

HEALTH AND POVERTY REDUCTION IN THE SOUTH CAUCASUS

Draft Working Paper

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“Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction. The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood.”

World Health Organization, “Macroeconomics and Health: Investing in Health for Economic Development”, Report of the Commission on Macroeconomics and Health, Geneva, December 2001.

Introduction:

Much work has been done already by the international community to assist the countries of the former Soviet Union – the Commonwealth of Independent States (CIS) – in their transition to democracy and in improving the well-being of their populations. However, the transition process has varied among the countries, requiring more focused efforts. At the same time much research has been done on the determinants of health and the links to poverty. Through initiatives such as the South Caucasus Health Information Project, the Canadian government is also making a contribution to the three countries’ reform efforts in the health sector, thereby laying the foundation for a better health system, and enhancing their capacity to monitor progress on goals associated with poverty reduction.

This Working Paper begins with a Situation Analysis, providing an overview of the central issues relevant to poverty and health, specifically in Armenia, Azerbaijan, and Georgia. Canada’s Response is then described, relying on the experiences of the Canadian Society for International Health in implementing the South Caucasus Health Information Project; the Paper concludes with consideration of Future Directions.

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Situation Analysis

After decades of structural reform packages that emphasized fiscal restraint and monetary reforms, the international donor community is realizing that economic reform does not in itself assist the development of low-income countries. Official Development Assistance (ODA) has been under transformation since 1970's and 80's, focusing more on social policy reform in the 90's. Most recently at the beginning of this new millennium, poverty reduction strategies are being developed to encompass the many facets of socio-economic reform, specifically identifying the importance of a healthy workforce for a well-functioning society, free from debilitating epidemics and mass suffering.

This multi-faceted approach to reform is especially necessary for the former Soviet Republics, a new group of transition countries in need of assistance since 1991, when not only did the Soviet Union disintegrate, but its republics' economies and social safety nets collapsed as well. The past decade has not been an easy one for many of these former Soviet Republics, who have had varying degrees of success with political and economic reform based on Western advice. The initial steep economic decline, followed by slow economic recovery, has taken its toll, and many of these newly independent states are now experiencing previously unknown levels of poverty.

Since 1999, the World Bank has been championing Poverty Reduction Strategy Papers (PRSP), individual reform strategies to assist countries in their fight against growing poverty. However, in order to target poverty reduction strategies, good data and reliable information are essential to identify where the gaps and inequities are that need to be addressed. By now, most low- and middle-income countries have completed their interim PRSPs and are working on completing the final document. From this point, each country with a PRSP has a strategic framework within which to undertake social and economic reforms with the support of various shareholders.

Low-Income CIS 7 Countries:

Since the transition period began in 1991, the number of people living on less than \$1 USD a day has risen more than twenty-fold in the countries of Europe and Central Asia; among the CIS 7 countries alone, there are nearly twenty million people living in extreme poverty.

In February 2002 the World Bank (WB), the International Monetary Fund (IMF), the European Bank for Reconstruction and Development (EBRD) and the Asian Development Bank (ADB), banded together to promote a new initiative to help the seven poorest countries of the former Soviet Union,. The CIS-7 Initiative is aimed at strengthening the conditions for poverty reduction, growth, and debt sustainability among the seven poorest countries of the CIS: Armenia, Azerbaijan, Georgia, the Kyrgyz Republic, Moldova, Tajikistan and Uzbekistan.

With the idea of giving additional support to the PRSP effort, the CIS 7 initiative proposes to foster poverty reduction, growth and sustainability in certain countries in Central Asia, the South Caucasus, and Moldova by:

- Improving conditions for economic development and private investment;
- Greater support from the international community for concessional financial support, technical assistance and policy advice; and
- promoting policy and institutional reform more resolutely in order to strengthen the capacity of governments, build greater public accountability and tackle corruption.

Although the CIS-7 initiative focus is generally on macroeconomic stability, transparency of public finances and tax reforms, it also emphasizes the targeting of resources to priority social services and safety nets. One challenge is to “ensure the adequate provision of health and education services.”

