

AZERBAIJAN¹



Azerbaijan (population 8.32 million people)² is a country in south western Asia that occupies an area of 86,600 km². It is bordered by Russia to the north, Georgia to the northwest, Armenia to the west and Iran to the south. Azerbaijan gained independence from the USSR in 1991.³ According to the United Nations human development index (HDI), Azerbaijan is ranked 101/177 countries worldwide (value 0.729).⁴ This places Azerbaijan in the group of countries with medium human development.

PALLIATIVE CARE SERVICE PROVISION

Current services

The country has just one palliative care service at present, delivering home care. This single source of palliative care development so far identified in Azerbaijan is the work of the Jewish Women's Organisation of Azerbaijan (JWOA), which has extended its earlier activities (begun in 1992) in support of chronically ill people to promote the idea of a mobile hospice service. The service, which is based in the country's capital Baku, aims to provide medical, psychological and social assistance to patients with a life expectancy of less than six months. The age of the patients in the pilot project varied between 30-75 years; 120 patients were assessed and 30 of these (27 women, 3 men) were admitted to the service.⁵ The pilot project (1998-9) has been described in a detailed report.⁶

The care for people with chronic and terminal illness provided by the state is limited to medical services (check-up, medication, surgery) and no social services are available for these people and their relatives. A few non-governmental organizations run projects that address the social and emotional problems of people with terminal illness. The Jewish Organization "HAVVA", in conjunction with the Azerbaijan Psychological Association (APA) provide training courses for oncologists on psychological problems of terminally ill patients and how to communicate with them. The psychologists help people diagnosed with cancer deal with the issues of dying and provide emotional support to their relatives. However, the projects run by NGOs are unable to cover all the people in need of help. There are no institutions that professionally train people how to work with grief, loss, and bereavement.⁷

Table 1: Palliative care provision in Azerbaijan 2005

		<i>Existing services (2005)</i>
Adult/paediatric	Inpatient palliative care units	0
	Inpatient hospices	0
	Consultant teams in hospitals	0
	Home care teams	1
	Day centres	0
	Adult/paediatric total	1
Paediatric	Inpatient palliative care units	0
	Inpatient hospices	0
	Consultant teams in hospitals	0
	Home care teams	0
	Day centres	0
	Paediatric total	0
Grand total		1

The concept of a hospice is still relatively new for Azerbaijan, although there is an extreme need for hospices in the country. For almost a decade, Gulara Narimanova, the director of INSAN Charitable Organization, has been working to establish hospices in Azerbaijan. With support from Pennzoil Caspian Corporation, a subsidiary of Devon Energy Corporation, plans for Azerbaijan's first hospice are finally underway. Equipment and furnishings for the new hospices have been donated by Dr. Wayne H. Roberts of Edmond, Oklahoma, whose son Wayne works as a geologist with Devon Energy in Oklahoma City. When Dr. Roberts retired from medicine in June 2000 after 63 years of practice, he gave Azerbaijan the medical equipment from Parkside Hospital, which he had built and opened in 1950. The donation includes operating room equipment, surgical tools and lab equipment, plus furnishings for 25 hospital rooms - hospital beds, stands, screens, sheets and blankets. TransOceanic Caspian packed the equipment into a container for its lengthy voyage. Devon Energy paid for the shipping from the United States to Baku and is now working with INSAN to set up the hospices. The first hospice will be located at the Oncology Center in Baku, which treats approximately 3,000 cancer patients each year. Hospices will also be established in the regions at Ali Bayramli and Imishli - the latter, primarily to serve the refugee population. Remaining equipment will be distributed to the Bone Tuberculosis Sanatorium for Children in Zagulba, which Pennzoil Caspian has sponsored since 1996.⁸

Palliative care beacons

There are no such examples yet in existence in Azerbaijan.

