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UNICEF Regional Office for Central and Eastern Europe
and the Commonwealth of Independent States

TransMonee 2005

DATA, INDICATORS AND FEATURES ON THE SITUATION OF CHILDREN IN CEE/CIS AND BALTIC STATES

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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COVER PHOTO

GEORGIA: Nugzar, 13, sits next to his mother, Eteri, and sister Maka, 12, at their home in the western city of Kutaisi. Poverty forced Eteri, who is widowed, to leave her children at the Musical Boarding School in the city, but they were able to return to her care thanks to a UNICEF-supported fostering project which is aimed at helping reunite children with their biological families and which has prevented more than 400 Georgian children from becoming permanently institutionalized.

The MONEE project was initiated in 1992 to monitor, analyze and disseminate information on social and economic trends affecting children in Central and Eastern Europe, the Commonwealth of Independent States and the Baltics as these countries entered into a new era of political, economic and social change. Correspondents in 27 National Statistical Offices contribute data, and in recent years also a Country Analytical Report on aspects of economic and social trends affecting children in their country. Their contributions form the backbone of the research carried out at the Innocenti Research Centre (IRC) on the region, including for the Innocenti Social Monitor which has been published regularly since 2002, and the annually updated TransMONEE database which contains a wide range of statistical information covering the period 1989 to the present on social and economic issues relevant to the welfare of children, young people and women.

The purpose of this report is to present key data, child indicators and selected findings from the information collected in the 2005 edition of the TransMONEE database.

The companion CD contains the TransMONEE database in Excel format along with copies of recent MONEE research and Country Analytical Reports and, for the first time, also a CD of the data in the DevInfo format (MoneeInfo). The database includes 80 indicators dealing with MDG+ and Human Development in 27 countries of Central and Eastern Europe and the Commonwealth of Independent States. The data on the DevInfo CD has been prepared by the UNICEF Regional Office for CEE/CIS based on the TransMONEE database produced by UNICEF IRC.

DevInfo is a general purpose database system designed for the collation, dissemination and presentation of human development indicators, specifically to support governments in MDG monitoring. DevInfo is a cost-effective solution for addressing the MDG monitoring requirements at national level. The system is available at no cost to all Member States, UN agencies and other development practitioners. The technology is distributed royalty-free. The product branding and packaging have been designed for broad ownership. With the support of UN country teams DevInfo is currently being implemented in more than 80 countries to support national statistical offices in monitoring the MDGs and disseminate national statistics on key human development indicators to a wide audience.

The MONEE project is financed by core funding from the Italian Government to UNICEF IRC, by contributions from UNICEF in the CEE/CIS/Baltics region and on DevInfo please see the website: www.unicef.org/ceecis. For more information on MONEE at UNICEF Innocenti Research Centre, please see the website: www.unicef.org/irc

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TRANSMONEE 2005: DATA, INDICATORS AND FEATURES ON THE SITUATION OF CHILDREN IN CEE/CIS AND THE BALTIC STATES

The economic growth in the region since the late 1990s has not always been fully reflected in public spending on health

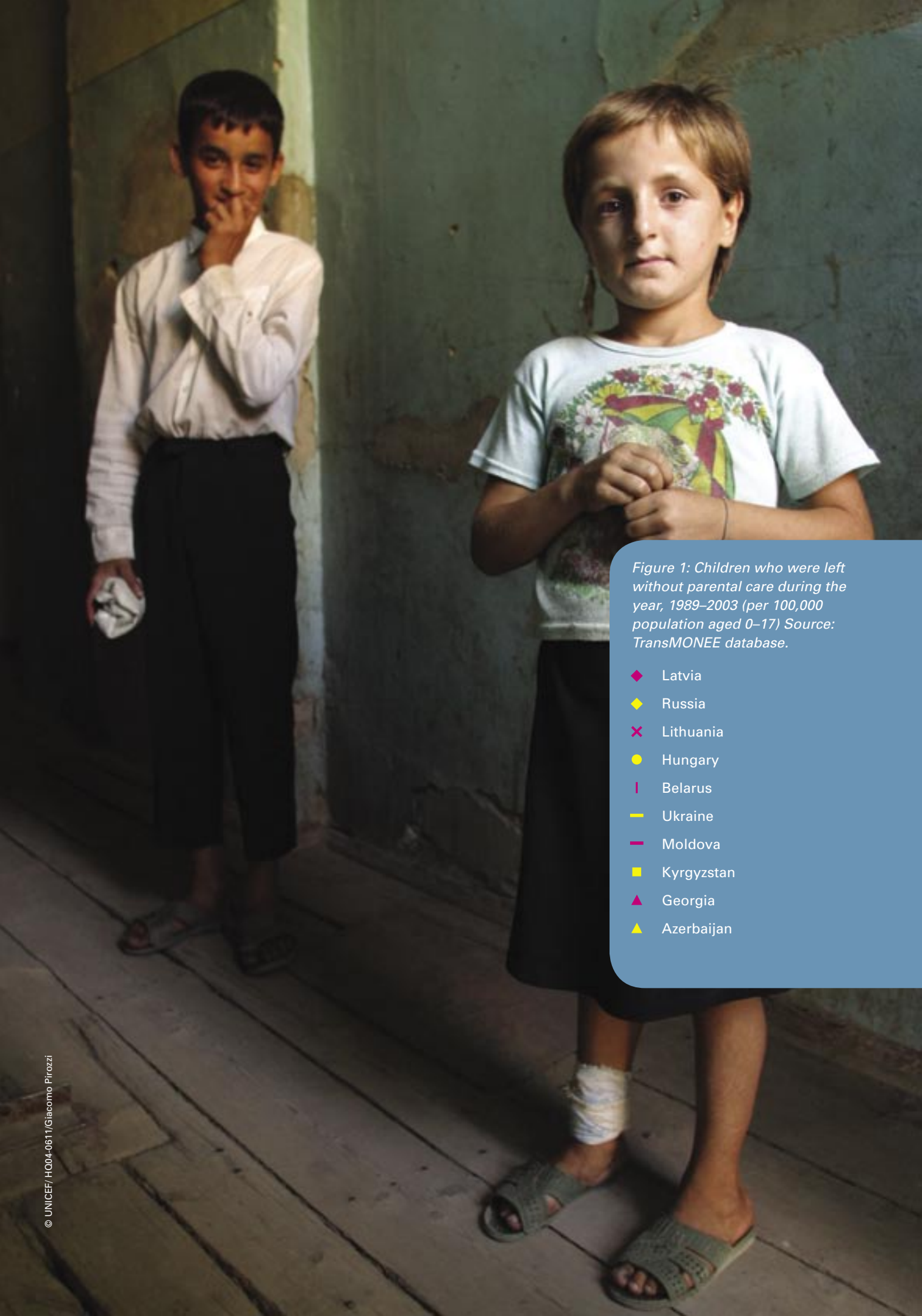
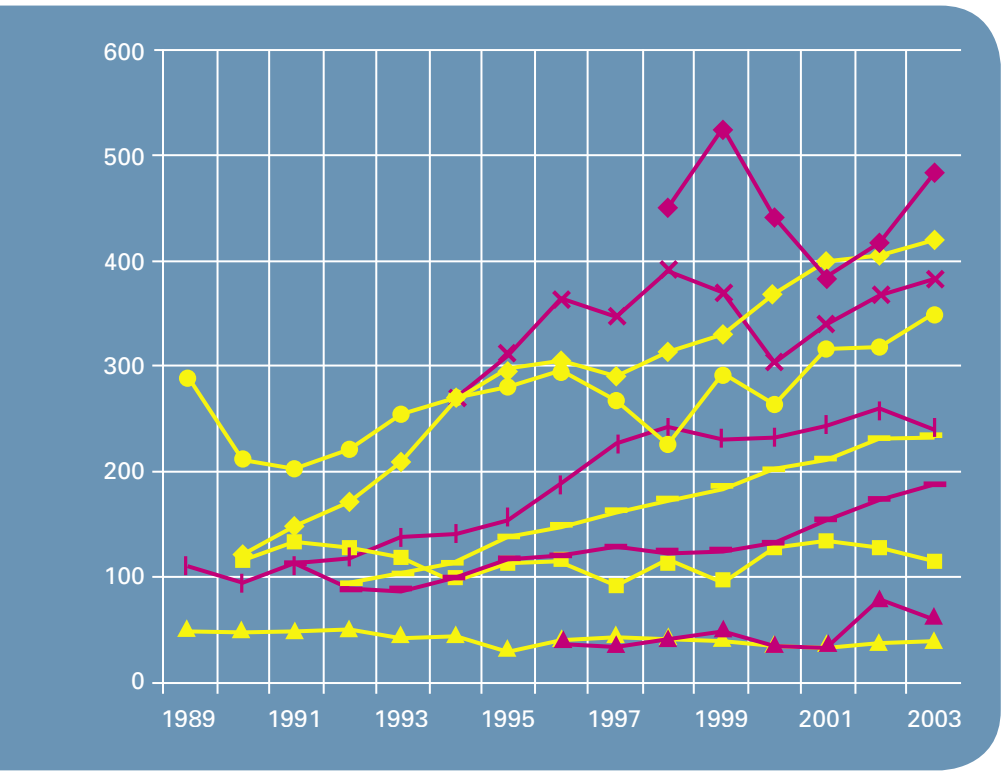