Poverty and Health:

As observed by the World Health Organization, "economic growth may be conducive to better income, social tolerance and welfare, and finally health, but such a positive effect is not automatic. The prerequisites of health can even be adversely affected under economic growth if the appropriate social policies are not in place."¹

The approach to reducing poverty has evolved over the past 50 years in response to deepening understanding of the complexity of development. Twenty years ago, the World Bank Group had already begun to articulate the understanding that physical capital was not enough, and “argued that improvements in health and education were important not only in their own right, but also to promote growth in the incomes of poor people.”² More recently, the *World Development Report 2000/2001* proposed a three-pronged attack on poverty that includes: promoting economic opportunity, empowering the poor, and enhancing security/reducing vulnerability.

This approach is consistent with the earlier understanding of the importance of health and education as keystones of economic development: A healthy workforce is essential to take full advantage of emerging market opportunities. While improved accountability in the public sector and greater access to health care for all income groups would also empower the poor, effective national action is necessary to help low-income groups, who are the most vulnerable, cope with shocks and manage risks such as disease and natural disasters. For example, credible health insurance provides the security poor families need to continue working and building their assets.

Challenges in the South Caucasus:

Over the past decade, the challenge of transition in the South Caucasus (Armenia, Azerbaijan, and Georgia) has been particularly acute; regional conflicts and refugee crises, combined with economic collapse and serious strain on infrastructure, have resulted in minimal opportunities for a relatively highly educated population.

There has been a dramatic decline in standards of living and of health in Georgia, Armenia and Azerbaijan. For instance, in Armenia the original collapse in output was so large that the current output is still less than 70% of its pre-transition level. The current average household purchasing power is still about 9 times lower than its recorded level in 1990, leading to widespread poverty. As well, the economic growth that occurred during the last seven years was not accompanied by notable improvements in social conditions and poverty indicators, partly due to the skewed distribution of wealth, which has led Armenia to suffer the worst income inequality levels in ECA. Where only one-fifth of the population was considered to be below the poverty line in 1988, latest statistics show that 55% of the population are considered poor, with another 13.5% being above the poverty line only marginally and thus are at risk of becoming poor.³

One need only look at the key health indicators, to compare standards of living of prosperous European countries as well as Canada, with those in the South Caucasus. High maternal and infant mortality rates are common to all three countries of the South Caucasus; the infant mortality rate in the South Caucasus countries is almost three times higher than the European Union's. Tuberculosis, which is controlled in Europe as a whole at 40.4 cases per 100,000 people, has escalated to an estimated 109.5 cases per 100,000 in Georgia.⁴ Vaccine preventable diseases, emerging nutritional deficiencies and malnutrition have potentially serious implications for child development, all of which were better managed and controlled during the Soviet period. In Azerbaijan, nearly 22% of children aged 6 to 59 months suffer from chronic malnutrition. Diphtheria, cancer and cardiovascular disease are all on the rise. New or re-emergent health problems are also affecting the region, such as malaria and HIV/AIDS.

Health Reform in Armenia, Georgia and Azerbaijan:

“Economic and social policies that focus on poverty reduction and equity in income promote investments in primary education and health to ensure wider participation of the poor in economic development. Without public support, which is linked to reducing poverty, measures aimed at achieving macroeconomic stability and structural reforms would be difficult to justify or implement.”⁵

All three countries of the South Caucasus are making efforts to improve the health situation, and have taken various steps toward development and implementation of health policy reforms. Georgia has developed a policy framework along the lines of the WHO "Health for All" approach, emphasizing the principles of justice, accessibility and equity. One of the features of Georgia's new health strategy is a state health insurance scheme, which is planned to cover the whole population by the year 2010. Armenia has made strides in the re-training of medical professionals, emphasizing a new role in public health. Azerbaijan has collaborated with foreign agencies in addressing the serious emerging health problems of the refugee population, such as malaria, tuberculosis, and high maternal mortality.

