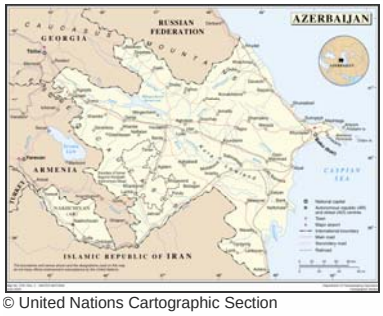
World Health Organization

Country Cooperation Strategy *at a glance*

Azerbaijan



Total population (2005)[1]	**8 411 000**
% under 15 (2005)[1]	**26**
Population distribution % rural (2005)[1]	**50**
Life expectancy at birth (2004)[2]	**65**
Under-5 mortality rate per 1000 (2004)[2]	**90**
Maternal mortality ratio per 100 000 live births (2000)[3]	**94**
Total expenditure on health % GDP (2004)[4]	**3.7**
General government expenditure on health as % of general government expenditure (2004)[4]	**2.9**
Human Development Index Rank, out of 177 countries (2003)[5]	**101**
Gross National Income (GNI) per capita US$ (2004)[6]	**950**
Adult (15+) literacy rate (2003)[5]	**98.8**
% population with sustainable access to an improved water source (2002)[5]	**77**
% population with sustainable access to improved sanitation (2002)[5]	**55**

Sources:
[1] United Nations Population Division
[2] World Health Report 2006
[3] World Health Report 2005
[4] WHO data on National Health Accounts
[5] Human Development Report 2005
[6] World Development Indicators 2005 (World Bank)

Azerbaijan has an area of 86 600 km² in the Caucasus region bordering the Caspian Sea. The autonomous republic of Nakhichevan is separated from the rest of Azerbaijan by Armenian territory. Azerbaijan regained independence in 1991 and became a Presidential Republic. There are 59 administrative districts (rayons) and 11 cities. The majority (83%) of the population are Azeri, 6% are Russian and 6% are Armenian. About 13% of the total population are refugees and internally displaced persons (IDPs). Most of the population are Muslim. An ongoing reform process, moving towards democracy and a market economy, is advancing gradually and economic growth is accelerating. The country is rich in minerals, mainly oil, on which the economy is heavily dependent.

HEALTH & DEVELOPMENT

The health sector faces budgetary constraints and has not benefited directly from increased oil revenues; the state budget for health is among the lowest in the Newly Independent States (NIS). Determining the health status of the population, which deteriorated in the early 1990s following independence and the war with Armenia, is difficult because of the unreliability of official statistics and under-reporting due to decreasing use of state health facilities. However, some indicators suggest improvement during the past decade. High childhood vaccine coverage under the Expanded Programme on Immunizations (EPI) is reported, although the data is uncertain. Poverty is an important health determinant; around half of the population lives below the poverty line.

The health system remains highly centralized and organized on the basis of centrally-determined norms without reference to local conditions or the changing epidemiological situation. Proliferation of small specialized facilities dilutes expertise and resources. Funding for health is controlled by the Ministry of Finance (MoF) independently of performance and service quality. The Ministry of Health (MoH) has weak stewardship capacity and lacks a clear health policy. Health promotion is not addressed.

Primary care services are not well developed and facilities are often in very poor condition, some lacking in water and electricity, and staff are poorly trained. Secondary care follows the former centralized soviet model with large numbers of hospitals and beds; many people attend hospitals for basic needs. Privatization of some facilities has been introduced but does not address the need for overall rationalization of services. Fees for some services, introduced in 1998, make up an increasing proportion of health expenditure (56% in 2000). Staff salaries are inadequate and informal payments are often required, particularly in rural areas. Implementation of mandatory health insurance has been delayed.

Noncommunicable conditions are the leading causes of death, mainly due to lifestyle factors, particularly tobacco and alcohol consumption. Most deaths are due to diseases of the circulatory system, cancers, external injuries and poisoning. Diabetes is important but the prevalence data is unclear. Mental health disorders and suicide rates are below the NIS average. Malnutrition is a serious problem in children, particularly in rural areas.

Tuberculosis, malaria and sexually-transmitted diseases are important public health problems. The death rate from tuberculosis is around 10 times the European average. Malaria increased sharply in the 1990s due to socioeconomic conditions, agricultural practices and population displacement; the incidence has fallen but measures are needed to avoid resurgence. Sexually-transmitted diseases are of growing concern. Gonococcal infection and syphilis rates have decreased but HIV infection is steadily increasing; knowledge on AIDS prevention is poor and a third of blood units are not adequately screened.