Reimbursement and funding for services

Health care generally in Azerbaijan is poorly funded following the economic collapse which accompanied the end of communism. The Jewish Women's Organisation of Azerbaijan has received assistance from Oxfam, and from the Open Society Institute.⁹

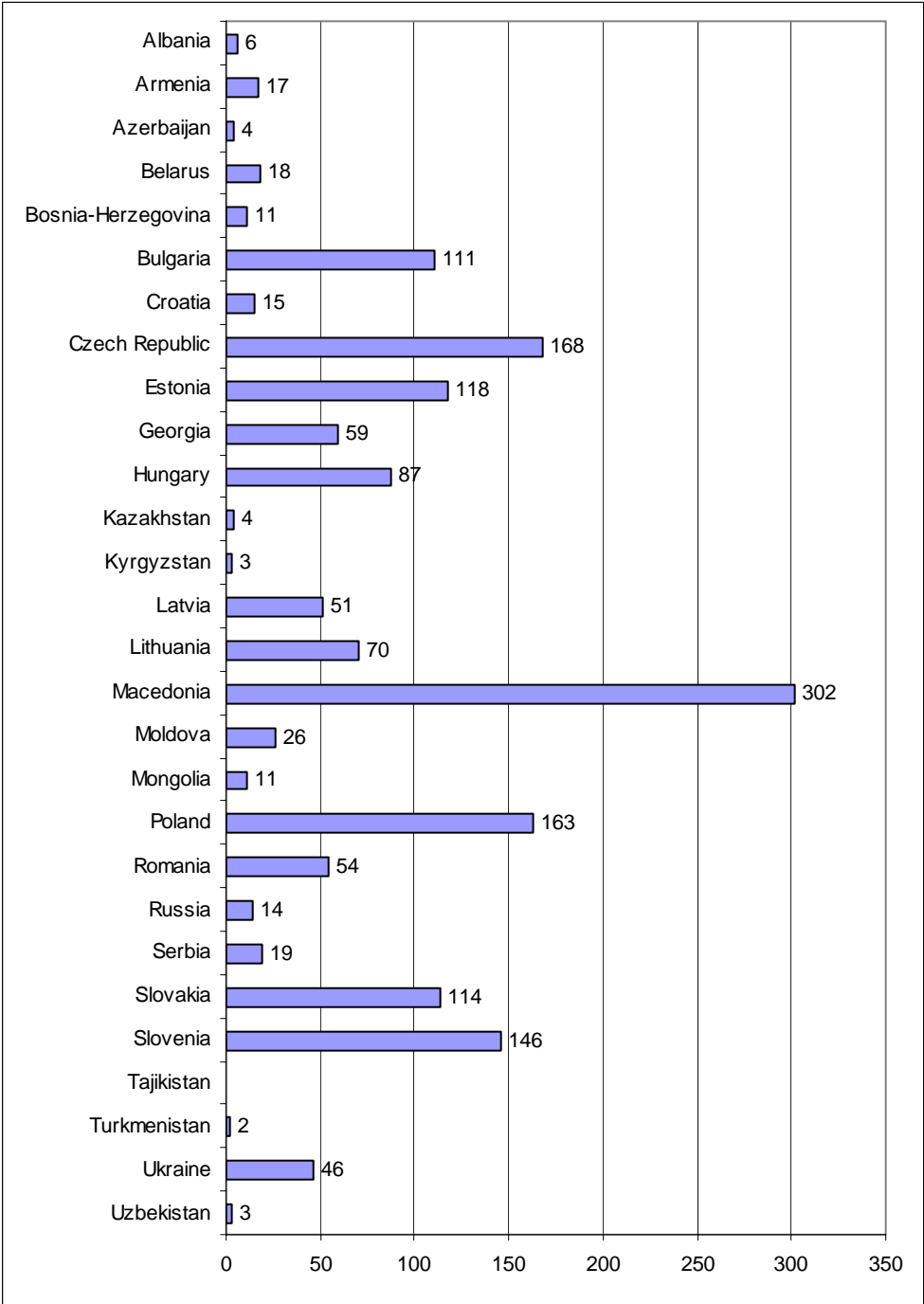
Opioid availability and consumption

The International Narcotics Control Board¹⁰ has published the following figures for the consumption of narcotic drugs in Azerbaijan (2004): morphine 1 kg; codeine 4 kg. Morphine

(immediate and slow release), fentanyl, oxycodone and hydromorphone are all described by one respondent as ‘difficult’ to obtain.¹¹

For the years 2002-2004, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)¹² in Azerbaijan was 4. This compares with other Commonwealth of Independent States as follows: Armenia 17; Georgia 59; Russian Federation 14 (Table 2).

Table 2: Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2002-2004 Central and Eastern Europe/Commonwealth of Independent States (plus Mongolia)



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2006. Statistics for 2002-2004.* New York: United Nations, 2006.

