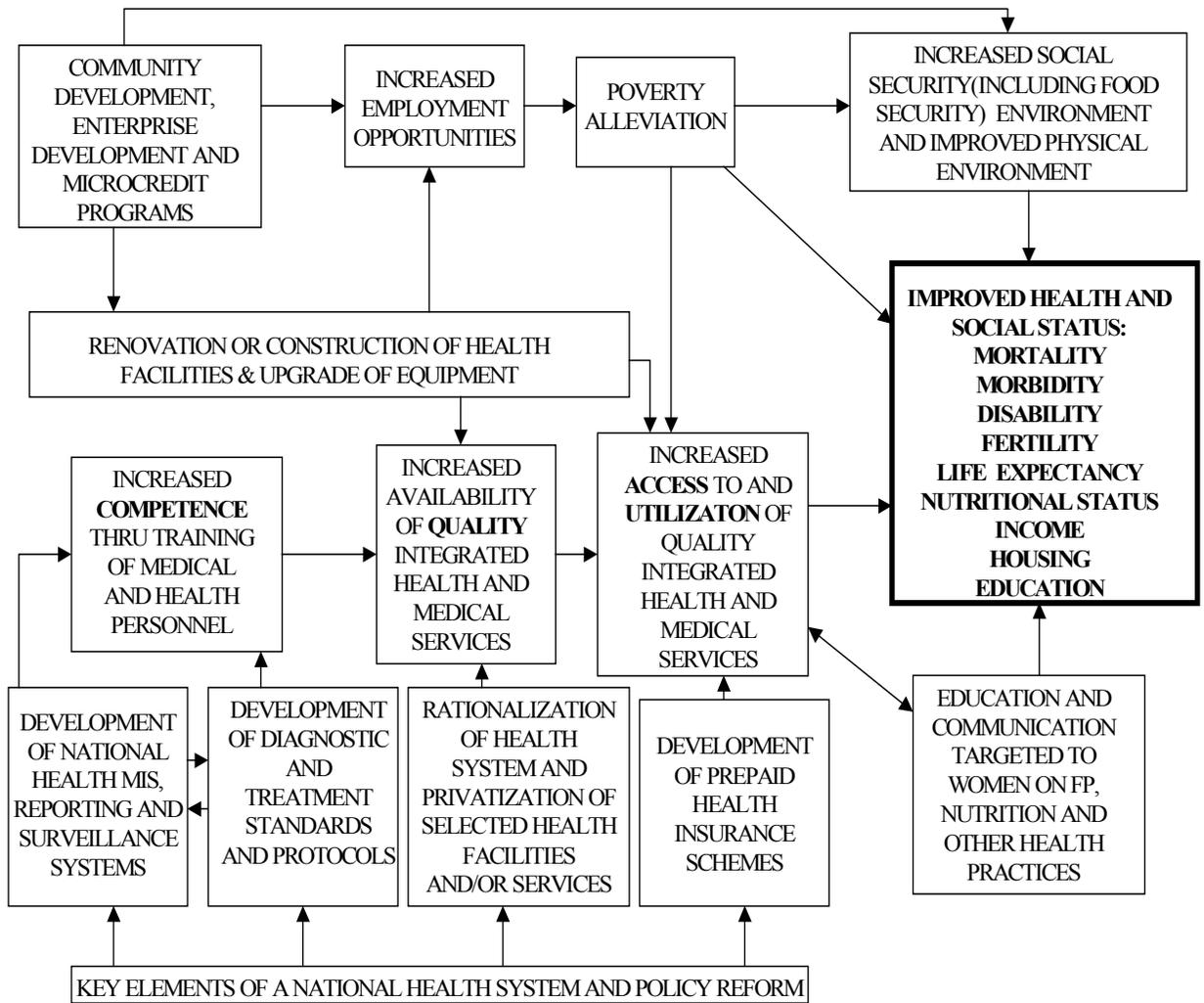
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The Conceptual Framework for planning a synergistic social and health development strategy and assistance program for Azerbaijan that was developed by the team (next page) takes into account the following realities:

- Health and social status have multiple determinants, some of which are within the conventional health sector and many of which are outside the conventional health sector, as discussed above;
- Poverty is one of the strongest determinants of health status (and social status), particularly in the context of Azerbaijan where most IDPs/refugees and many residents have little or no income;
- The current economic situation in Azerbaijan is unlikely to change very rapidly with respect to benefits that would be felt by the poorest population groups (oil and gas revenues are unlikely to be channeled to meet social or health needs);
- The health system has deteriorated, is under-financed, and remains in disarray, not only because of the scarcity of financial resources but also because of the serious need to plan and execute extensive health system and policy reform.

Interventions that can substantially improve the health and social status of the most vulnerable population groups at highest risk need not await execution of health system and policy reform. USAID's strategy for social and health development should be broad-based, multi-dimensional, and multi-sectoral for optimal synergistic effects and long-term sustainable development.

**CONCEPTUAL FRAMEWORK FOR HEALTH AND SOCIAL DEVELOPMENT IN AZERBAIJAN**



## **VII. STRATEGIC RECOMMENDATIONS: BUILDING A FOUNDATION FOR SYNERGISTIC SOCIAL, HEALTH AND MICROECONOMIC DEVELOPMENT**

~~The social and health assessment team has formulated five strategic approaches, given below under the five numbered sub-sections. Within these approaches, the team has also recommended consideration of various strategic elements (identified by bullets), and provided additional rationale and illustrative or elaborative material. The team is not recommending that USAID support all of these proposed initiatives but rather that USAID present the recommendations to the GOA and possibly to other selected development assistance organizations and agencies for further deliberation and strategic planning discussions. A more definitive USAID strategy and various programs and activities would flow and be defined during the proposed next steps (see Section VIII).~~

### **A. DEVELOP MULTI-SECTOR INTEGRATED DEVELOPMENT INITIATIVES IN AREAS WHERE RESIDENTS AND/OR REFUGEES/IDPS ARE MOST VULNERABLE AND AT HIGHEST RISK IN ORDER TO BUILD SYNERGISM FOR RAPID AND SUSTAINABLE SOCIAL, HEALTH, AND MICROECONOMIC STATUS IMPROVEMENTS**

As discussed in greater detail below, the foundation for synergistic social, health, and microeconomic development would be based on four strategic pillars that would:

- Improve the economic environment (family income), social security environment (food security), and the health-related physical environment (e.g., water, sanitation, housing, fuel) through innovative micro credit, enterprise development, and community development initiatives;
- Strengthen health system facilities, performance and financing mechanisms;
- Strengthen health system management, the quality of health data and of health services; and
- Strengthen health promotion, knowledge, practices and behavior.

### **B. IMPROVE THE ECONOMIC ENVIRONMENT (FAMILY INCOME), SOCIAL SECURITY ENVIRONMENT (FOOD SECURITY) AND THE HEALTH-RELATED PHYSICAL ENVIRONMENT (E.G., WATER, SANITATION,**

## **HOUSING, FUEL) THROUGH INNOVATIVE MICRO CREDIT, ENTERPRISE DEVELOPMENT, AND COMMUNITY DEVELOPMENT INITIATIVES**

**Support proven or new innovative micro credit and enterprise development initiatives that have the potential for increasing family income, alleviating poverty, improving food security, and improving the health-related environment (e.g., water supply, sanitation, housing, fuel) at the family and/or community levels.**

Well-designed microcredit and enterprise development initiatives have had considerable impact on the health and social status of beneficiaries and their communities in many countries, particularly when the local initiatives are planned in a participatory manner, are managed locally, and have the full consensus and active support of all community members who will be beneficiaries.