Figure 1: Children who were left without parental care during the year, 1989–2003 (per 100,000 population aged 0–17) Source: TransMONEE database.

- Latvia
- Russia
- Lithuania
- Hungary
- Belarus
- Ukraine
- Moldova
- Kyrgyzstan
- Georgia
- Azerbaijan

CHILDREN DEPRIVED OF A FAMILY UPBRINGING

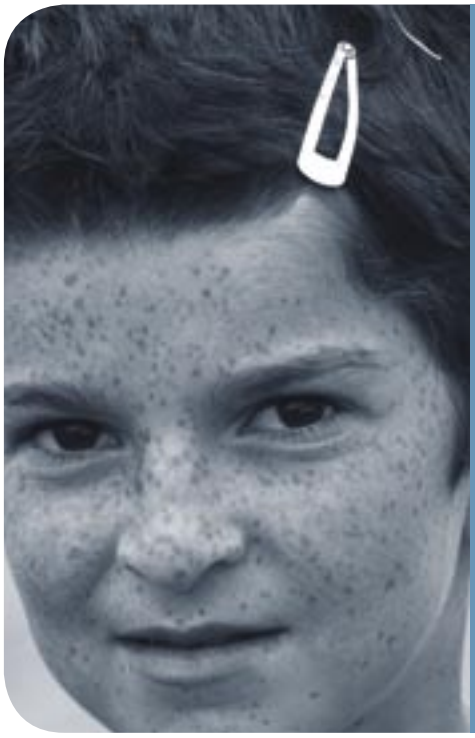
A small proportion of children in public care are orphans, but the overwhelming majority are ‘social orphans’, that is, children whose parent or parents are alive, but unable or unwilling to care for them.



It is a disturbing fact that, a decade after the start of the transition process in Central and Eastern Europe (CEE) and the Western Commonwealth of Independent States (CIS), even higher numbers of children are living apart from their families than before transition. Currently, as many as 1.5 million children in the region are living in out-of-home care, in one of the several thousand child institutions spread across the 27 countries or in guardian or foster care (families). In 2003, 1–2 per cent of the total child population in CEE and the Western CIS countries (as well as in Romania and Bulgaria), was living in public care, in contrast to about 0.5 per cent of the child population in other South Eastern Europe countries, the Caucasus and Central Asia.

Solutions for children without families: out-of-home care and intercountry adoption?

A small proportion of children in public care are orphans, but the overwhelming majority are ‘social orphans’, that is, children whose parent or parents are alive, but unable or unwilling to care for them. Main reasons for placing children in ‘public care’ are family poverty and dysfunctionality, the lack of preventive,



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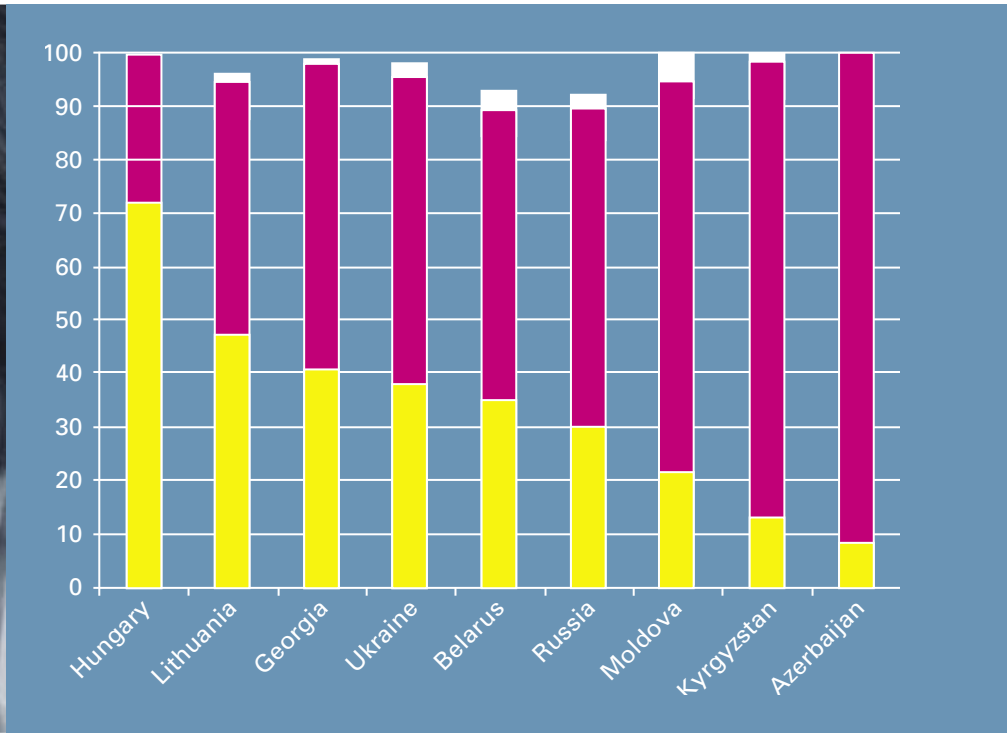