National and professional organisations

Azerbaijan appears to have no national guidelines, recommendations, standards or policies relating to palliative care.¹³ There is no education in palliative care at national level, though some events have been held locally, for doctors, nurses and others – at basic level only. There are no national palliative care or related organisations. Some WHO publications (*Symptom Relief in Terminal Illness* and *Cancer Pain Relief with a Guide to Opioid Availability*) have been translated into Azeri, with financial support in 2000 from OSI.¹⁴

Palliative care coverage

In 2005, the ratio of hospice/palliative care services in Azerbaijan was one service per 8.32 million inhabitants (see Table 3). This compares to one service per 7.7 million inhabitants in 2002.¹⁵

Table 3: Ratio of hospice/palliative care services per million population; Commonwealth of Independent States (plus Mongolia) (2005).

Armenia	1: 0.09m
Azerbaijan	1: 8.32m
Belarus	1: 0.81m
Georgia	1: 1.11m
Kazakhstan	1: 1.28m
Kyrgyzstan	1: 2.65m
Mongolia	1: 2.65m
Republic of Moldova	1: 0.27m
Russian Federation	1: 1.15m
Tajikistan	0: 6.53m
Turkmenistan	0: 6.56m
Ukraine	1: 2.59m
Uzbekistan	0: 26.01m

Source: EAPC Taskforce on the Development of Palliative Care in Europe (2005) *A Map of Palliative Care Specific Resources in Europe*. 4th Research Forum of the European Association for Palliative Care, Venice, Italy, 25th-27th May 2006/ Clark, D., and Wright, M. (2003) *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press.

Education and training

There is no information currently available on palliative care education and training in Azerbaijan.

Palliative care workforce capacity

There is no information currently available on the palliative care workforce capacity in Azerbaijan.

HISTORY AND DEVELOPMENT OF PALLIATIVE CARE

The only source of palliative care development so far identified in Azerbaijan is the work of the Jewish Women's Organisation of Azerbaijan (JWOA).¹⁶ The pilot project (1998-9) has been described in a detailed report, which notes:

‘The project’s problem consisted in and was aggravated by the fact that the patients’ relatives would not wish to bear the heavy burden of nursing [with patients who] suffer...a lack of attention, hopelessness and fear. The establishment of the hospice service at home has a great human sense because it is the only possible method of support intended for assistance to the patients and also their relatives, [who also] need moral and psychological aid and experience the same stresses together [with the patients]. To characterize our patients, we should say that we took under supervision those of them whom oncologists, radiologists and chemotherapists had already given up.’¹⁷

Nurses and ‘patronage sisters’ were especially trained to deliver the service and they in turn provided training for relatives. Following a detailed analysis of the medical, social and psychological problems of the patients and their families, the report of the pilot scheme makes the following conclusions: 1) hospice services should be free 2) hospice is a house of life, not of death 3) hospice is a complex of medical, psychological and social assistance to the patient 4) hospice is a school as well as support for relatives and friends of the patient. The report concludes with a quote from Victor Zorza: ‘the path to death is life up to the end.’¹⁸

Life/oral histories

No oral histories for Azerbaijan are currently available.

ETHICAL ISSUES

Patients with terminal illnesses have to rely on relatives, which puts an enormous burden both financially and psychologically on family members.¹⁹ People get diagnosed with a terminal illness very late and often it is a shock for the family to know that the person will die very soon. Accepting and dealing with death can be extremely hard for these people as well for their relatives. In Azerbaijan, the doctors and family members try to protect the patient by often hiding the real diagnosis, although this may create tension within the family.²⁰

PUBLIC HEALTH CONTEXT

Population

The major ethnic groups are Azeri 90.6%; Dagestani 2.2%; Russian 1.8%; Armenian 1.5%; other 3.9% (1999 census), with almost all Armenians living in the separatist Nagorno-Karabakh region. The major religious groupings are Muslim 93.4%; Russian Orthodox 2.5%; Armenian Orthodox 2.3%; other 1.8% (1995) (religious affiliation is still nominal in Azerbaijan; percentages for actual practicing adherents are much lower)²¹

Epidemiology

The adult mortality²² rate in 2004 is reported as 205/1000 population for males and 113/1000 for females.²³

In Azerbaijan, the WHO World Health Report (2006) indicates a life expectancy at birth of 63 years for males; 68 years for females (Table 4). Healthy life expectancy is 55.8 years for males; 58.7 years for females.²⁴

Table 4: Population life expectancy at birth, Commonwealth of Independent States (plus Mongolia) (2004)