Microcredit and enterprise development initiatives that give priority to women entrepreneurs, organized women's groups, or women-led organizations are most likely to have a positive impact on the social and health status of women, and on the social and health status of their family members. This would be particularly useful in Azerbaijan.

Microcredit and enterprise development initiatives can provide grants and/or low-interest credit for innovative projects that would create job opportunities for local residents and have the potential of expanding to larger areas or being replicated at low cost elsewhere. Some enterprise development initiatives could, for example, provide the financing needed for the renovation or acquisition of health facilities, the upgrading of medical equipment, or the provision of medical supplies, possibly for the launching of a revolving drug fund.

**Support proven or innovative community development programs that are directed towards improving food security and family income, alleviating poverty, and/or improving the health-related physical environment of households and communities.**

In addition to addressing the various determinants of health, community development initiatives can promote democratization and the advancement of civil society. Support for community action groups, village health committees, municipal councils and/or other local organizations with proposed innovative community development projects can be awarded on the basis of prescribed criteria relating to the degree of social and health benefits to be derived, such as improving the supply of quality foods for local consumption or improving the physical environment in ways that reduce health risks or promote health (improving community water supply, sanitation, schools, sports facilities).

In areas where health facilities need renovation or where privatization of health facilities and services is planned, the organization of local health committees could help establish local voluntary labor or employees, the promotion of services, and develop local health insurance schemes. Similar initiatives have already proven successful in some areas of Azerbaijan.

### **C. STRENGTHEN HEALTH SYSTEM FACILITIES, PERFORMANCE AND FINANCING MECHANISMS**

**Support the development of prepaid health insurance schemes, revolving funds for drug supplies, and other health financing mechanisms at the community or district level.**

There are a number of prepaid health insurance schemes and revolving drug funds currently being implemented by various organizations in Azerbaijan. As discussed in the next section, the assessment team recommends that USAID conduct a comprehensive evaluation of these programs and their specific interventions in order to determine which schemes and strategies are most feasible to be replicated in other areas, taking into account socioeconomic, demographic, and cultural characteristics of the various regions of the country. The results of the evaluation could be very useful for the planning of USAID's next health and social development assistance program.

**Support the regulated privatization of selected facilities and/or services.**

At the present time, there are very few private healthcare facilities in Azerbaijan. One private clinic is located in Gusar near the Russian border. The assessment team visited the clinic and observed that the facility was in better condition than most government health clinics, as it had modern and functioning equipment, was well organized, appeared to have good quality services, and was well utilized in contrast to most government clinics. It charged user fees that were less costly than the informal payments required at most government facilities where services are of dubious quality.

As there is a strong interest among many physicians to work in private health facilities, and as the quality of care in private facilities is likely to surpass that of government facilities, while offering quality services at a lower cost than the informal fees charged at government facilities, USAID is encouraged to support the regulated privatization of selected health facilities and/or services. However, the registration, site selection and development of private health care facilities should be regulated by the MOH to ensure that such clinics are located in areas of need (rather than create new problems of maldistribution of facilities and resources), that they offer a reasonable range of services, meet minimum standards of quality, and comply with MOH reporting requirements.

The start-up financing of private clinics and/or services might possibly be covered in part by enterprise development initiatives, as discussed above. Some financial institutions might be given some incentives, such as reduced taxes, for providing long-term loans at relatively low rates for initiatives that offer a social development or health service benefits.

**Support the training of master trainers who would, in turn, train health care leaders, medical directors, and managers in health care financing, financial management, accounting, and the operation of revolving funds for drug supply and of pre-paid health insurance schemes.**

There is a great deal of interest among health care leaders, medical directors, and managers who work in both public and private institutions, to undertake training in health financing, financial management, and accounting. Such training programs could also cover the operation of revolving funds for drug and medical supplies, and prepaid-health insurance schemes. Provision of such training would enable health leaders, directors and managers to budget and manage financial resources more accurately, and operate facilities more efficiently and effectively. The development of master trainers would enable the MOH to train personnel at all levels of the health system.

#### **D. STRENGTHEN HEALTH SYSTEM MANAGEMENT, THE QUALITY OF DATA, AND THE QUALITY OF SERVICES**

##### **Support for the development of a national health management information system (MIS), the strengthening of the health information system (HIS) and the related reporting system, and the design and testing of a national disease surveillance system.**

The current health data record keeping and reporting system in Azerbaijan has been regularly criticized by various international organizations and assessment missions for its poor data management (collection and recording of data, classification of data because of inadequate case definitions, lack of timeliness, and general unreliability). Thus, the data have limited utility for the formulation of health policies, the management of facilities and personnel, or clinical practice.

The World Bank-UNICEF-MOH Primary Health Care (PHC) Revitalization Project has undertaken the initial design and testing of a local, district level MIS to support the effective and efficient delivery of PHC services, but additional effort and resources will be necessary to carry the work forward and eventually launch a new national MIS more broadly. USAID has substantial experience in this field and could make substantial contributions, both technically and financially, in order to enable the MOH and GOA to overcome a major health system problem – the unavailability of reliable high quality health data.

An efficient disease surveillance system with a rapid response capacity also needs to be developed. The Sanitary Epidemiological Services (SES) and MOH reporting systems should be integrated or, at least, coordinated so that relevant data can be shared efficiently in order to support their respective needs for high quality data.

##### **Support for Development of Diagnostic and Treatment Protocols, and Clinical Guidelines.**

The development of diagnostic and treatment protocols, and of clinical guidelines for the diagnosis, treatment, and prevention of diseases and conditions that have the greatest burden on the population's health should be given a very high priority by the MOH and USAID. These important guides could be developed and distributed nationally under a national policy to improve the quality of care at the primary health care level throughout

Azerbaijan. Specific areas for guideline development need to be identified in close cooperation with the MOH and national professional organizations in order to facilitate consensus building, endorsement, promotion, and accountability for their use in all facilities.

### **Support Training of Medical and Public Health Personnel in Key Clinical and Public Health Subjects.**

In order to facilitate the broad application of the new clinical guidelines, and related materials such as clinical records and report forms, training programs for both medical and public health personnel will be necessary. Such programs would strengthen the clinical competence of primary care providers and others at the doctor-patient interface by promoting the concept of evidence-based medicine and use of the new clinical guidelines, clinical records, and report forms. Such training must be done rapidly as a means of strengthening both the quality of health and medical services and the quality of data.

While there are many possibilities to support out-of-country training through fellowships and short-term courses, such training can have an adverse effect by raising expectations beyond reality or by learning material not entirely relevant to the situation in Azerbaijan. [Note: Recently, a group of physicians and nurses from the Republican Hospital in Baku visited Baylor University, and returned with an extensive high-tech equipment “wish list” for use with donors. They dreamed of performing expensive high-tech diagnostic and therapeutic procedures, and high-tech surgery, if they could find a donor to provide the high-tech equipment. The MOH cannot afford to procure or even maintain the equipment, except at the expense of primary health care, disease prevention, and health promotion services, which could entirely prevent such diseases. Is the USA’s expensive, high-tech, tertiary care-focused, medical care-oriented health care system appropriate for Azerbaijan, given its economy, and the social and health challenges it faces today?] Short training courses of relevance to the needs of Azerbaijan should be conducted in country or within the region, although culturally sensitive instructors for such courses could come from institutions based in the United States or elsewhere.

Three fields of particular importance for capacity building among medical and health personnel in Azerbaijan are the important fields of preventive medicine, public health, and applied epidemiology. The strengthening of competencies in these fields are needed at central, district, and local levels. Supporting state institutions that provide undergraduate and postgraduate education and continuous professional development would foster the sustainability of these training programs and of competence in these fields, which provide the medical and health intelligence needed for evidence-based patient management and evidence-based health system management. Such courses should be conducted in country or within the region (including the European region) and use high-quality national or regional data for greatest relevance and post-training applications of knowledge gained.

