

## Serbia and Montenegro

*Serbia is situated in the Balkans and together with Montenegro has a combined land area of 102,350 km<sup>2</sup> (Serbia 88,412km<sup>2</sup>; Montenegro 13,938 km<sup>2</sup>). It has borders with Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Hungary, the former Yugoslav Republic of Macedonia and Romania. The capital of Serbia is Belgrade and the capital of Montenegro is Podgorica.<sup>1</sup>*



---

<sup>1</sup> Eradicate Conflict by Building Cultural Awareness, <http://www.countryreports.org/serbia.htm> passim.

## 1 Palliative care service provision

### 1.1 Current services (last updated: May 2002)

The following palliative care services are known to exist in Serbia:

		<i>Existing services (2002)</i>
<b>Adult</b>	Inpatient - Freestanding	0
	- Hospital unit	0
	- Hospital mobile team	0
	Nursing home	0
	Home care	1
	Day care	0
	<b>Total</b>	<b>1</b>
<b>Paediatric</b>	Inpatient	0
	Home care	0
	Day care	0
	Unspecified	0
	<b>Total</b>	<b>0</b>
<b>Grand total</b>		<b>1</b>

### *Current projects (last updated: May 2002)*

No palliative care projects, not yet operational services, are known to exist in Serbia.

		<i>Existing services (2002)</i>
<b>Adult</b>	Inpatient - Freestanding	0
	- Hospital unit	0
	- Hospital mobile team	0
	Nursing home	0
	Home care	0
	Day care	0
	<b>Total</b>	<b>0</b>
<b>Paediatric</b>	Inpatient	0
	Home care	0
	Day care	0
	Unspecified	0
	<b>Total</b>	<b>0</b>
<b>Grand total</b>		<b>0</b>

The only indication of a palliative approach within Serbian health services at this time can be found in the adoption of some of the core principles of 'supportive care' for oncology patients. At the IORS there is no formal supportive care team or unit, 'but we do have a group of people dedicated to supportive care – a 'supportive care

oriented group' ... we also have an Oncologic Intensive Care Unit with 4 beds where the patients are admitted for active supportive care. The main difficulty in creating a formal team/unit is the idea that supportive care is exclusively the field of the practising oncologist and that it should not be a separate discipline'. Nevertheless, the group hopes to create such a team in the near future and in the meantime it continues to develop its international links, including with Dr Eduardo Bruera in the USA, and with the Italian Group for Anti-emetic Research; with these there is involvement in international, multi-centre research studies.<sup>2</sup> The IORS team can list a number of other achievements.<sup>3</sup> It has had an influence on morphine prescribing policy (previously restricted to 200 mg per prescription). It has developed a formula for the manufacture of morphine syrup ('but this only exists at our Institute!'). It has organised several lectures and seminars and been responsible for some publications and also enabled two nurses to attend international conferences.

Serbia has no national guidelines, recommendations, standards or policy concerning palliative care.<sup>4</sup> Nevertheless, the Institute for Oncology and Radiology of Serbia (IORS), based in Belgrade, has translated the 1996 WHO publication *Cancer Pain Relief* and has published its own 'user friendly' handbook for physicians and nurses on the relief of cancer pain, entitled *Pharmacotherapy of Cancer Pain*. The WHO document *Symptom Relief in Terminal Illness* (1998) has been translated and presented to GPs and oncologists during 2001 and 2002; the translation of *Cancer Pain Relief and Palliative Care in Children* (1998) is ongoing. Both translations have been supported by funding from OSI. Since 1993 a series of publications on aspects of supportive care in cancer by the Belgrade group have appeared in Serbian medical journals. Access to oncology journals is improving but there is only limited access to relevant supportive care journals, and palliative care journals appear to be completely unavailable

### *Education*

In Belgrade, Serbia, GPs receive formal training (9 x 45 minutes) in the basic principles of supportive care, general assessment of the patient, the concept of quality of life, emergencies in oncology, treatment of anorexia/cachexia, and principles of

---

<sup>2</sup> ECEPT questionnaire, January 2001.