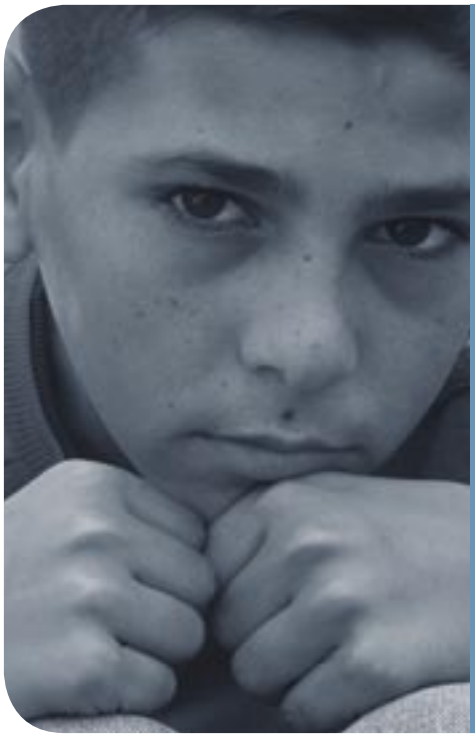

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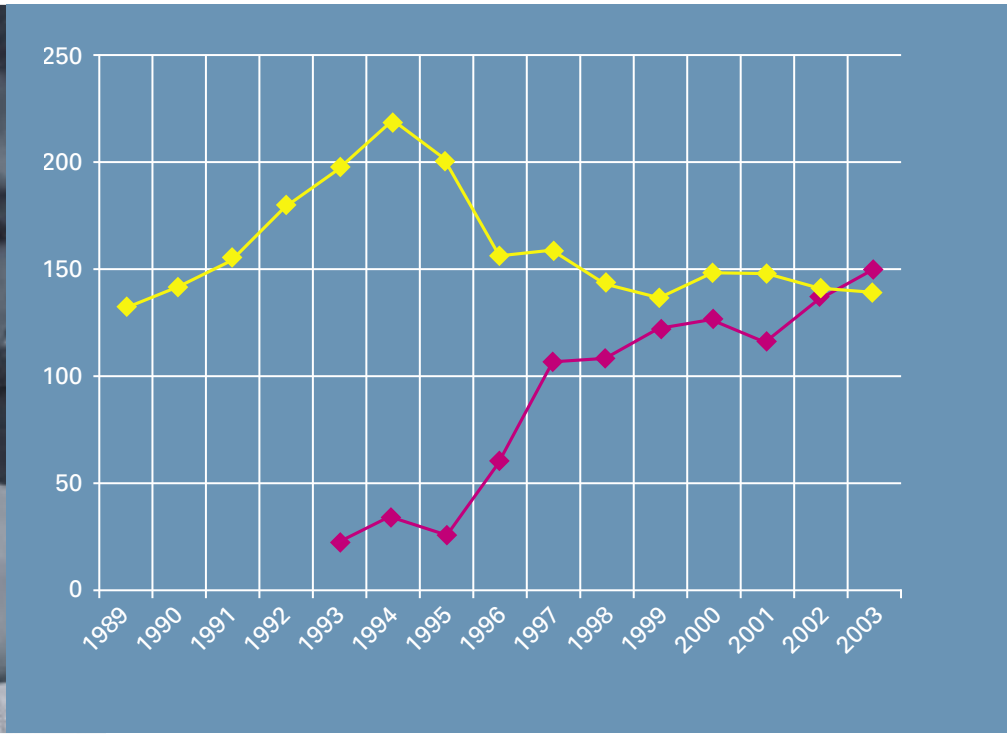


Figure 2: Placement of children who were left without parental care in 2003 (per cent) Source: TransMONEE database.

Entered public institutional care

Entered guardian care or were adopted

Entered educative institutions

Figure 3: Adoption trends in Russia, 1989–2003 (per 100,000 population aged 0–3) Source: TransMONEE database.

Domestic

Intercountry

inclusive measures and services for families and children at risk (including for children with disabilities), and the shortcomings of social welfare/public care responses.

In 2003 over twice as many children aged 0–17 were registered as left without parental care in Moldova, Ukraine and Russia than 10 years earlier. The numbers of children entering public care began to increase in the early 1990s, and are still climbing in some countries. Inter-country differences are widening across the region, as the numbers of children left without parental care have remained low and stable in the Caucasus and Central Asia in comparison with the Baltic States and CIS countries (Figure 1).

The patterns of 'out of home care' in selected countries – placement in institutions, foster care, guardianship or adoption – varies according to the region in which the child lives (Figure 2).

In the last decade this region has witnessed a shift towards family-based care in the form of guardianship and foster care, but in some countries institutional care remains predominant. Data available for two Central Asian countries (Kyrgyzstan and Uzbekistan) indicate that children there are more likely to be placed in substitute families – through foster care, guardianship, or adoption.

The Western CIS, the Baltic States and some Central European countries continue to report very high rates of institutional care. Data show that the overall rates of children in public care increased over the last decade most in the Baltic States.

Children who, for whatever reason, cannot be returned to their parents may be put up for adoption. This is often considered the best option, particularly for very young children, because it provides them with permanent care in a new family, where possible in the child's country of birth.

Of the 27 countries reporting to MONEE relevant data was unobtainable for Bosnia-Herzegovina, Kazakhstan, Tajikistan and Turkmenistan. In the remaining 23 countries, representing near 90 per cent of the region's child population, about 40,000 new adoptions were registered in 2003; that is, about the same number as 10 years earlier. In some countries this includes step-adoptions (adoption by a parent's new spouse) as the available data do not distinguish between the forms of adoption. Russia alone reported about 15,000 adoptions (excluding step-adoptions), followed by Ukraine and Uzbekistan with more than 6,000 adoptions each.

However, adoption does not necessarily take place in a child's country of birth. Available data shows that around 30 per cent of adopted children leave their land of birth on adoption. In Belarus, Russia, Ukraine and Bulgaria, the number of intercountry adoptions as a proportion of total adoptions increased markedly in the second half of the 1990s. In 2003 the highest share of intercountry adoptions took place in Belarus and Russia (around 50 per cent) followed by Bulgaria and Ukraine (about 35 per cent). In these countries the number of domestic adoptions remained relatively stable or even declined (in Belarus and Russia). Figure 3 reports domestic and intercountry adoptions as a proportion of the population aged 0–3 in Russia. The total adoption rate increased during the 1990s. While the rate of intercountry adoption climbed in the mid-1990s, the rate of domestic adoption fell. Intercountry adoptions have thus played a major role in increasing the total number of adoptions, to some extent replacing domestic. The reasons underlying these trends merits further exploration.

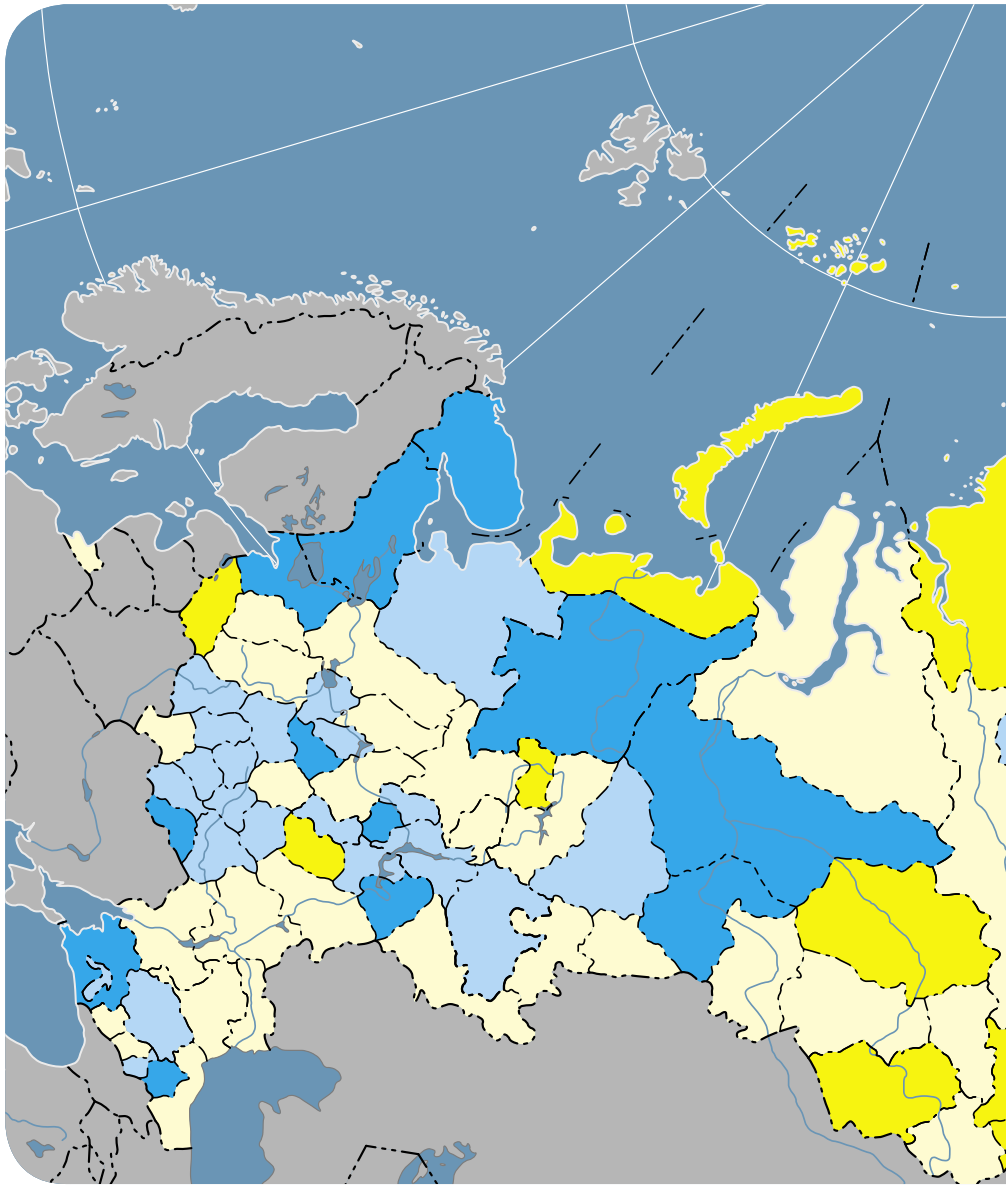
SUB-NATIONAL DISPARITIES IN INFANT AND MATE

The disparities at the sub-national level show that the probability of child and maternal survival may depend on where in the country a child is born

Data from a number of countries in the region suggest wide disparities within countries for infant mortality rates (IMR) and maternal mortality rates (MMR), as the key indicator for UN Millennium Development Goals 4 and 5.