## **E. STRENGTHEN HEALTH PROMOTION, KNOWLEDGE, PRACTICES AND BEHAVIORS**

### **Support the development of a National Health Information, Education and Communications Capacity.**

The development of a National Health Information, Education, and Communications capacity would enable the MOH to develop materials and messages for dissemination through school health education programs, national public media outlets, local NGOs, international NGOs, health care workers and medical professionals, reproductive health centers, private sector health facilities, and private sector employers. USAID support would foster the development of a national policy and plan for IEC and for selected IEC interventions and practices. An IEC Coordination Unit could be established to coordinate national and local IEC activities, to coordinate with other Ministries, and to ensure the effectiveness, efficiency, and consistency of the overall national program.

### **Support the Development of an IEC Training Capacity through an IEC Training Unit with Master Trainers.**

USAID support could most productively be directed to the development of a national IEC Training Unit with master trainers. These trainers would employ the training of trainer methodology to develop a critical number of IEC trainers. Master trainers would be trained in training methodology as well as IEC practices to perfect training proficiency that could later be applied to other health areas. Support for the development of IEC training curricula and materials should also be included.

### **Support the Development of IEC Capacity at the District Level by Training Designated Staff Who has the Authority and Responsibility for Launching IEC Activities in their Districts.**

USAID could usefully support the development of an IEC capacity at the district level by supporting 1) the training of designated staff, doctors or nurses, and 2) the implementation of IEC activities within their respective districts, in accordance with guidelines set by the MOH and/or in cooperation with USAID funded programs in the area.

## **VIII. PROCESS RECOMMENDATIONS: PROPOSED STEPS TO BUILD A SHARED VISION, STRATEGIC PLAN, AND THE ESSENTIAL PARTNERSHIPS FOR SYNERGISTIC DEVELOPMENT**

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The assessment team recommends that the following steps be taken in the immediate future in order to develop and refine the Mission's social and health development strategy, determine its main program foci, and plan future USAID social and health development programs and activities in Azerbaijan.

### **1. Conduct a Program Evaluation**

In order to capture lessons learned from current and past USAID-funded programs, projects and activities, an in depth evaluation of the umbrella grant and its sub-grantees should be conducted as soon as possible this year using external evaluators.

### **2. Engage the Government of Azerbaijan in Strategic Planning Discussions**

Initiate strategic discussions with the Ministry of Health, other development-oriented ministries and, as appropriate, the Cabinet of Ministers in order to build the rapport, mutual trust and long-term relationship necessary to enter into a partnership for sustained development that can have substantial impact on the social and health status of Azerbaijanis, particularly people who are most vulnerable in health, social and economic terms.

Strategic planning discussions could usefully involve two levels of the GOA and be sustained for the time necessary to develop an integrated development strategy and plan, and enable the government to design and begin implementing the policy and organizational reforms that might be necessary to implement the integrated development strategy in the agreed districts. The two levels for strategic planning and for policy and organizational reform might include:

- The Cabinet of Ministers or a strategic planning board appointed by the Cabinet that would authorize the development of an integrated multi-sector development plan, review and adopt (or modify) the plan, and then establish the necessary policy and organizational reforms for implementation of the integrated health, social and economic development plan in areas selected by this body.

The Cabinet of Ministers might wish to formulate a policy and plan for the creation of a supra-ministerial body, such as a National Social, Health and Economic Development Board with senior representatives of the major socioeconomic development-related ministries, that would be authorized to formulate the proposal for a multi-sector integrated development strategy and plan for Cabinet review and approval. Once

approved, the Cabinet or its designated coordinating body, if authorized, would set out the necessary policies and reorganization orders for implementation.

- The Ministry of Health and selected health-related ministries or other GOA bodies that would plan for their sector-specific programs aimed at improvements in the health and social status of Azerbaijanis, and improvements in the effectiveness, equity and efficiency of the sector, and explore the role that USAID might play in such a progressive undertaking.

The emphasis of such discussions might usefully emphasize the following topics:

- Important links between health, social, and economic development and the broader goal of sustainable human development;
- A vision of the total health sector in a pluralistic setting, including the government health sector, the private health sector, and the PVO/NGO health sector, and the productive relationships they can have in meeting the public's health needs;
- The changing role of government under a health reform initiative in which the role of government transitions from being a sole-source provider of health services to one of providing information, financial, standards and regulatory support, and of managing change and growth of the sector;
- Development of new tools for both the private and the government health sectors. While the private sector financiers and providers develop new tools for supporting and providing private sector goods and services, the government sector could develop new tools, and strengthen their capacity to use them for managing fiscal tools, and the legal and administrative tools to foster the desired improvements. The government sector should also take the measures necessary to collect, analyze and provide accurate, valid, timely and reliable health data and information of importance to both providers and consumers in order to improve the whole system and its impact on health; and
- High priority strategic issues, such as strengthening health resource management, establishing priorities and setting targets, listing essential drugs, decentralization of authority, rationalization of services, health care financing, privatization and the roles of private practitioners within the national health system.

**3. In consultation with the MOH, other donor agencies, the WB, PVO/NGOs, and others, conduct a joint strategic planning exercise that leads to the development of a**

**comprehensive strategic plan for the health sector in Azerbaijan that clarifies the respective roles of the participating institutions and organizations.**

The broad goals for the plan might include, for example:

- To improve health status and consumer satisfaction by increasing the effectiveness and quality of health services;
- To achieve greater equity by improving the access of underserved/vulnerable populations to quality health care; and
- To obtain greater value for money (cost-effectiveness) from health spending, considering improvements in both the distribution of resources to priority activities (allocation efficiency) and the management of resources that have been allocated (technical efficiency).

**4. Develop USAID/Azerbaijan’s health strategic framework from the comprehensive, coordinated strategic framework.**

**5. Develop a procurement instrument (RFA/RFP) to implement activities outlined in the USAID/Azerbaijan strategic framework.**

**6. Award agreement/contract to implementing partners and begin implementation.**

**7. Consider hiring one (1) PSC and one (1) FSN to be assigned to USAID/Azerbaijan to manage and monitor implementation.**

**8. Conduct periodic monitoring exercises with external consulting technical experts in order to monitor and facilitate implementation.**



## **IX. CONCLUSION: PROSPECTS FOR PRODUCTIVE PARTNERSHIPS TO ADVANCE SYNERGISTIC SOCIAL, HEALTH AND MICROECONOMIC DEVELOPMENT FOR ALL AZERBAIJANIS**

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Several bright stars are emerging on the development horizon in Azerbaijan that helps define the context for planning USAID's social and health development strategy and for engaging GOA and MOH leaders:

- The WB and the GOA have signed a \$5.5 million Health Reform Project, which UNICEF will help manage, that aims to strengthen strategic and health reform capacities of MOH officials at central and district levels, strengthen primary health care services in five additional districts using a quasi-experimental design to enhance the potential for learning important lessons, strengthen the reporting system and further design and test a management information system (MIS) to better manage resources and services at the primary care level.
- The WB has indicated interest to provide up to \$70-80 million in about two years in order to enable the MOH to implement a major PHC program in all districts of Azerbaijan, including the establishment of major diagnostic and treatment referral centers in every three to four districts.
- The MOH has appointed an MIS Task Group and is in the process of adopting the ICD-10 (International Classification of Diseases), making appropriate changes to its health records and report formats, and developing diagnostic and treatment protocols for some priority diseases.
- The Canadian International Development Agency (CIDA) has approved a \$3 million grant to enable the MOH to implement a national health information system.
- The Italian energy company, Agip, has made a \$1 million grant to the MOH for malaria control.
- The MOH, Ministry of Social Security, and Ministry of Justice are in the process of establishing the legal and regulatory arrangements for promotion and support of private medical practices and facilities.