<sup>3</sup> Questionnaire data (EAPC East).

cancer pain management. For postgraduate clinicians specialising in oncology, there are sessions (6 x 45 minutes) on similar topics and also the prevention of chemotherapy and radiotherapy induced emesis and psychosocial issues.<sup>5</sup> However, for undergraduate medical students, such subjects are dealt with only in the most limited way. A symposium focussing on supportive care is being planned for October 2004

In addition to these activities, we also identified the work of one NGO, based in Albania, but operating in Kosovo (see Albania country report). Ryder Albania Association (RAA) began a home care service in Pristina, Kosovo in April 2000 and cared for 107 patients in its first 9 months.<sup>6</sup>

*Help from EAPC:* One questionnaire listed detailed ideas about the help which might be given from EAPC; these included 'A high quality seminar for the country, covering all aspects – medical, organisational, drug policy; establish one comprehensive centre for education – one per country; research projects covering major cancers in the country; finance educational activities, including translation of books.'<sup>7</sup>

### *1.2 Reimbursement and funding for services*

No information currently available.

### *1.3 Opioid availability and consumption*

Immediate release morphine is described in one questionnaire as 'difficult' to obtain; slow release morphine is 'quite difficult'; fentanyl, oxycodone and hydromorphone are not available. There are restrictions on morphine prescription and the drug can only be prescribed for a two-week period.<sup>8</sup>

---

<sup>4</sup> Questionnaire data (Observatory)

<sup>5</sup> Snezana Bosnjak 'Yugoslavia: education/training in supportive and palliative care' Unpublished paper, prepared for ECEPT, March 2001.

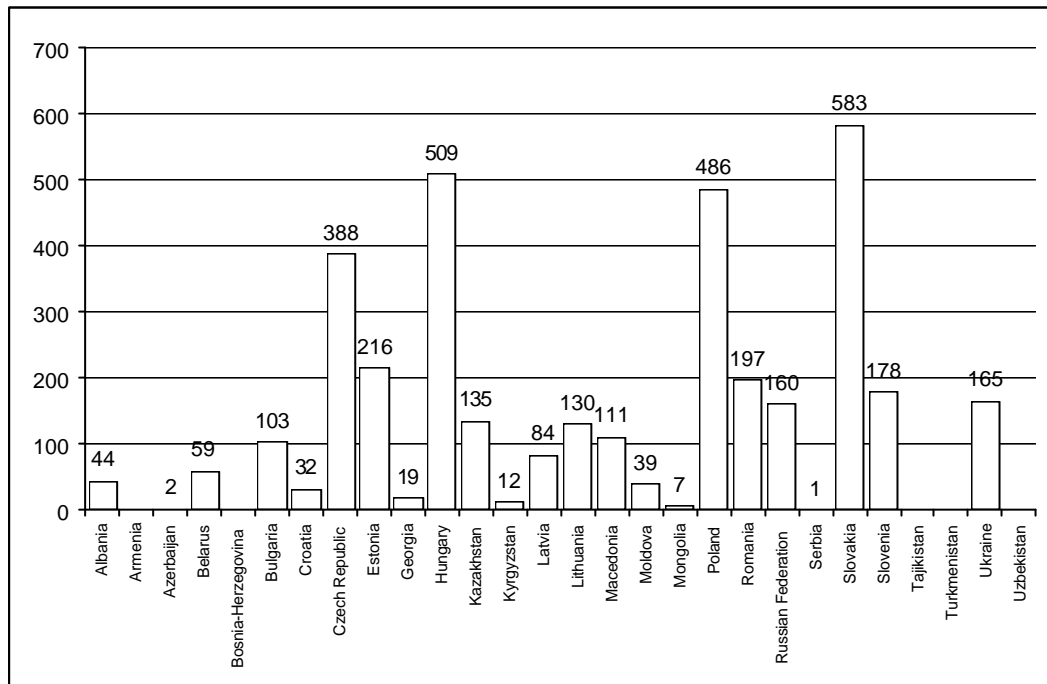
<sup>6</sup> Sallaku A, Prifti F, Huta K, Leka P, Rama R and Bicaj X. Aspects of palliative care in Albania and in Kosovo: the experience of Ryder Albania Association (RAA). Poster: *Seventh Congress of European Association of Palliative Care*, Palermo, Italy, 2001.

<sup>7</sup> Questionnaire data (EAPC East)

<sup>8</sup> Questionnaire data (EAPC East)

INCB data on opioid consumption in Serbia between 1994 and 1998 (years of major military conflict) are available only on a limited basis. Codeine consumption was 13 kg in 1994 and 93 kg in 1996; in the same years pethidine consumption was 3 kg per annum; and in 1994 methadone consumption was 4 kg. Data on the average daily consumption of defined daily doses of opioids per million inhabitants between 1994-98 are unavailable.<sup>9</sup>

*Average defined daily doses of morphine, Central and Eastern Europe (1994-1998)*



Source: Clark D, Wright M (2002) *Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press

#### 1.4 National and professional associations

A national association of palliative care was founded in April 2002. Nevertheless: ‘Control of symptoms and relief of suffering have not traditionally been a priority for clinical oncologists in Yugoslavia, who are mostly ‘tumour oriented’.<sup>10</sup>

<sup>9</sup> International Narcotics Control Board (2000) *Narcotic Drugs: Estimated World Requirements for 2000. Statistics for 1998*. New York: United Nations.