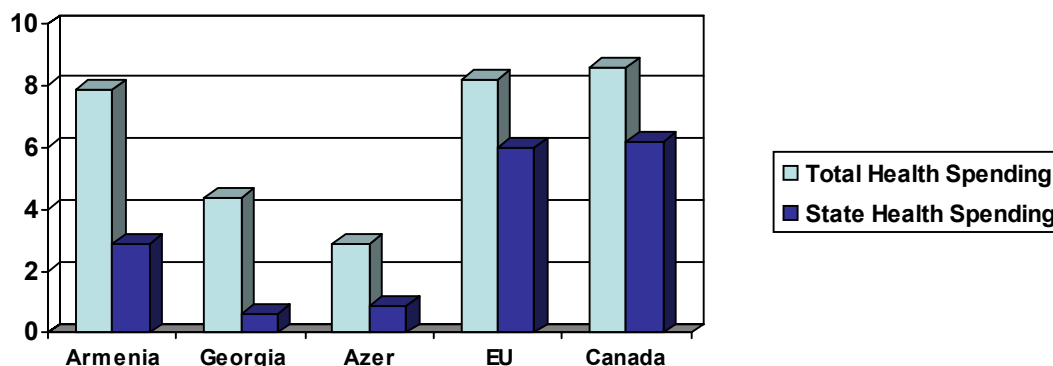
Unfortunately, the reality in the South Caucasus is that there is a severe lack of resources, state health care spending is the lowest in ECA, and informal payments account for more than 85% of all expenditures in the health sector. It is clear that access to health care is becoming increasingly dependent on whether a household can afford these “informal” payments, thus contributing to the sense of growing vulnerability of the poor. As an example, in Georgia in 1998, only 20% of seriously ill people were treated in a clinic and only 5% in a hospital, mainly due to lack of money. Chronic ailment of even one family member who needs medical treatment significantly increases the household risk of falling into poverty. “In Georgia, the average cost of one surgical treatment is seven times more than borderline households can afford”⁶

In Armenia, the percentage of informal payments in the health sector is the highest among CIS countries at 91%. Statistics show that since 1990, visits to health institutions declined by 2-3 times, due to unaffordability of such services for most of the population and the poor in particular. The need for informal payments is due to the lack of resources and the low salaries in the health sector. In fact, 17% of those employed in the public sector in Armenia are still considered very poor, with the average monthly salary at US\$26.⁷

As stated at the recent national conference on *Poverty and Health in Georgia*, “ill health and poverty are closely linked with the cause-and-effect running in both directions. That is, sick people are more likely to become poor, while those who are poor are more vulnerable to disease and disability. (We are) aware that better health of the nation contributes to economic growth. Thus spending more on health is a productive investment, rather than expenditure on consumption.”⁸

This being said, whereas the total amount of health spending as a percentage of GDP is informative, the difference between the total expenditure on health as a percentage of GDP and the percentage of public (state) spending on health in the South Caucasus is in many ways even more indicative of the governments’ investment in health.

Figure 1. Health Spending as Percentage of GDP, WHO 1997⁹



An Armenian health analyst who visited Canada on a study tour hosted by the Canadian Society for International Health pointed out the huge difference between total annual health spending per capita in Canada and Armenia: whereas Canada spends \$2,608 per inhabitant, Armenia spends just \$8!

However, according to the United Nations Development Program (UNDP), taking Georgia as an example, "insufficient financing is only half of the government's problems. The other half involves the management of these resources."¹⁰ The UNDP and other international agencies believe that, while it will take a long time to generate sufficient resources to fund the health care system adequately, there are some shorter-term measures that can be taken to improve efficiency.

Although Armenia, Azerbaijan, and Georgia are in the process of finalizing their PRSP's in an effort to encompass their reform strategies under one comprehensive framework, this does not mean that each country has a clear vision of how to reform their health sector. In fact, Georgia is the only one with a National Health Reform Policy, adopted in 2000. The goals of the Georgian programme are:

- Improved maternal and child health services;
- Reduction of mortality from cardiovascular diseases;
- Better prevention and treatment of cancer;
- Reduction in the incidence of injury;
- Reduction in the incidence of infectious disease; and
- Promotion of healthy lifestyles

The measurement of progress towards achievement of such goals requires the collection of data on incidence of diseases, and information on the effectiveness of interventions and quality of health services.