USAID is now well positioned to engage GOA and MOH officials, given the repeal of Section 907 and the warm reception that USAID received when initiating preliminary discussions with the MOH during the team's visit. MOH officials are clearly interested in continuing discussions with USAID, although USAID may wish to confer with other

bilateral and international development assistance organizations in Baku – and possibly discuss elements of this report – before entering into substantive discussions with MOH and other GOA officials.

The presentation of the Executive Summary of this report to Minister Insanov might usefully be done in the context of a meeting with the Minister of Health so that the new perspectives, strategic approaches, and recommendations presented in this report can be explained in general terms before MOH officials study the Executive Summary more carefully. When meeting with the MOH, USAID may wish to emphasize that the goal of the social and health assessment team’s recommendations, taken collectively, is to create powerful synergistic social, health and microeconomic development with sustainable benefits for all Azerbaijanis, beginning with the most vulnerable population groups who are currently at highest risk for unwanted disease, disability, fertility, and premature death.

Implementation of these recommendations, especially in the context of health policy and system reform, in partnership with USAID and other major development assistance organizations could create powerful synergies for faster and more sustainable social, health and microeconomic development in Azerbaijan.

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**ANNEX A**  
**SCOPE OF WORK**

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## SCOPE OF WORK

### SOCIAL/HEALTH ASSESSMENT OF REFUGEES/IDPS IN AZERBAIJAN

#### Introduction

The Azerbaijan conflict with Armenia in 1988 has resulted in approximately 850,000 refugees and IDPs residing in various districts in the country. Since 1993, USAID has supported a range of programs directed at assisting refugees/IDPs in Azerbaijan. Many of these have been humanitarian efforts directed at procuring supplies and rebuilding infrastructure. Due to US Government restrictions imposed by 907, work is focused only on IDPs and refugees, although the overall status of the country is generally poor. Within this framework, USAID Azerbaijan seeks to complete a current social/health assessment of the IDP/refugee situation in Azerbaijan, recognizing the diverse social, health, and socio-political and economic situation.

#### Background

Azerbaijan suffers from the same social and health problems as other NIS countries but with heavy social and health burdens and more serious infrastructure and systemic issues due to lingering internal conflicts. USAID has assisted Azerbaijan to meet the critical challenges of economic and democratic transition, and provided humanitarian assistance to the most vulnerable groups of IDPs/refugees.

All U.S. Government-funded activities in Azerbaijan are subject to the provisions of Section 907 of the FREEDOM Support Act (FSA). Section 907 states that, "United States assistance under this or any other Act may not be provided to the Government of Azerbaijan until the President determines, and so reports to Congress, that the Government of Azerbaijan is taking demonstrable steps to cease all blockades and other offensive uses of force against Armenia and Nagorno-Karabakh." In FY 1999, humanitarian assistance (including health) was exempted from 907. Although the Act by the U.S. Congress has restricted the scope of USAID's country assistance, USAID is making a substantial contribution to Azerbaijan as evidenced by the U.S. position as the major bilateral donor providing humanitarian assistance.

Economic trends worsened for everyone in Azerbaijan in the aftermath of independence from the Soviet system. This decline was exacerbated by the armed conflict over Nagorno-Karabakh that resulted in the displacement of 650,000 people from their homes and the influx of additional 200,000 Azerbaijani refugees from neighboring countries. The maternal mortality rate increased four-fold between 1990 and 1998 from 9.3 per 100,000 live births to 41 per 100,000 live births (*Statistical Yearbook of Azerbaijan 1999*). Unofficially, rates are quoted as 78-80 per 100,000 live births. The overall under-five mortality rate was 38 per 1000 in 1997, which is high compared with western standards of an average of 6 per 1,000. Morbidity and mortality rates appear to have ceased their upward spiral; the infant mortality rate has been stable at 20 per 1000 live births since 1997, according to the State Statistical Committee. This figure is considered unusually low due to Azerbaijan not using the international standard for classifying live births.

The greatest causes of mortality in Azerbaijan are related to cardiovascular disease and cancer. The incidence of malaria, tuberculosis, and outbreaks of vaccine-preventable diseases is widespread. There is virtually no published data available on the mortality and morbidity arising from acute respiratory infections and diarrheal diseases among children but these are thought to be among the leading causes of child morbidity. Communicable diseases, anemia and parasites also remain a major contributor to morbidity statistics. Again, although there are no reliable statistics from the Ministry of Health, surveys conducted by PVOs reported a high number of STIs.

## Goals

***The goal of the Azerbaijan Rapid Social/Health Assessment is to set the stage for future USAID participation in critical social/health areas. This assessment supports part of its Strategic Objective 3.1: Reduced Human Suffering in Conflict-Affected Areas. The primary focus of the Assessment is to examine the present state of health and social well being of IDPs/refugees living in Azerbaijan and to make recommendations on future goals, particularly as it relates to transitioning from relief to development.***

The technical scope of the assessment should focus primarily on issues of nutrition, environment, housing and general health status of the idp/refugee population. the assessment will consider the general accomplishments of projects as related to goals, constraints, failures, and finally, possibilities for the future, particularly as related to transitional development activities. the assessment should focus on information comprising a broad spectrum of health and social situations of refugees/idp's in azerbaijan. usaid and us government activities should be included as well as other international and national donors programs.

## Purpose and Objective

The objective of the assessment is to provide USAID/Azerbaijan with:

- A synthesis of the social and health status of refugees/IDPs currently living in Azerbaijan;
- Options and recommendations for a set of activities which are technically, economically, socially and politically sound;
- Suggestions for future direction for USAID-funded activities in the social/health sector in Azerbaijan for the next three years.
- In all of the above, consideration given to the existence of 907 or regarding transition and future directions without 907 restrictions.

The purpose of this activity is to assess the current health status of refugees/IDPs residing in Azerbaijan past accomplishments and current challenges; lessons learned; and to provide recommendations for future direction of activities. The final written report will make specific recommendations to strengthen health interventions in targeted areas most in need of assistance.

This social/health assessment will assist USAID/Azerbaijan in determining the best direction for future activities, as integrated into the greater country strategy. To the

extent possible, the assessment will be a summary and synthesis of information available and work previously completed. The assessment team will examine the results of current and previous projects in the targeted regions for successes and failures. The team will assess projects based on their benefit without regard to their current or past donor or benefactor. The intent of the assessment is to amass ideas for future projects, not to evaluate the status of current activities. While the assessment is not intended to be exhaustive, it is expected to be complete enough to provide USAID with adequate justification and rationale for selected directions and recommendations. Once the assessment report is complete, it will be used as the basis for discussions with the regional USAID mission toward the development of health and social assistance strategies.

### Assessment Strategy

1. Assemble written information already gathered and perform key informant interviews to collect secondary information on the health of IDPs and refugees in Azerbaijan; including population distribution, demographic information, morbidity, health system availability, primary risk factors, and nutrition (especially micronutrient deficiencies).
2. Define and characterize high-risk groups.
3. Perform a vulnerability analysis that highlights groups most in need of assistance.
4. Assess social indicators as they relate to the overall health and social status of IDPs/refugees with regard to employment/income, housing, and education.

### Methodology

An external team of three MEDS consultants will plan the assessment methodology with advice and agreement from USAID/Caucasus technical staff. They will work in Baku for three weeks gathering and reviewing relevant written materials and secondary data, interviewing key informants, and analyzing and compiling information. The team will meet with USAID/Caucasus several times throughout to seek information and direction, provide updates on the assessment progress and present early findings and recommendations.