<sup>10</sup> Snezana Bosnjak and Sinisa Radulovic ‘Undergraduate and postgraduate education in cancer pain management and palliative/supportive care in Yugoslavia’. Unpublished report to ECEPT, 2000.

### 1.5 Palliative care 'coverage'

There is a service providing palliative care for every 10.5 million people in Serbia.

*Ratio of hospice/palliative care services per million population, Central and Eastern Europe (2002)*

	<i>Ratio 1:</i>
Estonia	1: 0.14m
Poland	1: 0.15m
Slovenia	1: 0.32m
Bulgaria	1: 0.36m
Hungary	1: 0.37m
Latvia	1: 0.48m
Lithuania	1: 0.62m
Czech Republic	1: 1.02m
Albania	1: 1.03m
Romania	1: 1.07m
Slovakia	1: 1.33m
Macedonia	1: 1.98m
Bosnia-Herzegovina	1: 2.00m
Croatia	1: 4.60m
Serbia	1: 10.50m

*Source: Clark D, Wright M (2002) Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia. Buckingham: Open University Press*

### 1.6 Palliative care workforce capacity

No information currently available.

## **2 History and development of palliative care in Serbia**

### *2.1 Narrative history of palliative care in Serbia*

There is little palliative care available in Serbia at the present time. Oncologists in Serbia explain the situation:

‘... we do not have any kind of organised palliative care services, education and so on. I am one of the very rare people in my country interested in palliative care at all. Last week I had meetings with the decision making people in my country trying to explain to them the meaning of the term palliative care and to establish a first hospice or at least a palliative care unit in the country. I know very well that we need it badly since I have been dealing, as a medical oncologist, with cancer patients for more than 20 years. Unfortunately our situation, due to well known events in the country during the last 10 years, is very bad and it is not easy to find the way even for basic education, not to mention setting up palliative care services.’<sup>11</sup>

A questionnaire entry reads:

‘We need: (especially for cancer patients) hospital units and home care teams, hospices, more education for everyone (MDs, RNs, public, health professionals, government, money to import slow release morphine or methadone.’<sup>12</sup>

At least one oncologist from Serbia has been able to attend courses in palliative care outside the country: in England, Poland, Germany and Switzerland. She writes:

‘Ten years ago some initial interest was shown among medical professionals for this field. Unfortunately, thanks to the unfavourable situation in my country the people who should be concerned with the problem and who could initiate and help the development of palliative care are at the moment engaged with the problems of existence. They suggest that palliative care should be postponed for a while, although I do my best to explain that palliative care is a much better solution for our situation and cheaper than the usual treatment. So far my efforts have been fruitless.’<sup>13</sup>

### *2.2 Hospice/beacon case studies*

No information currently available.

---

<sup>11</sup> Natasa Milicevic, personal communication, July 2001.

<sup>12</sup> Questionnaire data (EAPC East).

<sup>13</sup> Questionnaire data (EAPC East)

### *2.3 Life/oral histories*

No information currently available.

### 3. Public Health Context

#### 3.1 Population

Combined, Serbia and Montenegro had an estimated population in July 2000 of 10,662,000. The ethnic groups in 1991, before the widespread war and population dislocation in the former Yugoslavia were: Serb (62.6%), Albanian (16.5%), Montenegrin (5%), Yugoslav (3.4%), Hungarian (3.3%), other (9.2%). Religious groups were: Orthodox (65%), Muslim (19%), Roman Catholic (4%), Protestant (1%), other (11%).

#### 3.2 Epidemiology

In 2000, life expectancy for men in Serbia was 69.31 and for women was 75.72 years; in Montenegro life expectancy is higher - 71.45 years and 79.82 years, respectively. Serbia has 20,000 cancer deaths per year.