In Armenia, the Ministry of Health (MOH) is completing its "optimization plan" as of April 1st, 2002. This involves reducing the MOH operating budget, amalgamating hospitals and polyclinics into general hospitals, selling off a number of facilities, and

reducing its own staff all in an effort to make budgetary spending more efficient. Armenia's PRSP states that "Public health service will be more targeted, affordable to the poor, efficient and modern".¹¹

Health reform strategies are less certain in Azerbaijan, although goals include "optimizing free and fee-based medical services on a regional basis, with a view to providing free universal medical care to the poorest parts of the country" and "achieving the maximum level of vaccination against the major infectious diseases."¹²

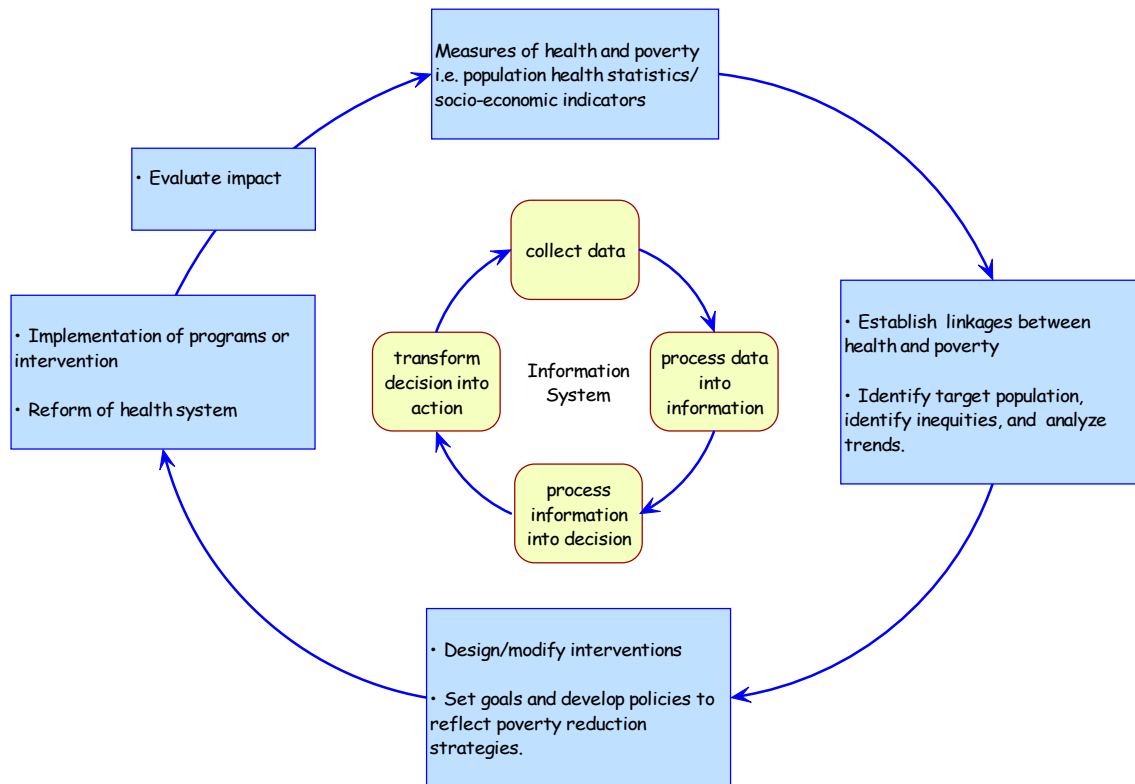
The Importance of HIS in the South Caucasus:

"... an effective assault on diseases of the poor will also require substantial investments in global public goods, including increased collection and analysis of epidemiological data, surveillance of infectious diseases, and research and development into diseases that are concentrated in poor countries."¹³

Reliable health information is essential for effective decision-making in the health system of any country. The current health information systems in the South Caucasus are largely inherited from the Soviet period. These were highly centralized, lacking in reliability and comparability within and amongst countries due to the use of different definitions and standards. With the breakup of the Soviet Union and consequent political and economic upheaval, information systems were disrupted, leading to dangerous gaps in knowledge about health trends.