Disparities in morbidity and mortality have increased in some Central and Eastern Europe (CEE) countries and the Commonwealth Independent States (CIS). Russia, where about 30 per cent of all children of the CEE/CIS region are born, has a nationwide trend of decreasing infant mortality rates. According to Country Analytical Report for Russia (2004) the IMR decreased from 19.9 in 1993 to 12.4 in 2003. However, at the sub-national level there are many regions where IMR is double the national average and some regions where the figure may be up to four times the minimum/maximum ratio (Figure 4). For example, in the autonomous okrug of Netets, the autonomous okrug of Chukotka, the Republic of Tuva and Republic of Ingushetya the IMR stands at 29, 28, 27.6 and 27.1 respectively. More significantly, the gap between the regions within the country is increasing. The ratio of maximum and minimum IMR in Russia since 1989 increased from 2.59 to 4.19 in 2003.

The ratio of highest to lowest IMR also increased in other countries in the region. In the period 1993–2003 it increased from 2.3 to 6.3 in the Czech



Republic, from 2.8 to 5.2 in Bulgaria in the period 1992–2003, from 4.8 in 1990 to 11.7 in 2003 in Azerbaijan; and from 1.4 in 1990 to 4.2 in 2002 in Estonia (Country Analytical Reports 2004).

As in many other countries, mortality rates in Romania for children under 5 years of age is higher in rural than urban areas: in 2003 U5MR was 17 in urban areas, but 24 in rural areas (Country Analytical Report, 2004). The Ministry of Health of the Republic of Tajikistan reported MMR in 2002 as 45 cases per 100,000 live births. However, in the mountainous Gorno-Badakhshan Autonomous Area the MMR was 116.3, which was more than double the national average, while in Dushanbe it was 58.9.

RNAL MORTALITY RATES

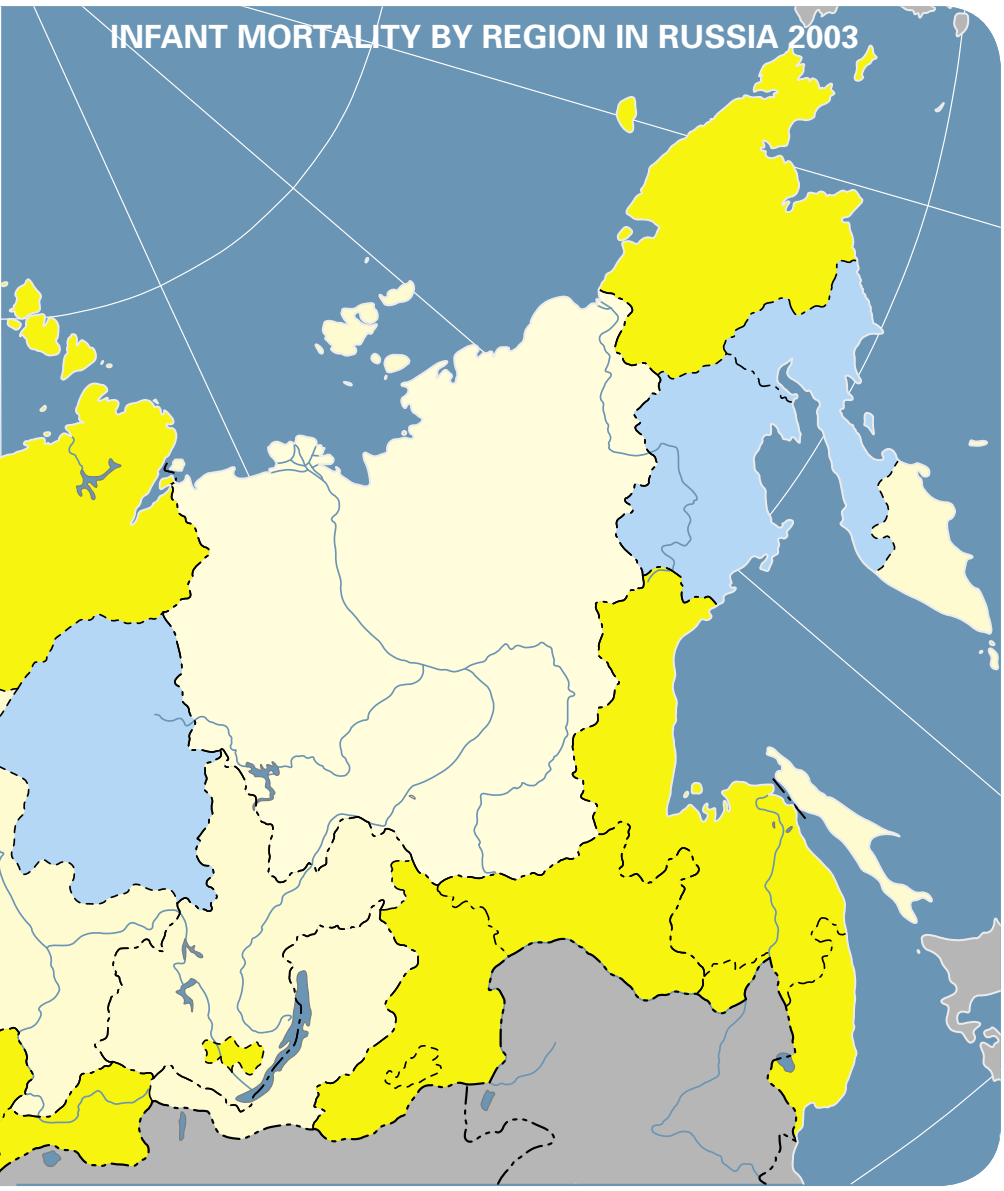


Figure 4: Infant mortality by region in Russia, 2003 Source: TransMONEE database.

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The training and experience of 'skilled health professionals', especially in rural areas, need to be updated and more resources need to be targeted at health care services in rural areas, including emergency obstetrics care.

The disparities at the sub-national level indicate that the probability of child and maternal survival depend on where in the country a child is born. Geographical and economic conditions of the regions within countries affect access to health care facilities and the distribution of skilled health personnel. For example, in the northern part of Albania over 66 per cent of villages do not have out-patient clinics, and many villages in Ukraine have no primary health care facilities (Country Analytical Reports, 2004).

With the exception of a few countries such as Albania, Serbia and Montenegro and Tajikistan, almost all countries in the CEE/CIS region report that over 98 per cent of births are attended by skilled health professionals in health institutions. Despite this, however, the training and experience of 'skilled health professionals', especially in rural areas, need to be updated and more resources need to be targeted at health care services, including emergency obstetrics care.

DEATHS FROM ACCIDENTS AND INJURIES AMONG 15–19 YEAR OLDS

Figure 5: Mortality among young people aged 15–19, average 1999–2003 (per 100,000 relevant population) Source: TransMONEE database.

Injuries

Natural causes

Notes: For Estonia the average is for1999–2002; for Serbia and Montenegro the average is for 1999–2001; for Tajikistan the average is for 1994–1997. Injuries: by ICD-10 external causes of mortality (road accidents, accidental drowning, poisoning, suicide, homicide and other external causes). For more information on mortality among young people (15–24 year olds) and its relationship to alcohol and other drug use, as well as comparison with EU countries, see 'Young People and Drugs: increasing health risks', in Innocenti Social Monitor 2004.

In most countries in the region road accidents are one of the major causes of death due to injuries among young people.

In Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS) on average about 30,000 young people aged 15–19 died every year in the period 1999–2003. The highest mortality levels in this age group are reported for Russia (135 per 100,000 population), followed by three Central Asian countries (Kazakhstan, Tajikistan, Turkmenistan) Ukraine, Belarus and the Baltic States (Figure 5). The risk of dying for teenagers in Hungary, FYR Macedonia, Slovakia and Armenia is only one-third of that in Russia.

In most countries of the CEE/CIS the major cause of death among teenagers is injury due to accidents, poisoning, suicide or violence. In the period 1999–2003, in 19 out of the 25 countries for which data are available, at least 50 per cent of all deaths among young people aged 15–19 were due to injuries. The recently observed share of mortality due to injuries varies from relatively low levels of around one third in Central Asia (Uzbekistan, Azerbaijan, Tajikistan) and the Caucasus (Georgia, Azerbaijan), to relatively high levels of three-quarters or over in the Baltic States, Belarus and Russia. In all parts of the CEE/CIS, death rates due to injuries among young people aged 15–19 have fallen since the mid-1990s.

There is a huge gender discrepancy in mortality from accidents and injuries (Figure 6). In most CEE/CIS countries boys have on average a risk of death which is at least 3 times higher than that for girls. The largest gaps are reported by Azerbaijan and Georgia (about 5 times higher), and the smallest occurs in Turkmenistan (almost double).

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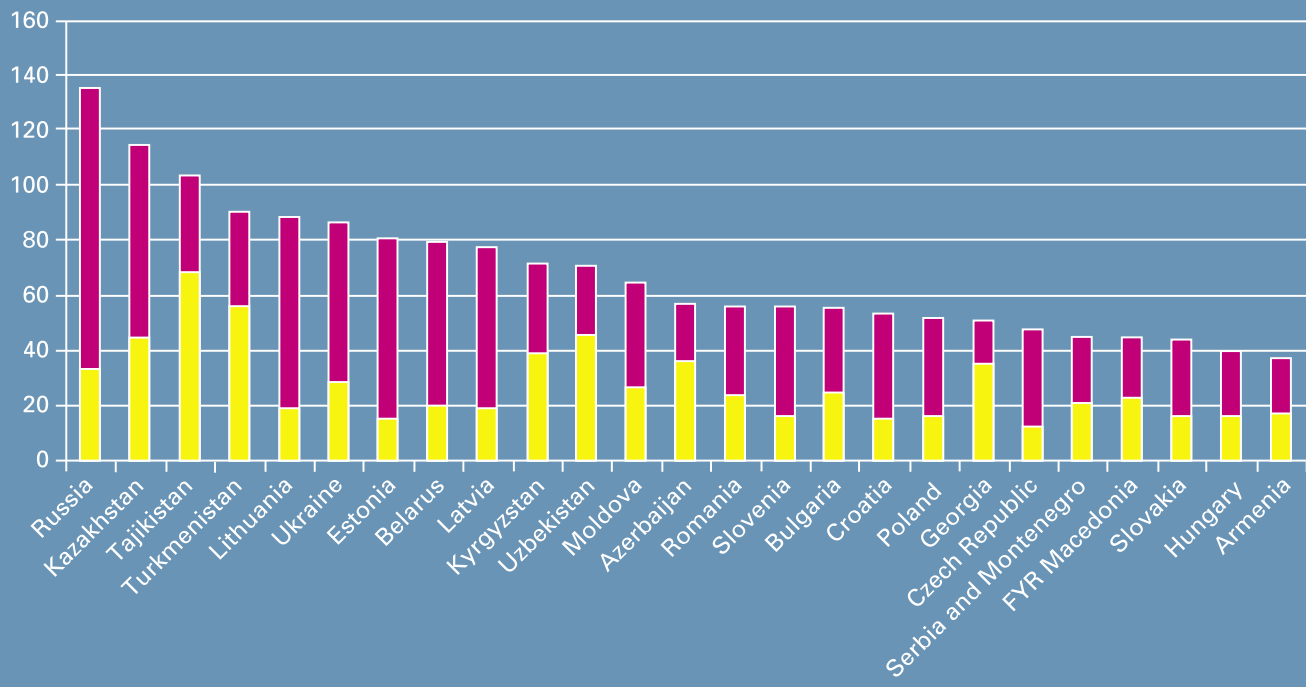
The second major cause of violent death due to injuries is suicide.

In most countries in the region road accidents are a major cause of death due to injuries among young people. For example, in 2003 road accidents accounted for over 50 per cent of all deaths for external causes among 15–19 year olds in Latvia and 40 per cent in Lithuania.



In Russia, Belarus and Lithuania suicide rates among boys increased by 70-80% over the period and are the highest in the region

The second major cause of violent death due to injuries is suicide. Boys have a 3–5 times higher probability of committing suicide than girls. Available data indicate that in 2003 suicides accounted for about 20–30 per cent of boys external deaths in most countries. In the region suicide annually accounts for the deaths of about 3,500 boys and 800 girls aged 15–19 (2,000 and 800 respectively in 1989), every sixth boy and one out of ten girls in this age group died as a result of suicide in 2003.

At the beginning of the transition period the highest suicide rates among boys aged 15–19 were recorded in Estonia, Russia, Kazakhstan (22–27 suicides per 100,000 population), followed by the other two Baltic States. In the early 1990s suicide rates among boys climbed in most countries in the region, but in some the rates subsequently fell and settled at the lower level or similar to pre-transition level. This trend was observed in 14 out of 23 countries in the region for which data are available. Other countries show an opposite trend – in Russia, Belarus and Lithuania suicide rates among boys increased by 70–80 per cent over the period and are the highest in the region (Figure 7), followed by Poland, Croatia, Ukraine, Kazakhstan and Kyrgyzstan with increases of 30–40 per cent.

This strikingly increasing trend in some countries among boys was not replicated for girls. In the 1990s the trend of suicides rose slightly for girls and young women. Nevertheless, in recent years the suicide rate for girls has been lower than, or at the same level as a decade ago in most countries.

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In most countries of the CEE/CIS the major cause of death among teenagers is injury due to accidents, poisoning, suicide or violence.

Figure 6: Ratio of mortality due to injuries between boys and girls aged 15–19, average 1999–2003 (level among girls = 100) Source: TransMONEE database.