*Population and life expectancy, Central and Eastern Europe (2000)*

	<i>Population</i>	<i>Life expectancy</i>	
	<i>Millions</i>	<i>Male</i>	<i>Female</i>
Albania	3.1	64.3	72.9
Bosnia- Herzegovina	3.9	68.7	74.4
Bulgaria	7.9	67.4	74.9
Croatia	4.6	69.8	77.7
Czech Republic	10.2	71.5	78.2
Estonia	1.3	65.4	76.5
Hungary	9.9	66.3	75.2
Latvia	2.4	64.2	75.5
Lithuania	3.7	66.9	77.2
Macedonia	2.0	70.2	74.8
Poland	38.6	69.2	77.7
Romania	22.4	66.2	73.5
Serbia	10.5		
Slovakia	5.3	69.2	77.5
Slovenia	1.9	71.9	79.4

*Source: World Health Report 2001*

*WHO age standardised death rates per 100,000 population,  
Central and Eastern Europe (1995-1998)*

	<i>Year</i>	<i>All causes</i>	<i>Cancer</i>
Albania			
Bosnia- Herzegovina			
Bulgaria	1998	958.9	123.3
Croatia	1997	836.0	174.2
Czech Republic	1998	706.6	182.9
Estonia	1998	907.7	157.8
Hungary	1998	917.8	219.4
Latvia	1998	955.2	152.1
Lithuania	1997	817.2	149.4
Macedonia	1997	809.1	126.6
Poland	1996	812.2	165.2
Romania	1998	933.9	130.6
Serbia			
Slovakia	1995	820.9	172.3
Slovenia	1997	666.1	167.5

*Source: World Health Organisation: World Health Statistics 1997-1999*

### *3.3 Health care system*

No figure for current health care system expenditure could be obtained for Serbia and Montenegro.

### *3.4 Political economy*

The swift collapse of the Yugoslav Federation in 1991 was followed by war, the destabilization of republic boundaries, and the break-up of important inter-republic trade flows. Output in Serbia and Montenegro dropped by half in 1992-93. Like the other former Yugoslav republics, it had depended on its sister republics for large amounts of energy and manufacturing. The break-up of many of the trade links, the sharp drop in output as industrial plants lost suppliers and markets, and the destruction of physical assets in the fighting all have contributed to the economic difficulties of the republics. Hyperinflation ended with the establishment of a new currency unit in June 1993; prices were relatively stable from 1995 through 1997, but inflationary pressures resurged in 1998. Reliable statistics continue to be hard to come by, and the GDP estimate is extremely rough (GDP per capita was estimated at \$1,800 in 1999). The economic boom anticipated by the government after the suspension of UN sanctions in December 1995 failed to materialize. Damage to Serbia's infrastructure

and industry by the NATO bombing during the war in Kosovo added to the problems.<sup>14</sup>

---

<sup>14</sup> Eradicate Conflict by Building Cultural Awareness, <http://www.countryreports.org/serbia.htm> passim.

## **4 Ethics and ethnography**

### *4.1 Ethical issues*

No information currently available.

### *4.2 Ethnographic studies*

No information currently available.

## 5 References and further reading

### 5.1. References

- <sup>1</sup>: Eradicate Conflict by Building Cultural Awareness, <http://www.countryreports.org/serbia.htm>: passim.
- <sup>2</sup>: ECEPT questionnaire, January 2001.
- <sup>3</sup>: Questionnaire data (EAPC East).
- <sup>4</sup>: Questionnaire data (Observatory)
- <sup>5</sup>: Snezana Bosnjak 'Yugoslavia: education/training in supportive and palliative care' Unpublished paper, prepared for ECEPT, March 2001.
- <sup>6</sup>: Sallaku A, Prifti F, Huta K, Leka P, Rama R and Bicaj X. Aspects of palliative care in Albania and in Kosovo: the experience of Ryder Albania Association (RAA). Poster: *Seventh Congress of European Association of Palliative Care*, Palermo, Italy, 2001.
- <sup>7</sup>: Questionnaire data (EAPC East)
- <sup>8</sup>: Questionnaire data (EAPC East)
- <sup>9</sup>: International Narcotics Control Board (2000) *Narcotic Drugs: Estimated World Requirements for 2000. Statistics for 1998*. New York: United Nations.
- <sup>10</sup>: Snezana Bosnjak and Sinisa Radulovic 'Undergraduate and postgraduate education in cancer pain management and palliative/supportive care in Yugoslavia'. Unpublished report to ECEPT, 2000.
- <sup>11</sup>: Natasa Milicevic, personal communication, July 2001.
- <sup>12</sup>: Questionnaire data (EAPC East).
- <sup>13</sup>: Questionnaire data (EAPC East)
- <sup>14</sup>: Eradicate Conflict by Building Cultural Awareness, <http://www.countryreports.org/serbia.htm>: passim.