In the field, the evaluation team will undertake the following specific activities:

1. Meet with USAID/Caucasus staff. The team will hold two formal briefing meetings with USAID staff. On arrival, the team will meet with USAID staff to clarify Mission perspectives, activities and priorities of the assessment. The team will present a work plan for implementing the assessment. During the assessment, USAID staff will accompany the team on field visits, as necessary.

A final briefing near the end of the TDY will be made at which time a verbal report will be submitted. The result of the meeting will be to summarize current conditions and recommend how to strengthen and improve future strategic approaches to treatment of the refugee/IDP population. Interim briefings, as appropriate, may be undertaken in Azerbaijan with Mission staff participating on the evaluation team.

2. Review relevant documentation. The team will review relevant documents such as UN reports; work plans; operations research reports; assessments; progress and quarterly reports from groups working with IDPs/refugees in Azerbaijan. USAID/Caucasus will assist in providing relevant documents.
3. Meet with stakeholders in selected regions in Azerbaijan. The team will collect information through interviews, discussions or focus groups with key stakeholders, e.g., participating agencies (UNHCR, WHO, MCI, IMC,) including USAID staff, community development members and health workers of District Health Stations.
4. Make site visits. The team will meet with social/health workers at selected social and health facilities and with community members and caretakers at outpatient clinics in areas serving significant numbers of refugees/IDPs. Team members should also interview clients at clinics and social service centers.

## Audience

The primary audience for the assessment is USAID/Caucasus and USAID/Washington. Portions of the report will also be disseminated and shared in-group process meetings with international NGOs and by distribution of the final report to relevant parties.

## Team Preparation

1. Prior to the team's departure for fieldwork, designated member(s) will collect health sector information in Washington, DC with assistance and guidance from USAID/Azerbaijan.
2. Prior to field work, a designated team member will speak with representatives of USAID/Washington (desk officer, E&E, G/PHN), CDC, participants in the AIHA partnership program, the World Bank, other donors and PVOs, to obtain information regarding past projects and current activities in Azerbaijan.
3. A two-day team-planning meeting will take place in Baku in order to clarify team roles and responsibilities, discuss the assessment scope of work, and formulate an assessment work plan, timeline, and methodology.

## Report

*THE OUTCOME OF THIS ASSESSMENT WILL BE A FINAL REPORT. THE TEAM WILL BE RESPONSIBLE FOR COMPLETION OF THE FINAL REPORT SYNTHESIZING FINDINGS AND RECOMMENDATIONS. THE REPORT SHOULD BE CONCISE, NOT EXCEEDING 30 PAGES WITH APPENDICES, AS NEEDED. THE TEAM LEADER WILL BE RESPONSIBLE FOR COMPLETING THE REPORT ON TIME AND SUBMITTING IT TO THE MISSION. THE FINAL REPORT SHOULD INCLUDE THE FOLLOWING SECTIONS:*

*EXECUTIVE SUMMARY*

*BACKGROUND*

*METHODOLOGY*

*DESCRIPTION OF ACTIVITIES*

*SUMMARY OF KEY ISSUES*

*CONCLUSIONS*

*RECOMMENDATIONS*

*ANNEXES*

Suggested Annexes or sections woven into the report are listed below and as Annexes to this scope of work:

1. Socioeconomic and Political Context: (Briefly)
  - A. Key socioeconomic indices for the population (size, mortality, income, literacy),
  - B. Political/security environment,
  - C. Current public policies that affect the availability of and access to services in the public and private sectors,
  - D. Key trends, official attitudes toward policy reform in the social/health sector,
  - E. Household-level economics, including spending.
2. Social/Health System
  - A. Structure, range and quality of available **social** services (public and private),
  - B. Public and private **health** services, as above, including a brief description of the availability and access to essential drugs and vaccines,
  - C. Public access to services with specific reference to women, children and the elderly or other vulnerable parts of the population,
  - D. Caliber of staff and equipment at service delivery facilities.
3. Priority Social/Health Problems:
  - A. Provide epidemiological profiles, which outline the major social/health problems with specific attention to women, children and the elderly,
  - B. Note how key social issues impact health findings, i.e., smoking-lung cancer, domestic violence-pregnancy,

- C. Describe the capacity of existing systems to respond to these priority problems.
- 4. USAID Assistance to date in the social/health sector
  - A. Summarize USAID assistance to date,
  - B. Comment on the extent to which this assistance responds to priority concerns noted above,
  - C. Other Donor and NGO Activities
    - 1) Summarize other donor and NGO assistance
    - 2) Comment on the extent to which this assistance responds to priority concerns noted above.
- 5. Opportunities for USAID Involvement
  - A. Identify potential priority opportunities for USAID participation in health/social sector assistance,
  - B. Identify USAID's comparative advantage in pursuing specific assistance opportunities.
  - C. Identify constraints and issues that may affect USAID's responses to priority problems.
- 6. Conclusions and Recommendations
  - A. Suggest an integrated and strategic approach to the sector,
  - B. Outline a draft framework, including possible objectives and results,
  - C. Suggest a possible range of program activities,
  - D. Identify critical areas needing further assessment.

#### IV. Suggested Team Composition

The team will be comprised of individuals who can tolerate extremes of temperature, long hours, and harsh travel conditions. Accommodations may be quite primitive. Food, although plentiful, will not be varied. Team members must be in good health and physical condition.

##### **A. Core Team**

- 1. Team Leader – Requires experience in crisis work as well as development projects. Required LOE: 27 days, including one week in Washington for assignment briefings and preparation; three weeks field work, four days travel and nine days for report preparation.
- 2. Public Health Specialist – Requires prior international experience, preferably in the NIS assessing health and social conditions and development of appropriate/feasible donor responses to such problems. Must have excellent conceptual and drafting skills. Required LOE: 23 days including one week in Washington for briefings and preparation for fieldwork with four days travel.
- 3. Epidemiologist – Requires prior experience in the assessment of health and social issues and in the examination, analysis and interpretation of epidemiological data to determine implications for program reform. Required LOE: 23 days including three weeks field work; four days travel; and eight report preparation.

## B. Administrative/Logistical Support

A local organization must be chosen to provide support to the evaluation team including assistance in providing a physical work and meeting space, interview contacts and appointments, local travel arrangements, hotel accommodations and interpretation.

### Level of effort

For the consultants hired by the project, the level of effort will be approximately as follows:

Background Reading	2 days
Travel Days	4 days
Team Planning	2 days
Interviews/Discussions in Baku	4-6 days
Interviews/Discussions in the field	4-6 days
Analysis & Report Writing	4-6 days
Oral Presentation	1 day
Addressing USAID/NGO Partner Comments	2 days
Total number of working days:	23-27 days

### Administrative and logistical arrangements

1. Relationships. The team leader will report directly to the Coordinator, USAID/Azerbaijan. The team leader will work closely with the Regional Health Advisors and Regional Coordinators. As necessary, the Regional Legal Advisor and Regional Executive Office, USAID/Tbilisi will provide supplementary guidance.
2. Completion of Deliverables. The contract will be considered successfully completed when the team leader submits to USAID/Azerbaijan the document described in the "Scope of Work". Two paper copies of the final document shall be delivered to the Coordinator's office. In addition, the team leader will submit an electronic copy of the entire document in Word on a 3.5" diskette.
3. Office space and equipment. Because office space is limited, the team will **not** be provided with temporary workspace at USAID Baku. The team leader will be required to have a personal computer and should arrange with the logistics coordinator for temporary workspace and other assistance with the local administrative/logistical support providers, as needed. No access to USAID Azerbaijan services, facilities, or staff will be provided.
4. Transport. Local transport and per diem will be reimbursed at the USAID rate for Azerbaijan on a daily basis. Airline tickets will be reimbursed on a cost basis, upon submission of official receipts.