<i>Country</i>	<i>Life expectancy at birth</i>	
	<i>Male</i>	<i>Female</i>
Armenia	65	72
Azerbaijan	63	68
Belarus	63	74
Georgia	70	77
Kazakhstan	56	67
Kyrgyzstan	59	67
Mongolia	61	69
Republic of Moldova	64	71
Russian Federation	59	72
Tajikistan	62	64
Turkmenistan	56	65
Ukraine	62	73
Uzbekistan	63	69

Source: WHO World Health Report 2006

In 2006, UNAIDS reports:

‘The epidemics in Eastern Europe and Central Asia continue to grow and are affecting ever-larger parts of societies in this region. The number of people living with HIV in this region reached an estimated 1.6 million in 2005 - an increase of almost twenty-fold in less than ten years. AIDS claimed almost twice as many lives in 2005, compared with 2003, and killed an estimated 62,000 adults and children. Some 270,000 people were newly infected with HIV in the past year. The overwhelming majority of people living with HIV in this region are young; 75% of the reported infections between 2000 and 2004 were in people younger than 30 years (in Western Europe, the corresponding figure was 33%).’²⁵

UNAIDS also specifically highlight the increase in HIV infections in Azerbaijan:

‘By the end of 2004, Azerbaijan reported 718 HIV cases; 111 of these had been reported with AIDS, including 50 who died. Three quarters of the HIV cases notifications included a known route of transmission; 60% of them had been infected through injecting drug use. In 2004, 121 new HIV cases were reported; of the 87% that identified the transmission mode, 66% had been infected through injecting drug use. Available data suggest that 45% of people living with HIV were infected outside of the country, mainly in the Russian Federation and Ukraine. Eighty per cent of all HIV cases are among men. The majority of HIV cases (44.3%) are registered in Baku, the capital. The dominant mode of transmission there is injecting drug use (63% of cases with a known transmission route). Local traditions prohibit women from actively seeking care for HIV/AIDS or other STIs, a situation compounded by a general lack of access to HIV testing and counselling. A mandatory HIV testing policy no longer exists in Azerbaijan, and as of 2003, about 2.3% of the population had been tested. Results from a WHO-supported survey conducted in late 2003 show an HIV prevalence of 16.5% among IDUs (13% in Baku and 19.5% in Lenkoran) and a hepatitis C prevalence rate of 55%. These figures are much higher than the

routinely collected surveillance data. The most affected group is the so-called street IDUs, a group that remains outside the focus of national HIV prevention and care efforts. Prevalence in this group is 12 times higher than among IDUs registered at narcology centres in Baku. In Lenkoran, all known PLWHA were street IDUs. The number of opiate users is very high in Azerbaijan, and is estimated by the United Nations Office on Drugs and Crime (UNODC) to be around 0.2% of the adult population, of which 50-60% inject heroin. HIV prevalence among female sex workers is around 8.5%. The prevalence of other STIs is also quite high, e.g. syphilis 9% and Chlamydia 63%. Condom use rates remain very low.²⁶

Health care system

The health care system in Azerbaijan continues to function in the Soviet-style, although several private clinics have opened and the government has partially switched to paid health care. Generally it is a state-subsidized sector, with a little-developed insurance system. Since the collapse of the Soviet Union, the efficiency of the medical care has undergone deterioration, especially at the primary level. Issues such as quality and access to medical services have become a subject for concern.²⁷ It is estimated that ‘most patients in Azerbaijan (78% in 1999) have to make “informal” payments both in money and in food, especially in rural areas.’²⁸

The problems of the health care system in Azerbaijan since the end of communism have been listed as:

- Lack of funding due to economic collapse;
- Lack of management capacity in-country as, historically, all decisions had been taken previously in Moscow;
- Failure to adapt to limited resources and to reduce overcapacity in accordance with agreed priorities;
- Disruption of the former soviet health network and the system of medical supplies;
- Weaknesses in primary health care;
- Low population coverage in the national transition;
- Disappearance of health promotion programmes.²⁹

In 2003, the total per capita expenditure on health care³⁰ was Intl \$140 (3.6% of GDP).³¹ Among the Commonwealth of Independent States, this figure falls within a spending range of Intl \$ 71 in Tajikistan (4.4 % of GDP) and Intl \$570 in Belarus (6.4% of GDP). At 3.5%, the smallest spending as a percentage of GDP is in Kazakhstan (Tables 5 and 6).