In the past few years, all three countries have been working with various shareholders in an effort to develop effective health information systems (HIS). Their goal is to base their systems on data that is valid, reliable, and comparable, and to integrate clinical, administrative, and financial health information so that it becomes an effective support for choosing priorities, optimizing investments, avoiding duplication, and improving the quality of care.

Figure 2. The Role of Information Systems in Health System Reform and Poverty Reduction



As described above, effective action requires the support of an information system that provides the means for the collection, storage, and communication of data; the processing of data and statistics into information; and, the presentation of information as a basis for decision-making. This cycle of activities within the health sector is of particular importance, especially within the context of PRSP's. An accurate assessment of needs (i.e., recognizing the poor, identifying inequities) is required for appropriate targeting and design of interventions, and given the scarcity of resources, the impact of these interventions (whether they are local programs or national reform initiatives) must be monitored and evaluated in terms of changes in health outcomes and other socio-economic indicators.

Armenia, Georgia and Azerbaijan, realizing that they will not have all the available resources for health sector reform that they will need, understand the importance of integrating reliable health information systems into their health reform plans. For instance the Georgian National Health Policy aims to improve its HIS to “provide correct strategy, tactics and operative decisions”, acknowledging the fact that “not all health spending yields high long-term rates of return and health gains depend on using available resources in productive and efficient way”.¹⁴

Azerbaijan has included close cooperative measures with non-governmental and international organizations, such as the World Bank, in their plan to monitor its poverty reduction strategies. “The improvement of the health care monitoring system, performance of multiple-indicator group surveys in cooperation with UNICEF for improvement of data on public health and increasing the effectiveness of measures aimed at its improvement.”¹⁵

In short, reliable district-sensitive health information will provide measurable indicators of the link to, and impact of poverty; the more locally sensitive the indicators, the more specific the targeting on poverty will be.

Currently there is a significant difference between official health statistics and the reality of the situation. While the Ministries of Health state that the immunization of children is a priority, which is reflected in the official data, anecdotal and survey data show that there are significant gaps in national immunization campaigns. Discrepancies in data are commonplace, making it impossible to accurately monitor progress and evaluate the success of the various interventions. This situation is not unique to the health sector, however, given that health indicators are significant within the context of PRSP's, it is critical that the health information systems are improved.

Figure 3. Immunization Coverage of Children in Georgia

Immunization Coverage	Official Data (%)	Data collected by UNICEF (%)
Full Immunization (0-2 years)		43
Immunization against poliomyelitis	91-92	64
Immunization against diphtheria	82	74
Immunization against measles	87	55
Source: Situation analysis, Women and Children in Georgia, 1999, UNICEF		

Canada's Response

The Key recommendation of the WHO Commission on Macroeconomics and Health, was to “scale up the access of the world’s poor to essential health services, including a focus on specific interventions. The low- and middle-income countries would commit additional domestic financial resources, political leadership, transparency, and systems for community involvement and accountability, to ensure that adequately financed health systems can operate effectively and are dedicated to key health problems... (High-income countries) would resolve that lack of donor funds should NOT be a factor that limits the capacity to provide health services to the world’s poorest peoples.”

As Canada contemplates growing involvement in this part of the World, we should be mindful of this warning. If we simply promote trade and industrial development without also promoting effective social policies aimed at fighting poverty, we run the risk of doing more harm than good. As the region begins to re-establish economic activity in industry, mining, and agriculture, it is important to ensure that human development is deliberately promoted and sustained through capacity building, policy development, public participation, and concern for a more equitable distribution of resources for health.

Risks to human health must be adequately identified and mitigated in the process of development, otherwise negative trends will simply continue. By the same token,

promotion of health and wellbeing can contribute to economic development through improvements in productivity and reduced health care costs. Canada's approach to health (population health) considers both the medical and non-medical determinants of health. This approach, coupled with new initiatives in health information that strive to integrate these determinants into the information systems, strengthen the ability to monitor the impact of various public policies on the health and well-being of individuals and communities. This should be an essential approach to monitoring the progress of sustainable health and development, and could serve as useful resources for countries taking on reform across various sectors.