5. Work week. A six-day workweek is authorized, without a premium payment.

## II. ANNEXES

1. Objectives of assessment
2. Data collection
3. Data points
4. Additional sector specific information
5. Data analysis and interpretation
6. Relevant reading materials
7. Important contacts

### Annex 1 – Objectives of Assessment

- Effective collection and use of information for planning, monitoring and evaluation.
- Social/Health seeking behavior of refugees/IDPs.
- Existing knowledge and IEC materials.
- Access to pharmaceutical outlets
- Performance and skills of NGO trained workers in facilities attended primarily by refugees/IDPs
- Community programs and delivery systems
- Potential for financing mechanisms
- Management information systems
- Potential for community development

### *ANNEX 2 – DATA COLLECTION*

The following sector specific data points will be collected as an overall health and social system assessment. In this short duration assessment, information from numerous sources will be obtained and compiled. Only the targeted field data collection of primary data in a few specific areas will be possible because of the short time available.

### Annex 3 – Data Points

Specific data points will be organized by sector. The following is a non-inclusive list of data points to **consider**. This should be adapted to USAID data needs for Azerbaijan.

#### Demographic Evaluation:

Regional size and population  
Number of families in household  
Head of household and education  
Number and location of refugees  
Number and location of IDPs  
Migrant populations  
Ethnic composition of population and displaced  
Movement and regional population stability  
Age and sex stratification  
Family unit and pertinent customs

#### Health sector:

Crude mortality rate estimates  
Deaths per month  
Deaths in under 5 population per month  
Vaccination (EPI) coverage and practices  
Incidence of vaccine preventable diseases  
Most common illnesses stratified by age group  
Diarrheal illness over the prior two weeks  
ARIs over the past two weeks  
Source of health care for under 5  
Access to pre-natal care  
Trauma and injury

#### HEALTH SYSTEMS ANALYSIS

Access to health care (curative and public health)  
Health care access for vulnerable populations (pregnant women, children, elderly, disabled)  
Staffing of health facilities  
Immunization status for under 5  
Drug and equipment availability  
Training programs  
Level of NGO participation and coordination

#### FOOD AND NUTRITION

##### FOOD DELIVERY AND ACCESS

Markets and pricing  
Rates of PEM  
Breast feeding for children <2  
Anthropometry (<5 and <12)  
Micronutrient deficiency syndromes  
Record keeping and nutritional surveillance capacity in local health system  
Current food aid programs and NGOs  
Other possible measures include thyroid screening (exam) and hemoglobin (lab)

### ***ANNEX 4 ADDITIONAL SECTOR SPECIFIC INFORMATION***

#### Environmental:

Geographical features and climate considerations  
Shelter specifications and variations

#### **ACCESS TO CLOTHING AND CLEANING MATERIALS**

Vectors

#### Water and sanitation:

Local water sources and quality  
Sanitation practices and cultural issues  
Variations in sanitation practices by groups and region  
Water born disease prevalence

LOGISTICS

Food and material transport  
Supply availability  
Availability of personal transport

**Annex 5 Data Analysis and Interpretation**

Data management will be accomplished by Epi Info 6.1 or similar software. Anthropometric software will be used to calculate HFW and Z-scoring.

***ANNEX 6 RELEVANT READING MATERIALS***

In 1996, the CDC and UNICEF (in collaboration with Relief International and MSF-Holland) conducted a health and nutritional assessment of Azerbaijan.

USAID Azerbaijan Strategic Plan, 2001-2003, May 2000.

Azerbaijan Nutrition Survey, supported by USAID, WHO & UNICEF, April 1996.

IMC Two Part Baseline Survey on Primary Health Care and Population Health Needs and Utilization of Health Care Services, August 2000.

**Annex 7 Important Contacts**

American International Health Alliance (AIHA)—Jeyhoun  
International Medical Corps (IMC)  
World Bank  
UNICEF  
UNHCR  
UNDP



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**ANNEX B**

**REFERENCES AND PRINCIPAL DOCUMENTS REVIEWED BY THE  
AZERBAIJAN SOCIAL AND HEALTH ASSESSMENT TEAM, FEBRUARY  
2002**

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**REFERENCES AND PRINCIPAL DOCUMENTS REVIEWED BY THE  
AZERBAIJAN SOCIAL AND HEALTH ASSESSMENT TEAM, FEBRUARY  
2002**

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Ministry of Health Azerbaijan Republic, United Nations Population Fund and the World Health Organization, 2001. **National Reproductive Health Strategy, Azerbaijan Republic (2001-2005)**. MOH, UNFPA, WHO, Baku, Azerbaijan.

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**ANNEX C**

**KEY CONSULTATIONS AND SITE VISITS CONDUCTED BY THE  
AZERBAIJAN SOCIAL AND HEALTH ASSESSMENT TEAM, FEBRUARY  
2002**

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**KEY CONSULTATIONS AND SITE VISITS CONDUCTED BY THE  
AZERBAIJAN SOCIAL AND HEALTH ASSESSMENT TEAM, FEBRUARY  
2002**

- February 6, 2002 USAID/Washington:  
Paul Holmes, Mary Jo Lazear, and Tim Clary
- February 12, 2002 USAID Mission, Baku, Azerbaijan:  
Mr. Bill McKinney, Country Coordinator  
Mr. Khalid Hasan Khan, Humanitarian Assistance Specialist  
Ms. Catherine Fischer, Regional Health Specialist  
Ms. Gulnara Rahimova, Project Management  
Specialist/Humanitarian Sector
- February 12, 2002 DRH/CDC in Baku, Azerbaijan:  
Dr. Leo Morris, Chief, Behavioral Epidemiology & Demographics  
Research Branch, and Dr. Florina Serbanescu
- February 13, 2002 UNICEF, Baku, Azerbaijan:  
Mr. Nazim Agazade, Project Officer and Acting Representative  
Dr. Dinara Kulieva and Dr. Shahin Huseynov, Health Officers
- February 14, 2002 MOH, Baku, Azerbaijan:  
Minister Ali Insanov, First Minister of Health, Ministry of Health  
Professor Alexander Umnyashkin, Adviser to the Minister of  
Health
- February 14, 2002 UNHCR, Baku, Azerbaijan:  
Ms. Nailya Velikhanova, Senior Field Clerk
- February 14, 2002 UNFPA, Baku, Azerbaijan:  
Mr. Ramiz Alekperov, Program Officer, and Ms. Jamilya  
Kerimova
- February 15, 2002 AIHA, Baku, Azerbaijan:  
Mr. Jeyhoun Mamedov, Program Coordinator
- February 15, 2002 ICRC, Baku, Azerbaijan  
Dr. Fuad Mirzayev, Head of Medical Program
- February 15, 2002 Save the Children Federation, Baku, Azerbaijan:  
Mr. Michael C. Halbert, EO Program Manager and Technical  
Advisor  
Kishor N. Sharma, Program Manager, Integrated Community  
Development