The WHO overall health system performance score places Azerbaijan 103/191 countries. This composite measure of overall health system attainment³² is based on a country’s goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

Table 5: Health expenditure (Intl \$) per capita: Commonwealth of Independent States (plus Mongolia) 2003		Table 6: Health expenditure (Intl \$) as a percentage of GDP: Commonwealth of Independent States (plus Mongolia) 2003	
Country	Per capita	Country	% GDP
Armenia	302	Armenia	6.0
Azerbaijan	140	Azerbaijan	3.6
Belarus	570	Belarus	6.4
Georgia	174	Georgia	4.0
Kazakhstan	315	Kazakhstan	3.5
Kyrgyzstan	161	Kyrgyzstan	5.3
Mongolia	140	Mongolia	6.7
Republic of Moldova	177	Republic of Moldova	7.2
Russian Federation	551	Russian Federation	5.6
Tajikistan	71	Tajikistan	4.4
Turkmenistan	221	Turkmenistan	3.9
Ukraine	305	Ukraine	5.7
Uzbekistan	159	Uzbekistan	5.5

Source: WHO World Health Report 2006

Political economy

In Azerbaijan, GDP per capita is Intl \$ 4,337. This falls within the range of \$1,816 (Tajikistan) and \$11,807 (Belarus) in the Commonwealth of Independent States (see Table 7).³³

Table 7: GDP per capita (Intl \$): Commonwealth of Independent States (plus Mongolia) 2004

Country	GDP per capita (Int \$)
Armenia	5,697
Azerbaijan	4,337
Belarus	11,807
Georgia	4,829
Kazakhstan	9,982
Kyrgyzstan	3,287
Mongolia	2,373
Republic of Moldova	2,709
Russian Federation	10,865
Tajikistan	1,816
Turkmenistan	5,947
Ukraine	6,216
Uzbekistan	3,125

Source: WHO World Health Report 2006

Despite a cease-fire, in place since 1994, Azerbaijan has yet to resolve its conflict with Armenia over the Azerbaijani Nagorno-Karabakh enclave (largely Armenian populated). Azerbaijan has lost almost 20% of its territory and must support some 750,000 refugees and internally displaced persons as a result of the conflict.³⁴ Azerbaijan's number one export is oil. Azerbaijan's oil production declined through 1997, but has registered an increase every year since. Negotiation of production-sharing arrangements (PSAs) with foreign firms, which have thus far committed \$60 billion to long-term oilfield development, should generate the funds needed to spur future industrial development. Oil production under the first of these PSAs, with the Azerbaijan International Operating Company, began in November 1997. A consortium of Western oil companies is scheduled to begin pumping 1 million barrels a day from a large offshore field in early 2006, through a \$4 billion pipeline it built from Baku to Turkey's Mediterranean port of Ceyhan. Economists estimate that by 2010 revenues from this project will double the country's current GDP. Azerbaijan shares all the formidable problems of the former Soviet republics in making the transition from a command to a market economy, but its considerable energy resources brighten its long-term prospects. Baku has only recently begun making progress on economic reform, and old economic ties and structures are slowly being replaced. There is a need for additional foreign investment in the non-energy sector. Trade with Russia and the other former Soviet republics is declining in importance while trade is building with Turkey and the nations of Europe. Long-term prospects will depend on world oil prices, the location of new pipelines in the region, and Azerbaijan's ability to manage its oil wealth.³⁵

FURTHER READING

Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 165-6.

http://www.eolc-observatory.net/global_analysis/azerbaijan.htm

REFERENCES

¹ Report last updated October 2006

² EAPC Taskforce on the Development of Palliative Care in Europe (2005) *A Map of Palliative Care Specific Resources in Europe*. 4th Research Forum of the European Association for Palliative Care, Venice, Italy, 25th-27th May 2006

³ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

⁴ Report of the United Nations Development Programme 2005 (HDI 2003). Launched by the United Nations in 1990, the Human Development Index measures a country's achievements in three aspects of human development: longevity, knowledge, and a decent standard of living. It was created to re-emphasize that people and their lives should be the ultimate criteria for assessing the development of a country, not economic growth. Current (2003) values range from 0.963 (Norway, 1/177 countries) to 0.281 (Niger, 177/177 countries). Countries fall into one of three groups: countries 1-55=high development; 56-141=medium development; 142-177=low development:

<http://hdr.undp.org/statistics/data/indicators.cfm>

<http://hdr.undp.org/statistics/data/countries.cfm?c=AZE>

⁵ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

⁶ Jewish Women's Organisation of Azerbaijan. Unpublished report on 'Creation of a mobile "hospice" service for Baku city.'