According to the Canadian Institute for Health Information (CIHI), which has been involved in the *South Caucasus Health Information Project*, "we can't come up with long term solutions until we have a better understanding of what the problems are."

Canada should take the opportunity to assist these countries in transition now when they are determined to move forward with their poverty reduction plans. In the area of social development, Canadian experts can contribute significantly. Within the health sector alone, Canada can contribute in the area of good governance (the role of civil society in Canada is significant in shaping public policy), public administration (particularly with experience of decentralization of the delivery of health services), and capacity-building overall. Canada's health system, founded on the goal of equity through the principles of universality and accessibility, demonstrates the possibilities of an equitable approach to social policy.

The First Ministers of Canada have committed their governments to strengthening "a Canada-wide health infostructure to improve quality, access and timeliness of health care for Canadians".¹⁶

South Caucasus Health Information Project:

The Canadian Society for International Health has been active in the South Caucasus in the field of health information systems since 1999 with two phases of the *South Caucasus Health Information Project* (SCHIP), funded by the Canadian International Development Agency. In that time, the three countries have been working closely with a number of international organizations, such as UNFPA, UNICEF, UNDP, USAID and the World Bank in their reform efforts. However, the *South Caucasus Health Information Project* is the only program in the region focusing on capacity-building in health information systems, where HIS is seen by a group of international donors and shareholders as the means to facilitate the most effective allocation of limited resources, and monitor health trends, both in terms of health outcomes and health systems restructuring.

While the South Caucasus countries are pursuing efforts to decentralize their health systems, it is apparent that there is a lack of management culture in policy planning process:

“In the Newly Independent States (NIS), health care systems and their corresponding statistical reporting were highly centralized, practically without any feedback of data to the local level. This situation has also led to a lack of practice and skills among health managers to make full and proper use of available information to support policy-making and health service management at all levels of the health service.”¹⁷

Thus, CSIH aims to strengthen health reform in Georgia, Armenia and Azerbaijan, through the appropriate application of health information technology and information management strategies, by enhancing institutional and individual capacity in health information management and supporting greater access and application of health information to improve health and well-being. While the development and installation of HIS within SCHIP is limited to demonstration projects in each country, improved understanding and use of HIS will result in improved data quality and a greater amount of

reliable information for health care providers, decision-makers and consumers, and potential demand to scale up such an approach.

As a result of the South Caucasus Health Information Project, there will be:

- Institutional capacity for training in health information systems and health informatics for decision-makers and health professionals;
- A cadre of local expertise within the health sector, for the development and management of information systems;
- A functional health information system demonstration project reflective of each country's health priority (e.g., maternal child health, primary health care reform); and
- Opportunities for learning first-hand about others' experiences with health reform, specifically with respect to HIS, through regional events and study tours to Canada.

Through training and development of local information systems, the project contributes to the South Caucasus countries' ability to build and use the tools necessary to identify needs and monitor progress in health sector reform within the context of poverty reduction.

Future Directions:

The Canadian Society for International Health proposes the following be considered as a means of supporting Armenia, Azerbaijan, and Georgia, along with the other CIS-7 low-income countries:

- **Greater technical assistance supported by increased ODA;**
- **Integration of comprehensive HIS into PRSPs**
- **Building on existing Canadian expertise and current initiatives;**
- **Focus on institutional strengthening and good governance;**
- **Adoption of a long-term vision focused on social development; and,**
- **Promotion of greater awareness of the impact of shareholders' interventions.**

As stated in the joint World Bank/IMF paper addressing poverty reduction in the CIS 7 countries, the **international community can and should do more to help the countries' various agendas for adjustment and structural reform through technical assistance, grants and other financial support.**¹⁸ Currently, the Canadian International Development Agency has a budget of \$4 million for the eight countries of the South Caucasus and Central Asia. This amount is of limited significance unless it is focused appropriately in a way that would support specific initiatives within the framework of the PRSPs. **Increased Canadian ODA and technical assistance in the region**, with a more targeted and sharpened focus on marginalized groups and their specific needs to reduce the increasing inequities, is critical to supporting the countries in their struggle against poverty.