- February 15, 2002      Mercy Corps, Baku, Azerbaijan:  
Mr. William R. Holbrook, Chief of Party  
Ms. Mary Hennigan, Health Program Manager
- February 16, 2002      World Bank Resident Mission, Baku, Azerbaijan:  
Mr. Rasul Bagirov, Operations Officer, HD
- February 18, 2002      Shamakhi District Health Department:  
Dr. Bahtiyar Abbasov, Head Doctor, and team
- February 18, 2002      Goychay District Health Department:  
Dr. Shabon Osmanov, Head Doctor, and team
- February 18, 2002      IDP camp in Barda, Yevlakh  
Dr. Kubra Hanum, local ambulatory doctor, and the local IDP  
government representatives
- February 18, 2002      Akhtachi Village:  
Dr. Ikram, Head Doctor of Akhtachi Village Hospital
- February 18, 2002      Sabirabad District Health Department:  
Dr. Rahil Musayev, Head Doctor, and team
- February 18, 2002      Saatly District Health Department:  
Dr. Adil Mursalov, Head Doctor, and team
- February 18, 2002      IDP camp at Bahramtapa  
Dr. Bahman Shukurov, DAC Head Doctor
- February 19, 2002      Shaki District Health Department and Regional Hospital:  
Dr. Mahil Gafarov, Head Doctor, and team
- February 19, 2002      Gabala District Health Department, Hospital, Mirzabaliyev Village  
DAC:  
Dr. Sabir Bayramov, Head Doctor and team, local ambulatory  
doctor, Village Executive Committee and Municipal Council  
representatives
- February 19, 2002      Masally District Health Department and Hospital:  
Dr. Rasim Azizov, Head Doctor, and team
- February 19, 2002      Sigdash Village DAC:  
Dr. Yusif, DAC Head Doctor

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- February 19, 2002 Salyan District Health Department and Hospital:  
Dr. Ibragim Guliyev, Head Doctor, and team
- February 20, 2002 CHF, Baku, Azerbaijan:  
Mr. Christopher Siliski, Country Director
- February 21, 2002 Khizi District Health Department and Hospital:  
Dr. Behdash Nabiyev, Head Doctor, and team
- February 21, 2002 Gusar District private health care facility:  
Dr. Malik Kerimov, Head Doctor, and team
- February 21, 2002 Sumqayit Hospital and Dr. Karlen Abbasov, Head Doctor  
Republican (Mirkasimov) Hospital and Hospital Director
- February 22, 2002 ADRA, Baku, Azerbaijan:  
Mr. Conrad Vine, Nakhchivan Health Development Program  
Director (and Micro Credit Projects Director) and Ms. Jenni  
Sequeira, Nakhchivan Health Development Program Director (and  
Health Projects Director)
- February 23, 2002 National NGO, “Family and Society”, Baku, Azerbaijan:  
Dr. Faiza Aliyeva, President, and Director of the Republican  
Center for Family Planning
- February 25, 2002 IMC, Baku, Azerbaijan (and multiple interactions during Feb. 10-  
26):  
Mr. Adam Sirois, Country Director  
Dr. Natalia Valeeva, Primary Health Care Officer  
Mr. Hamidzade Fuad, Office Manager/Logistics  
Mr. Ibrahimov Fuad, Field Coordinator  
Ms. Adele Gafurova, Administration  
Mr. Rasim Hagverdiyev, Driver
- February 26, 2002 USAID Mission, Baku, Azerbaijan:  
Mr. Bill McKinney, Country Coordinator  
Mr. Khalid Hasan Khan, Humanitarian Assistance Specialist  
Ms. Catherine Fischer, Regional Health Specialist  
Ms. Gulnara Rahimova, Project Management  
Specialist/Humanitarian Sector
- February 26, 2002 MOH, Baku, Azerbaijan: Professor Alexander Umnyashkin,  
Adviser to the Minister of Health
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**ANNEX D**

**KEY FINDINGS OF THE REPRODUCTIVE HEALTH SURVEY, AZERBAIJAN,  
2001, ADRA, MC, SCS, CDC, USAID, UNFPA AND UNHCR**

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**KEY FINDINGS OF THE REPRODUCTIVE HEALTH SURVEY, AZERBAIJAN,  
2001, ADRA, MC, SCS, CDC, USAID, UNFPA AND UNHCR****FERTILITY AND PREGNANCY EXPERIENCE****Fertility Levels and Patterns**

- The total fertility rate for the three years preceding the survey was 2.1 births per woman, slightly above the replacement level. This is about 20 percent higher than the fertility rate of the other Caucasus region countries, Georgia and Armenia, but substantially lower than the central Asian republics, excepting Kazakhstan.
- Similar to other countries of the region, Azeri women initiate and complete childbearing in an early age. The highest fertility levels are among 20-24 year old and 25-29 year old women, accounting for 36 percent and 32 percent respectively, of the TFR.
- Fertility amongst adolescent women (44 births per 1,000 women aged 15-19) is the fourth highest, contributing 11 percent of the TFR.
- Women aged 35-39 and 40-44 make minimal contributions to total fertility rates account for only 5 percent and 2 percent respectively of all fertility.
- Out-of-wedlock births are rare and unmarried women contribute very little to overall fertility (less than 5 percent of births were out-of-wedlock).
- Fertility among women living in urban areas, including Baku, was on average almost 30 percent less than among rural women in the three-year period preceding the survey. By region, women living in the Central areas and in Baku had the lowest level of fertility (1.8 and 1.9 births per woman).
- Fertility rates were comparable among the IDP and non-IDP women.

**Induced Abortions Levels and Patterns**

- The total induced abortion rate (TIAR) was 1.5 times higher than the TFR during the three years prior to the survey (3.2 vs. 2.1).
- The age pattern of abortions is concentrated at 25-29 years of age (177 induced abortions per 1,000 women) and 30-34 years of age (176 per 1,000), accounting for 50 percent of TIAR.
- The abortion rates were equally high and varied little by background characteristics, with the exception among internally displaced women who reported substantially higher rates. IDP women reported the highest TIAR (4.7 abortions per woman) and all the age-specific abortion rates among these women were higher than among non-IDP women.
- 57 percent of women reported their last pregnancy as unintended and the majority of them (84 percent) reported it was unwanted rather than mistimed.
- The preference among women for small families is reflected not only in the declining fertility levels and high abortion rates, but also in their stated desires to not have more children. Among women in union, over two thirds of respondents (69 percent) reported that they do not want to have more children.

## CONTRACEPTIVE KNOWLEDGE AND USE

### Contraceptive Awareness and Knowledge of Use

- Azeri women have a relatively high level of family planning awareness, contrasting with their low prevalence of modern contraceptive use; 87 percent had heard about at least one contraceptive method. The level of overall awareness of either modern or traditional methods was slightly higher among urban than rural women.
- Overall, no modern method was recognized as very effective by a majority of women, partly because substantial numbers of women lacked awareness of modern methods.

### Current Contraceptive Prevalence

- About half (55 percent) of women currently in legal or formal unions were currently using a method of contraception but only 12 percent used modern methods.
- Modern contraceptive use was twice as high in urban areas as in rural areas (29 percent vs. 13 percent); it was higher in Baku (35 percent) than in any other region, among 25-44 year olds than among young adults, and among those with at least one living child than among childless couples.
- By far the most prevalent method in use among women in union was withdrawal (41 percent), which accounts for 73 percent of contraceptive prevalence. IUDs, which were used by 6 percent of women in union, and condoms (3 percent) were the next most used methods and accounted for 78 percent of modern methods. Contraceptive sterilization, despite an overwhelming desire by most women to have no more children, was used by only 1 percent of women currently in union; the pill was also used by only 1 percent of women in union.

### Sources of Contraceptive Services

- The public medical sector is in general the largest source of contraception (54 percent). Hospitals with gynecologic wards and maternity wards supplied 27 percent of women currently in union with their current method of contraception.
- Women's consultation clinics supplied 21 percent of women, whereas polyclinics and village hospitals and dispensaries supplied only 5 percent of women.
- Commercial sales, particularly through pharmacies, are the second largest source of contraceptive supplies (35 percent).
- IDP and refugee women were less likely to obtain contraceptive supplies in public hospitals and clinics (43 percent vs. 54-59 percent) and more likely to receive a method from a health clinic operated by NGOs.