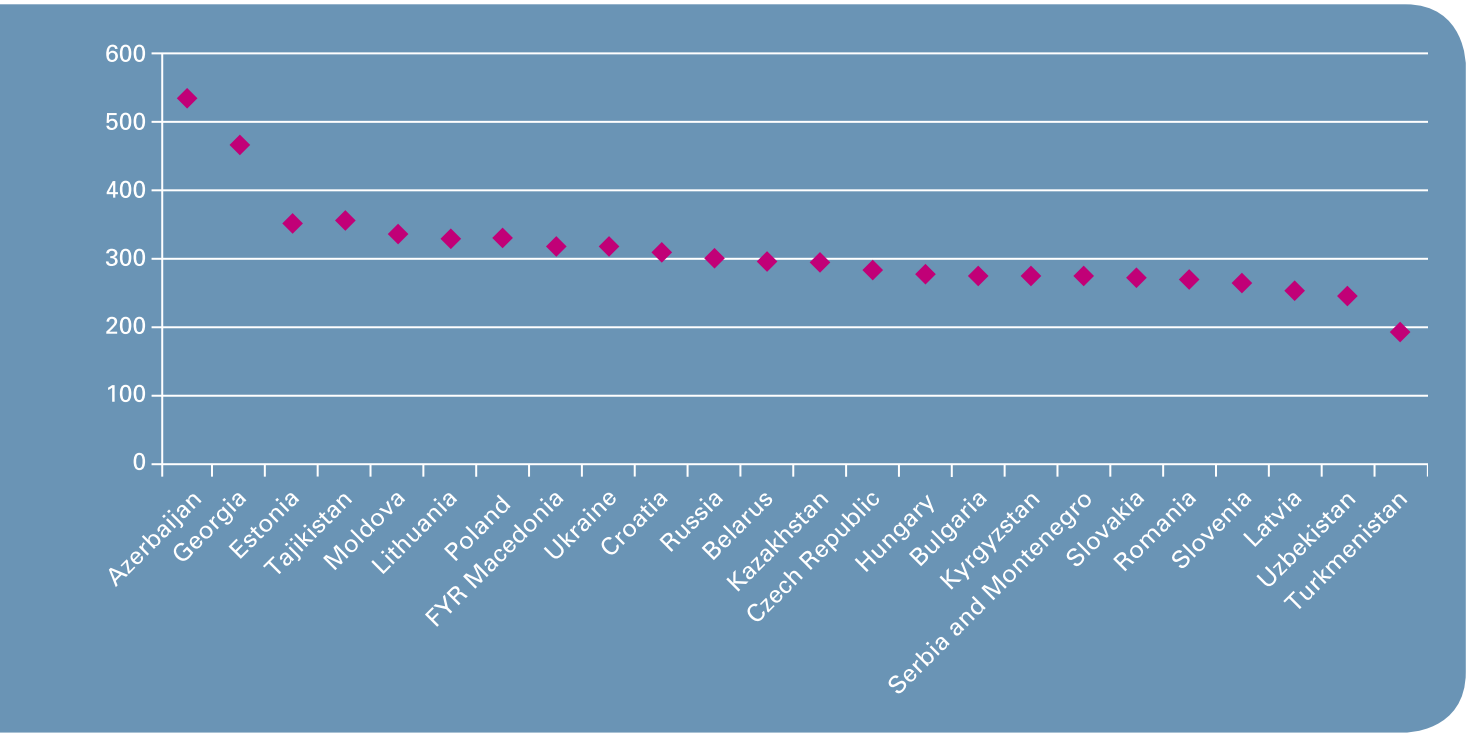
Notes: Excluding the ratio (12.5) for Armenia, caused by small numbers of deaths; average for Estonia is for 1999–2002; average for Serbia and Montenegro is for 1999–2001; average for Tajikistan is for 1994–1997.

Figure 7: Mortality due to suicides among young people aged 15–19, average 1999–2003 (per 100,000 relevant population) Source: TransMONEE database.

Boys

Girls

Notes: Average for Estonia is for 1999–2002; average for Serbia and Montenegro is for 1999–2001.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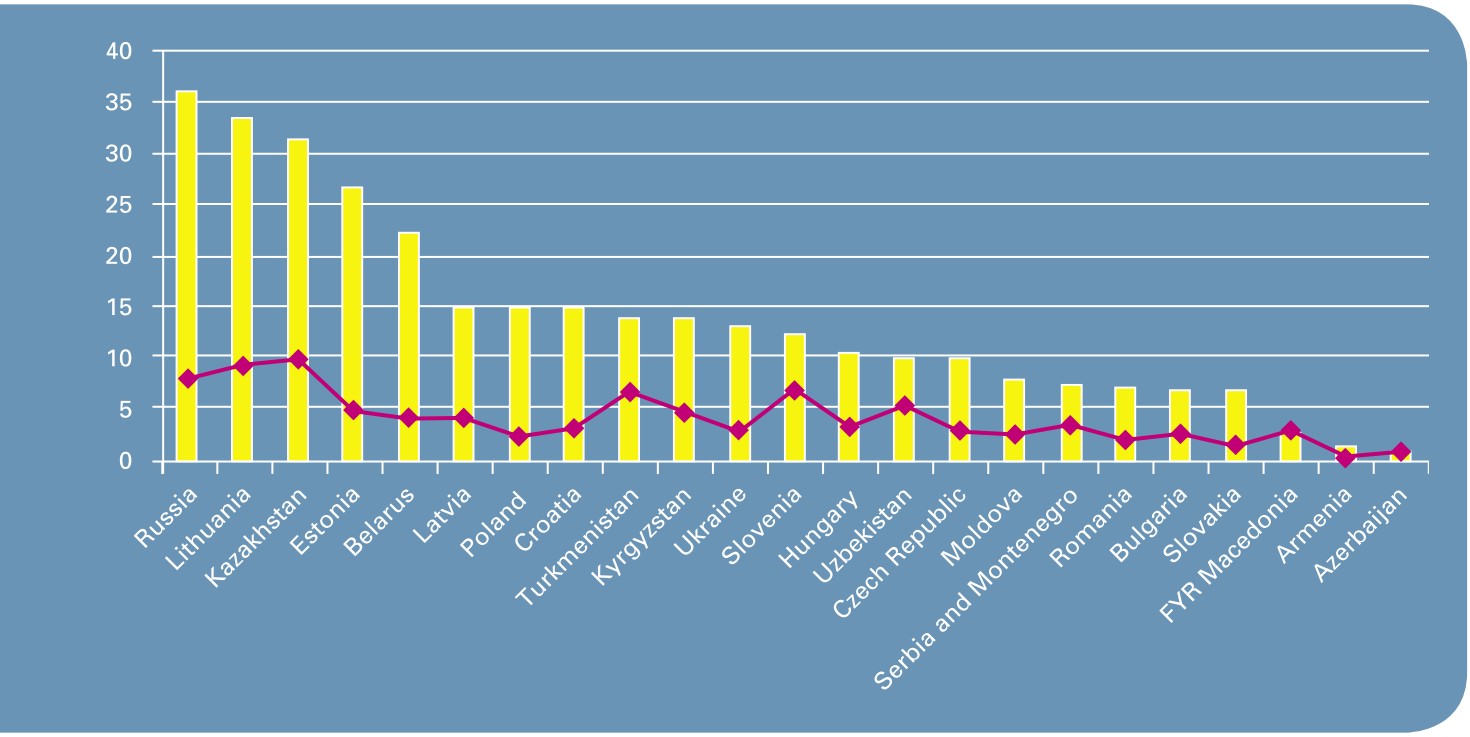
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Hungary
Uzbekistan
Czech Republic
Moldova
Serbia and Montenegro
Romania
Bulgaria
Slovakia
FYR Macedonia
Armenia
Azerbaijan

Figure 8: Incidence of syphilis for girls and boys aged 15–17 in CEE/CIS countries and the Baltic States, 1989–2003 (per 100,000 relevant population) Source: TransMONEE database.