⁷ Ismayilova, A. L., and Ismailzade, F. 2003. *Contemporary Social Problems and Gaps in Social Work Services in Azerbaijan*. Baku State University/OSI Azerbaijan.

⁸ Petroleum section; Penzoil Caspian. 2001. Bringing Hospices to Azerbaijan. *Azerbaijan International*, 9.1, Spring 2001.

⁹ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

¹⁰ International Narcotics Control Board (2005) *Narcotic Drugs: estimated world requirements for 2006. Statistics for 2002-2004*. New York: United Nations, 2005.

¹¹ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

¹² The term *defined daily doses for statistical purposes* (S-DDD) replaced the term *defined daily doses* (DDD), which had previously been used by the Board. The defined daily doses for statistical purposes are technical units of measurement for the purpose of statistical analysis and are not recommended prescription doses. Their definitions are not free of a certain degree

of arbitrariness. Certain narcotic drugs may be used in certain countries for different treatments or in accordance with different medical practices and therefore a different daily dose could be more appropriate. The defined daily doses for statistical purposes indicated should be considered approximate and subject to modification if more precise information becomes available. The defined daily doses for statistical purposes for ethylmorphine, hydromorphone, ketobemidone, morphine, opium, oxycodone, phenazocine and tilidine were modified in 2003. The modifications followed the recommendations made in 2002 by an expert group that reviewed the defined daily doses for statistical purposes used by the Board for the analysis of the consumption of narcotic drugs, taking into account the developments in the most common dosages, indications and methods of administration of the narcotic drugs listed above. For example, in the case of morphine, the defined daily dose for statistical purposes was changed from 30 mg to 100 mg in order to reflect its increased consumption by oral administration, instead of by parenteral administration. International Narcotics Control Board. *Narcotic Drugs: estimated world requirements for 2006. Statistics for 2002-2004.*

¹³ EAPC Stockholm Questionnaire.

¹⁴ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

¹⁵ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

¹⁶ Clark, D., and Wright, M. 2003. *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press, Azerbaijan, pp. 125-128.

¹⁷ Jewish Women's Organisation of Azerbaijan. Unpublished report on 'Creation of a mobile "hospice" service for Baku city'

¹⁸ Jewish Women's Organisation of Azerbaijan. Unpublished report on 'Creation of a mobile "hospice" service for Baku city'

¹⁹ Petroleum section; Penzoil Caspian. 2001. Bringing Hospices to Azerbaijan. *Azerbaijan International*, 9.1, Spring 2001.

²⁰ Ismayilova, A. L., and Ismailzade, F. 2003. *Contemporary Social Problems and Gaps in Social Work Services in Azerbaijan*. Baku State University/OSI Azerbaijan.

²¹ <https://www.cia.gov/cia/publications/factbook/geos/aj.html>

²² This refers to adult mortality risk, which is defined as the probability of dying between 15 and 59 years.

²³ <http://www.who.int/countries/aze/en/>

²⁴ <http://www.who.int/countries/aze/en/>

²⁵ <http://www.unaids.org/en/>

²⁶ http://www.unaids.org/en/Regions_Countries/Countries/azerbaijan.asp

²⁷ Ismayilova, A. L., and Ismailzade, F. 2003. *Contemporary Social Problems and Gaps in Social Work Services in Azerbaijan*. Baku State University/OSI Azerbaijan.

²⁸ *Highlights on Health in Azerbaijan*. Copenhagen: World Health Organisation European Region, March 2001:21.

²⁹ *Health Care Systems in Transition: Azerbaijan*. Copenhagen: World Health Organisation Regional Office for Europe, 1996, preliminary version: 3.

³⁰ Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries.

<http://www3.who.int/whosis/country/compare.cfm?country=s&indicator=strPcTotEOHinIntD2000&language=english>

³¹ <http://www.who.int/countries/aze/en/>

³² Tandon, A., Murray, C. L. J, Lauer, J. A, and Evans, D. B. *Measuring overall health system performance for 191 Countries*. GPE Discussion Paper Series: No 30; WHO

³³ <http://www.who.int/countries/aze/en/>

³⁴ http://www.usaid.gov/regions/europe_eurasia/countries/az/index.html
<http://www.countryreports.org/azerbaijan.htm>

³⁵ <https://www.cia.gov/cia/publications/factbook/geos/aj.html>