### Reasons for Not Using Contraception

- The most common reasons for not currently using contraception were related to pregnancy (40 percent), lack of current sexual activity (19 percent) and female fecundity impairment and the presence of pelvic inflammatory disease (15 percent).
- Reasons for not using a method did not vary much between IDP/R and non-IDP/R women but differed sharply by age group. Younger women in union were more

likely to be either pregnant or in the postpartum period (52 percent) or were seeking to become pregnant (24 percent), whereas women aged 35-44 years were likely to not be able to get pregnant.

### **Unmet Need for Contraception**

- About one of three women (38 percent) had a potential demand for contraception – defined as the sum of current contraceptive use (met need) and the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed births – including 7 percent of current users of modern methods, 25 percent of current users of traditional methods, and 7 percent of non-users at risk for unintended pregnancy.
- According to the most recent census data, this translates into an estimate of 775,000 women aged 15-44 years with a potential for family planning services.

### **Communication with Family Planning Providers**

- Two of three women were advised by a health care provider to use the current or last modern method (65 percent by a physician and 2 percent by a nurse or a midwife).
- One in four women started using her last method at the partner's suggestion (22 percent) or at her own counsel (4 percent) by passing any potential medical advice.
- In 4 percent of cases the choice of method was made at the suggestion of a pharmacist and in the remaining cases, the choice was suggested by a friend (three percent) or a relative (one percent).

## **PREGNANCY, DELIVERY AND BREASTFEEDING**

### **Prenatal Care**

- Of the 3,430 births reported since January 1996, about two thirds of women (70 percent) had received some prenatal care, of those, almost two thirds (64 percent) had received their first prenatal care visit in the first trimester.
- Approximately one in five of all women had the first visit during the 2<sup>nd</sup> trimester and 6 percent during the third trimester.
- Rural women, residents of the South region, those who did not complete secondary education or had a low social economic status (SES) and women who had already had two or more births, were more likely not have any prenatal care.
- Only 6 percent of births within the past five years had received adequate or adequate plus care while 81 percent had received inadequate prenatal care.
- The principal source of prenatal care was a women's consultation clinic (46 percent). The second source of most prenatal visits was a maternity (36 percent) or village hospital (13 percent). Rural dispensaries and private clinics provided prenatal care for 2 percent and 1 percent respectively of pregnant women.
- 3 percent of women received prenatal care at home.

### **Intrapartum Care**

- Most deliveries in the past five years took place in maternities (56 percent) or village hospitals with inpatient obstetrical care (17 percent).
- One in four births, however, was delivered outside medical facilities and less than one percent were delivered in private clinics.
- Home deliveries were relatively high among rural residents (36 percent), those living in the Central, South, and South-West regions (35 percent, 36 percent and 39 percent), those with low levels of education or SES (39 percent and 36 percent respectively), IDP/R women and non-IDPs living in conflict areas (41 percent and 35 percent), those with four or more other births (42 percent) and those with no prenatal care (48 percent).

### **Poor Birth Outcomes**

- Of all births during the 1996-2001 period, 21.2 per 1,000 were stillbirths.
- The stillbirth rate was higher among women living in urban areas than in rural areas (26 vs. 17 per 1,000), among residents of the West and Central regions (38 and 31 per 1,000), among women aged 35-44 years, among women with postsecondary education, and among those with three or more previous births.
- The incidence of low birth weight was 12 percent. Higher rates were reported by rural women, women in the Southwest, South, and Central regions (18 percent, 15 percent, and 14 percent respectively), women with low education (16 percent) or low SES (16 percent), IDP and non-IDP women living in conflict areas (16 percent), women with at least three prior births, women with no prenatal care (17 percent) and those delivered at home (18 percent).
- The incidence of prematurity (birth before 37 weeks of gestation) was 5.7 percent.

### **Breastfeeding**

- The majority of babies (95 percent) born during 1996-2001 were breastfed at least for short periods of time.
- Of infants who were breast fed, only 2 percent began breastfeeding during the first hour after birth. The majority of children began breastfeeding between 1 hour and the completion of the first day (49 percent) or during the second day of life (26 percent).
- The mean duration of any breastfeeding was 11.6 months. For most of this time, however, breastfeeding was only partial.
- The mean duration of exclusive breastfeeding was 0.4 months and with the exception of the women residing in the Central region, did not vary greatly by maternal characteristics.
- Very few children were exclusively breastfed for the length of time recommended by the WHO (WHO recommends that all children under four months of age should be exclusively breastfed).

### **Prevalence of Routine Gynecologic Visits**

- Only about one in two (57 percent) sexually experienced women had ever been examined by a gynecologist during a routine exam and only 22 percent were examined in the previous 12 months.

- 15 percent of women had undergone an exam within the past three years and 21 percent more than three years ago.
- Rural residents, women living in the South and West, younger women, women with lower education, and those not currently employed, were more likely to have never received preventive gynecologic exams.

### **Breast Self-Exam**

- Less than one of three (30 percent) sexually experienced women of childbearing age has ever heard about breast self-exam and only one of ten (10 percent) has ever performed this procedure.
- Awareness of breast self-exam is higher among urban than rural residents (37 percent vs. 21 percent) among women residing in Baku (49 percent), increased with age and education level, was higher among women currently employed, and among those who underwent routine gynecological exams.

### **Pelvic Inflammatory Disease (PID)**

- Overall, 27 percent of all women and 42 percent of ever-married women reported PID.
- Those most likely to report PID were women who ever had a routine gynecologic exam (64 percent).

### **Other Health Conditions**

- One in six women reported that she had been told by the doctor that she had high blood pressure; 14 percent reported urinary tract infections; 2 percent had been diagnosed with Hepatitis B, and a few women had been told that they have Diabetes.

## **KNOWLEDGE AND EXPERIENCE OF SEXUALLY TRANSMITTED DISEASES**

### **Knowledge of AIDS and other STDs**

- A high percentage (75 percent) of women have heard of HIV/AIDS but significantly fewer women have heard of syphilis (41 percent) and gonorrhea (35 percent).
- Only 12 percent of women have heard of trichomonas, 85 have heard of Chlamydia, 7 percent were aware of bacterial vaginosis, 6 percent and 5 percent, respectively, knew that genital warts and genital herpes were transmitted sexually.
- Although three fourth of women were aware of HIV/AIDS, only one in six (16 percent) said that she knew where HIV test are provided, including 3 percent who have been tested for HIV/AIDS.
- Only 28 percent of the women who had heard of HIV knew that the disease could be present with no symptoms.

### **Self-Reported STD Testing and Diagnostic**

- According to the women's responses, the most often diagnosed STDs were yeast infection and trichomoniasis. Overall, five percent and one percent, respectively, of all women aged 15-44 reports having had a yeast infection and trichomoniasis infection.
- Women living in Baku (12 percent and 3 percent), women with university education (12 percent and 3 percent), and women with two or more lifetime sexual partners (22 percent and 9 percent) were more likely to report positive testing, probably due to differences in health seeking behaviors and access to health services.
- A history of other STDs was very seldom reported; only 0.3 percent of women have been diagnosed with chlamydia, 0.2 percent with gonorrhea, and 0.1 percent with genital herpes, or bacterial vaginosis.
- When interpreting results one should be cognizant that laboratory resources in Azerbaijan are quite limited and, for STDs, without testing there is no diagnosis. Only 19 percent of sexually experienced women have ever been tested for STDs.

### **Self-Reported STD Symptoms**

- Almost one in three sexually experienced women reported abnormal vaginal discharge and 2 percent reported "sores, warts, or ulcers in the genital area".
- Reports of vaginal discharge and sores were higher among women who have ever been tested for or diagnosed with a STD, suggesting that STD symptoms were severe enough to seek medical attention.
- Among women who have recently experienced vaginal discharge, 78 percent reported also low abdominal pain, 51 percent reported vaginal itching, 41 percent reported pain during sexual intercourse, and 37 percent reported painful urination.