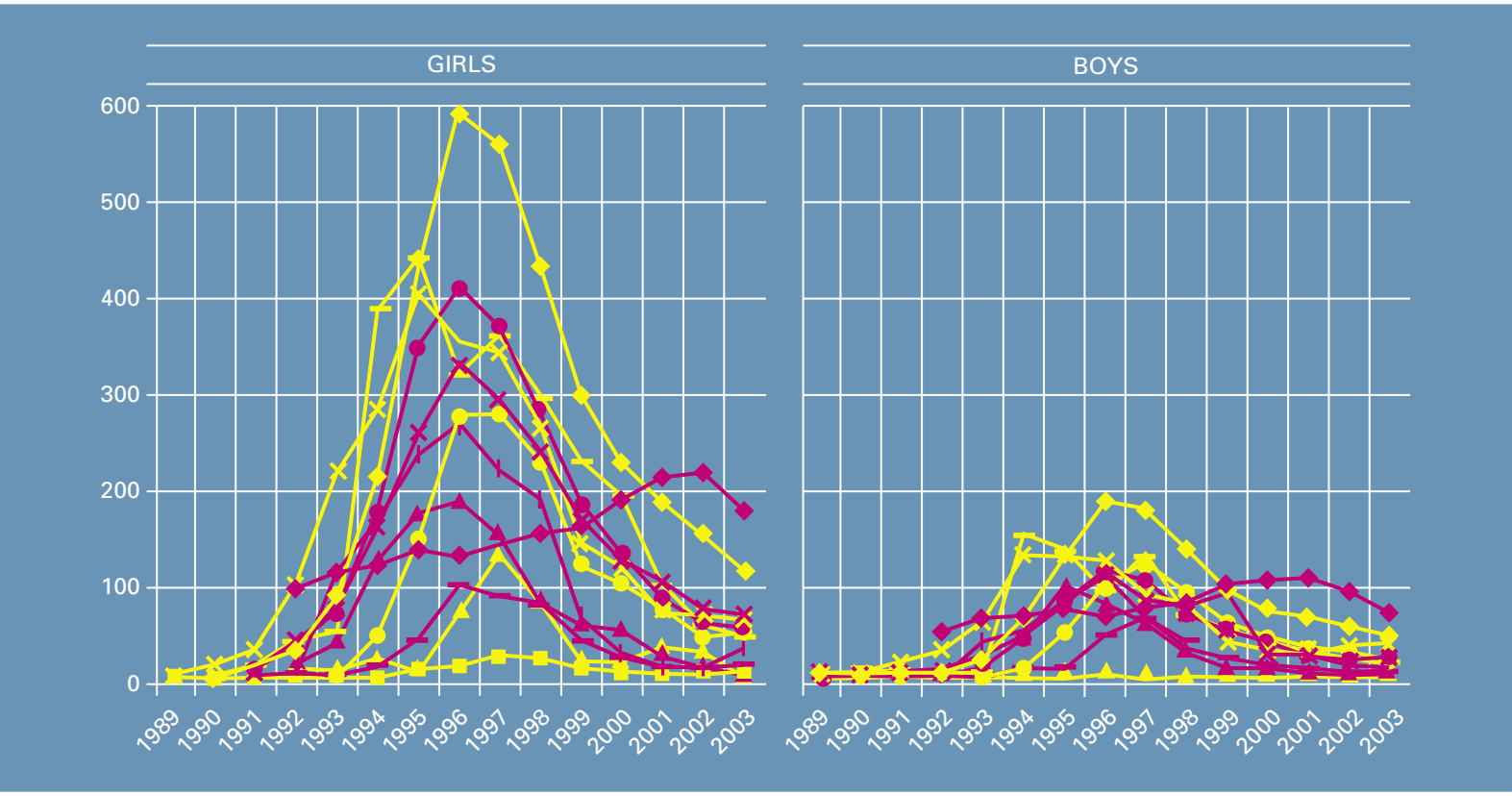
- *Romania*
- *Russia*
- *Ukraine*
- *Moldova*
- *Belarus*
- *Kazakhstan*
- *Latvia*
- *Estonia*
- *Kyrgyzstan*
- *Turkmenistan*
- *Lithuania*
- *Georgia*

INFECTIOUS DISEASES AMONG YOUNG PEOPLE: SYPHILIS AND TUBERCULOSIS AS SERIOUS HEALTH CONCERNS

Although many developing countries have undergone a transition in causes of mortality from infectious diseases towards circulatory system diseases, injuries and cancers, the major cause of morbidity in Central and Eastern Europe (CEE), the Commonwealth of Independent States (CIS) and the Baltic States remains infectious diseases. Recent trends in infectious diseases such as syphilis and tuberculosis (TB) among young people in the region aged 15–17, although declining, continue to be a major public health issues, especially as both diseases are closely related to HIV/AIDS.

Despite decreasing trends in most countries of the region, syphilis incidence are still high. The rates peaked in most countries in the region between 1995 and 1997 and then subsequently declined (UNICEF, 2003).

The trends are similar across the region. Increased rates of infection have been explained as related to political and social changes, poverty, the deterioration of services, poor quality private care and self-medication (Reidner et



al., 2000; Tichonova et al., 1997) all of which suggest a substantial delay compared to other adverse health impacts affecting the region in the wake of transition. When the rates of sexually transmitted infection (STI) increased sharply, governments in the region held international meetings, made changes in their legislation and introduced international guidelines on STI care. For example, STI care became anonymous and confidential in many countries. National guidelines on STI case management have been developed in 9 countries, STI treatment free of charge was continued in 12 countries including Kazakhstan, Moldova, Georgia, etc. (WHO, 2002).

Different explanations are proposed for the declining trend in STIs. Some researchers suggest that it is the result of increased awareness among the population through better public health programmes and treatment, while others suggest that the registered incidences do not reveal the real situation due to underreporting by the private sector and self-medication (Riedner et al., 2000; Ulrich Laukamm-Josten et al., 2002; Tichonova et al., 2003; WHO, 2001).

There has been an alarming increase of syphilis among girls aged 15–17

The trend in incidence of syphilis among young people mirrored that for adults in the period 1989–2003, showing considerable variation over time and geographically. In particular, there has been an alarming increase of syphilis among girls aged 15–17. In Russia between 1989 and 1996 the reported incidence of the disease in this age group increased 87 times from 6.8 to 591.5 per 100,000 of the relevant population (TransMONEE database, 2004). And despite a significant decline since 1996, the incidence of syphilis among this age group in Russia in 2003 was still 17 times higher than in 1989 (op. cit.). Furthermore, in some areas of the Russian Federation, such as the Autonomous Areas of Taimur and Evenk, the syphilis rate per 100,000 population is 3.5 to 3.7 times higher than the national average (Country Analytical Report, 2004).

The incidence of syphilis is much higher for girls than for boys (Figure 8). The difference in rates was higher in the mid-1990s when the overall rate peaked, and the gap subsequently narrowed with the decline in infection rates. The highest difference in the rates of syphilis between girls and boys aged 15–17 was recorded in 1996 when the rate for girls was eighteen times the rate for boys (Georgia). In 2003 the highest differences were recorded in Tajikistan and Ukraine (seven and four times greater for girls respectively). The use of contraception and awareness of STIs among young people in the region is relatively low. According to survey data, in Romania 70 per cent of boys aged 15–19 reported having sex before marriage and 39 per cent had used a condom the first time they had sex (UNICEF, 2002). The same survey showed that in Ukraine, 99 per cent of girls had heard of HIV/AIDS but that only 9 per cent could correctly identify three main ways to avoid sexual transmition.

According to the literature girls tend to have a higher physiological risk of STIs than boys and often have older sexual partners. However, in the USA for example the cases of syphilis increased among men while they dropped among women in the period 2000–2002 (Erbelding, 2004). Reporting rates may also be a factor: it has been suggested that greater stigma is attached to use of STI services for boys and young men than for girls, as reproductive health services, including treatment for STIs, are relatively new for males in these countries.

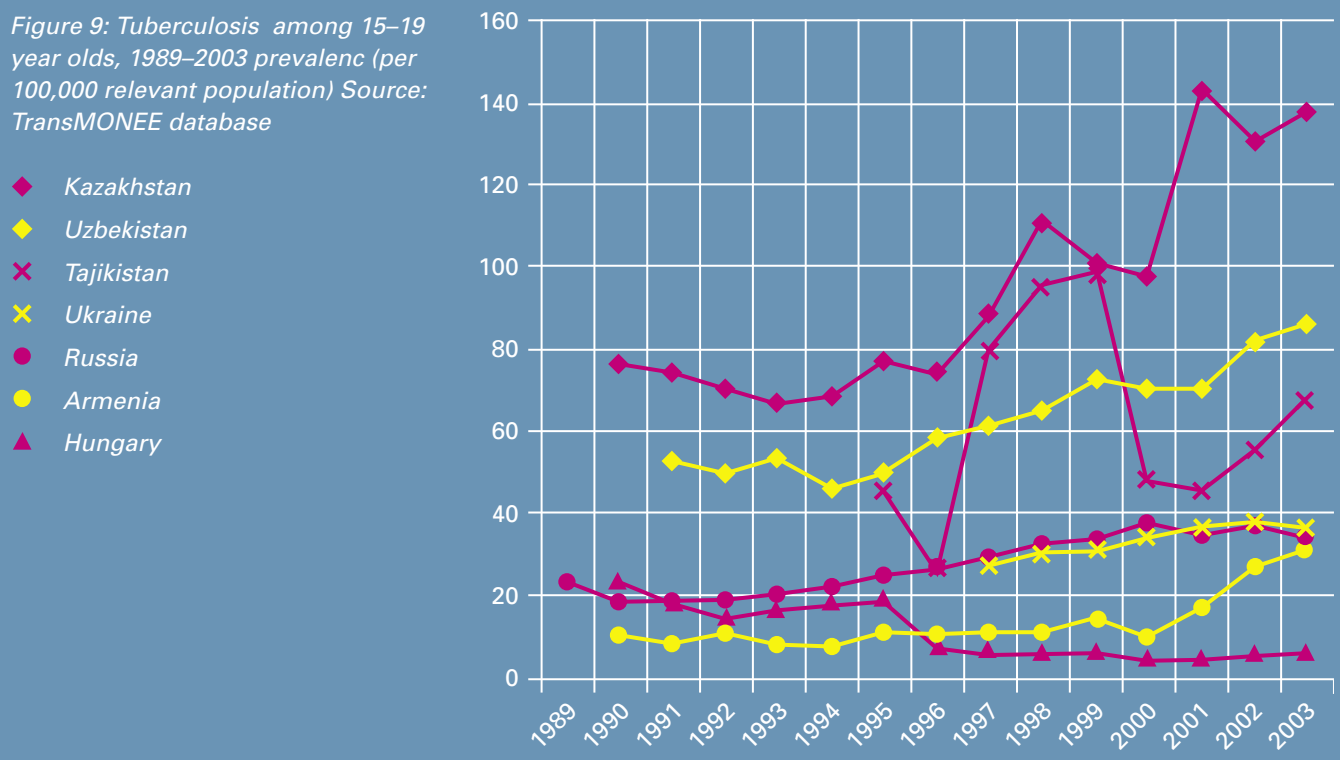
Although the degree of gender and regional discrepancy differs among countries, girls in CEE/CIS region have a higher risk of STIs than boys and thus need policies and actions targeted directly at them, with counselling and treatment services made available throughout the entire country.