“The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood.” **Reliable health information provides the evidence of these linkages and the underlying, resulting inequities, and as such should be a key component of any strategy aimed at reducing poverty.**

We should recognize where Canadian expertise lies, and consider what Canada can offer that others can't. For example, Canada's health system, founded on the goals of equity and principles of public accountability, universality and accessibility, can produce excellent examples and lessons learned for the CIS-7 countries in their own social-sector reform agendas. Donors should support Canadian initiatives that can maximize impact **by building on partnerships with Canadians to exchange ideas and share expertise to gain from ongoing initiatives in order to ensure sustainable human development.**

The scope of Canadian investment in the CIS-7 countries has been limited to date in comparison to other members of the international community. Given the existing financial constraints Canada should recognize that the areas where much can be accomplished with fewer resources are those that invest in human capital, rather than simply infrastructure, and that assist with the development of approaches and tools for use by the countries in their social reform efforts. Therefore, Canadian efforts

should continue to support the human capital that will enhance **institutional strengthening and good governance by advocating public accountability by enriching the management capacity and decision-making skills of leaders, and rely on initiatives that provide the foundation for major change.**

The CIDA-funded South Caucasus Health Information Project supports such a focus on institutional strengthening as basis for effective allocation of scarce resources. Such attention to targeting inequities will allow for an improved understanding of the roots of poverty and effective strategies to reduce its impact.

Canada must recognize that a long-term, holistic vision and strategic investment is necessary to effect change. This vision must be locally-owned, in other words the reform initiatives must be developed by the country itself as expressed in various policies and strategies, and must be supported by the international community for the long-term. Through consultations and discussions such as Strengthening Aid Effectiveness, and the Consultations on the Caucasus and Central Asia, hosted by CIDA/DFAIT in Calgary in September 2001, CIDA has already begun to develop this vision, and to recognize that **investment in development requires a sustained commitment by the donor community and broader understanding of the various factors, such as health, that impact the social development of the region.**

In order to find creative solutions to the increasingly severe inequities caused by poverty, the four international financial institutions, who hosted the CIS 7 initiative meeting, pledged to hold a conference later in 2002 involving nongovernmental organizations and other analysts, in order to share ideas about solutions to the region's problems from the broadest possible constituency. CSIH supports these types of initiatives, which **bring together the many donors and experts.** Such an initiative should promote greater awareness and coordination of key Canadian partners from government, the private sector and NGOs, that can and should provide strong, high caliber technical assistance. Together, such cooperation can successfully contribute to the goal of fighting poverty, and promoting sustainable health and development in the world.

End Notes:

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Health Statistics for Armenia, Azerbaijan, Georgia, Europe and Canada (2000)

Indicator	Armenia	Azerbaijan	Georgia	European Region	Canada
Life Expectancy at Birth	74.5 years	71.5 years	74.0 years	73.6 years	78.9 years
Infant Mortality Rate	14.3 per 1,000 lb.	16.2 per 1,000 lb.	15.1 per 1,000 lb.	11.1 per 1,000 lb.	5.3 per 1,000 lb.
Maternal Mortality Rate	25.4 per 100,000 lb.	30.0 per 100,000 lb.	51.3 per 100,000 lb.	19.0 per 100,000 lb.	3.8 per 100,000 lb.
Total Health Expenditure as % of GDP	7.9% (state spending 1.6%)	2.9% (state spending 0.9%)	4.4% (state spending 0.6%)	8.2% (state spending 6%) for EU	8.6% (state spending 6.2%) (1997)
GDP	USD\$1.9 bn	USD\$4.9 bn	USD\$3 bn	N/A	CAD\$138.8 bn

Note: Due to the general unreliability of data from the South Caucasus and the inconsistencies of statistics from sources within the same country, these statistics have been collected from various sources.