Environmental factors are important health risks. About 25% of the population does not have access to safe water and waste water disposal, with rural areas most disadvantaged. Much surface water is polluted by heavy metals and pesticide residues. Data for foodborne disease are unclear. Atmospheric pollution is high, mainly from electricity power stations; reliable environmental monitoring systems do not exist.

Economic development after independence has been slow, with economic diversification and poverty reduction impeded by problems of governance and financial management. However, the State Programme for Poverty Reduction and Economic Development (SPPRED) was signed in 2003 with specific aims for institutional reform including health. The forecast of economic growth, mainly due to the oil revenues, is among the highest in the world (2006).

OPPORTUNITIES	CHALLENGES
• Launch of SPPRED (Azerbaijan's Poverty Reduction Strategy Paper, PRSP) • Political stability and prospects for economic growth; emerging commitment to democratic reform and development of civil society • Accession to the Council of Europe in 2001 • Commitment to United Nations (UN) Millennium Development Goals (MDGs) • Biennial Collaboration Agreement between MoH and WHO.	• Centralized health system; weak MoH capacity; lack of health reform strategy; inadequate information system • Unequal access to health services especially in rural areas and vulnerable groups; inadequate quality control of services • Lack of coherence in health financing; inefficient reliance on direct payments by users including informal payments • Limited human resource (HR) capacity at different levels; low staff salaries, no HR development plan, outdated medical curricula • Inadequate physical infrastructure; poor access to essential drugs • Inadequate health budget; lack of transparency; insufficient coordination of external aid • Pharmaceutical industry largely uncontrolled and unregulated.

PARTNERS

The World Bank is the largest international agency contributing to health system reform. Many UN agencies are represented in Azerbaijan, coordinated through UNDP, including UNCTAD, UNESCO, UNFPA, UNHCR, UNICEF, UNIDO, UNIFEM, WFP and WHO. The IMF, IOM and the Coordination Unit on Technical assistance of the European Union (TACIS) are also represented. Several agencies support activities such as health reform, primary health care, malaria, reproductive health, food safety, poverty reduction, migration issues, and environmental protection.
Around 50 intergovernmental organizations (IGOs) and nongovernmental organizations (NGOs) deliver humanitarian aid and assistance to refugees, IDPs and other vulnerable groups. Most of the assistance from the United States of America has been in this area, with programmes largely administered by NGOs.

OPPORTUNITIES	CHALLENGES
• World Bank support for health sector reform • Many UN agencies and NGOs active in health-related programmes • Involvement of IGOs in development and launch of SPPRED.	• Coordination of external aid from many different organizations • Increasing investment in long-term development; reducing dependency on aid for emergency relief.

WHO STRATEGIC AGENDA (2004-2010)

WHO is adopting a more strategic focus and a systems approach, focusing more on outcomes as well as long term sustainability of its interventions. Strong alliances with other international agencies will strengthen coordination and avoid overlap and duplication. WHO will also assume a greater role as an honest broker, offering high level policy advice and guidance to the MoH and supporting the Government's efforts to reform the health sector, improve the health status of the population, reduce inequities in access to basic services, and improve the quality of care. The strategic agenda focuses on:

- **National policy for health.** Advocate for Government support for health sector reform with explicit values and goals; promote coherent inter-sectoral cooperation for health; delineate guiding principles for each health service function with goals, implementation strategies and indicators; involve MoF in planning; improve coordination between Government and international agencies.
- **Financial reforms.** Promote MoH and MoF cooperation on: reorganization of health budget; district level mechanisms to supplement budgets and create incentives for productivity and efficiency; phasing out the automatic link between facilities and resource allocation; planning an equitable allocation of resources based on needs. Development of appropriate monitoring and reporting systems.
- **Service provision.** Shifting resources from secondary and tertiary care into primary and preventive services; rational allocation of HR; increasing use of nurses in rural areas; expansion of successful primary care pilot models; integration of training in pilot projects; integration of public health and social care in primary care.
- **Human resources and physical infrastructure.** Reduction of excess capacity to be implemented gradually as the health sector reform process progresses.

ADDITIONAL INFORMATION

WHO country page **http://www.who.int/countries/aze/en/**
EURO country page **http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=AZE&CtryInputSubmit**