Tuberculosis (TB) infection continues to increase in CIS countries despite recent economic growth and international efforts

Tuberculosis (TB) infection continues to increase in CIS countries despite recent economic growth and international efforts to address the disease. TB among the population in general, and among children in particular, is a growing problem especially in countries such as Kazakhstan, Uzbekistan, Tajikistan, Ukraine and Russia. Figure 9 shows a growing trend in TB prevalence among young people aged 15–19, with the highest prevalence of 137.6 cases per 100,000 relevant population in Kazakhstan, followed by Uzbekistan and Tajikistan. The incidence of TB among children under 15 peaked at 19.1 per 100,000 persons in 2001 in Russia (Country Analytical Report, 2004). The increase in the incidence of TB has also been associated with an increase in the death rate due to TB, linked to

The major cause of morbidity remains infectious diseases

Figure 9: Tuberculosis among 15–19 year olds, 1989–2003 prevalenc (per 100,000 relevant population) Source: TransMONEE database



emergence of drug-resistant strains and late diagnosis; 40 per cent of the newly registered patients in Russia were at the stage of pulmonary decomposition (op. cit.). In Central Asian countries, deaths due to TB of the respiratory tract among young people aged 15–24 accounted for over 50 per cent of the mortality caused by infectious diseases: 53 per cent in Tajikistan (2001), 63.2 per cent in Uzbekistan (2000), and 66.3 per cent in Kyrgyzstan (2002) (WHO mortality database, latest years where data is available).

Besides constituting serious health problems in their own right, syphilis and TB also worsen the situation of HIV/AIDS in the region, insofar as TB is a leading cause of death for those infected with HIV. High levels of syphilis and other STIs are associated with the heterosexual transmission of HIV in the region. In Russia heterosexual transmission of HIV accounted for 4.7 per cent of new cases in 2001 and rose to 17.0 per cent of new cases in 2003 (WHO, 2005). The number of people living with HIV in the region reached 1.4 million (UNAIDS, 2005). A further increase in HIV rates is expected in Central Asia and some countries in Eastern Europe due to the spread of intravenous drug use. The symptoms and treatments of TB and syphilis are already well documented. Therefore Higher priority is needed in funding, organizing and making the services available, especially for young and vulnerable population.

Young girls in the CEE/CIS region have a higher risk of STIs than young boys and thus need policies and actions targeted directly at them, with counseling and treatment services made available throughout the entire country.

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CONTINUED LOW PUBLIC EXPENDITURE ON HEALTH AND INCREASING OUT-OF-POCKET PAYMENTS IN CENTRAL ASIA AND THE CAUCASUS

The most vulnerable members of society – children and the elderly – are hit hardest

The economic growth in the CEE/CIS region since the late 1990s has not been fully reflected in public spending on health in many countries of Central Asia and the Caucasus. By 2003, countries in Central Europe followed by the Baltic States have recovered economically and exceeded their 1989 GDP per capita level (Figure 10). In contrast countries of Central Asia and the Caucasus have not fully recovered to their 1989 level although they have achieved steady increases in GDP per capita since the mid-1990s.

In many Central and Eastern Europe (CEE) countries, between 1990 and 2003 public expenditure on health rose slightly as a percentage of GDP. It has however remained low, and it continuously declined in countries such as Tajikistan, Albania, Armenia, Azerbaijan, Kazakhstan (below 2 per cent of GDP) and Uzbekistan (2.4 per cent of GDP) (Figure 11). While the Czech Republic, Hungary and Slovenia spent around 6 per cent of national GDP on health, Georgia and Tajikistan spent only 0.7 per cent of GDP (2003), and 0.8 per cent of GDP (2002) respectively, thus lagging far behind the WHO target of 5 per cent of GDP for health.

The economic growth in the region since the late 1990s has not always been fully reflected in public spending on health

A high level of public expenditure does not necessarily guarantee better health, but health spending makes an important contribution to reducing morbidity and mortality. The TransMONEE database shows that the countries in Central Asia and the Caucasus with the lowest public expenditure on health in 2003 also had the poorest health indicators in the region. For example, the highest IMR in the region was 43.6 per 1,000 live births in Tajikistan, and the highest MMRs were 49.3 and 45.5 per 100,000 live births in Kyrgyzstan and Georgia respectively. The highest U5MR was 27.6 per 1,000 live births in Georgia.

The highest incidence of tuberculosis was reported in Kazakhstan, with 160.4 per 100,000 population. The countries with highest incidence of sexually transmitted diseases (syphilis and gonorrhea) were Kyrgyzstan with 221.3 cases per 100,000 population, and

Kazakhstan with 208.6. These statistics indicate that public health expenditure matters and has a significant impact on the health of a population: investment in public health initiatives helps check the spread of infectious illness and addresses underlying weaknesses in the health system.

Translating the GDP percentage spent on health care, real expenditure for health in these countries is very small. According to WHO estimates, in 2002 Tajikistan spent US$2 per capita compared to the US$35 recommended by the Commission on Macroeconomics and Health. Real expenditures on health in Central Asian countries in 1995 were between 25 and 33 per cent of the 1990 levels (Falkingham, 2000). Since 2003 this decline has continued in all of these countries with the exception of Turkmenistan.

A high level of public expenditure does not necessarily guarantee better health, but it is an important contributory factor in reducing morbidity and mortality.

The persistently low levels of public expenditure earmarked for health have been associated with increased out-of-pocket expenditure, leaving people exposed to dramatically high health expenses particularly for catastrophic illness. In all five countries of Central Asia, private sector expenditure on health consists of 100 per cent out-of-pocket payment, with no third-party contributions including health insurance (WHO, 2005). Analysis of national expenditure on health in these countries between 1998 and 2002 shows that when general expenditure on health declined, private-sector health expenditure, and particularly out-of-pocket payments, increased. In Tajikistan household expenditure on health is four times greater than national expenditure on health (World Bank, 2005). An extensive literature shows how out-of-pocket payments (official and unofficial) affect the use of health services. For example, in Georgia up to 30 per cent of the population, and 50.7 per cent of the poor population in western Georgia, did not seek medical care due to high cost of out-of-pocket payments (Gamkrelidze et al., 2002). The most vulnerable members of society – children and the elderly – are most severely affected. In Tajikistan, the take-up rate for health care among the poorest quintile of the population was one-third that for the richest quintile (Country Report, 2004). 72.5 per cent of the Tajik population that took medicine for chronic diseases belonged to the richest quintile of the population (Country Report, 2004).

The pervasive downward trend of public expenditure on health in Central Asian countries and the Caucasus, and its negative effect on health of the population and on access to and affordability of health services, all warrant more effective policy action, including renewed consideration of strengthened social insurance systems and other systems of risk pooling.

Figure 10: Change in GDP per capita, 1989–2003

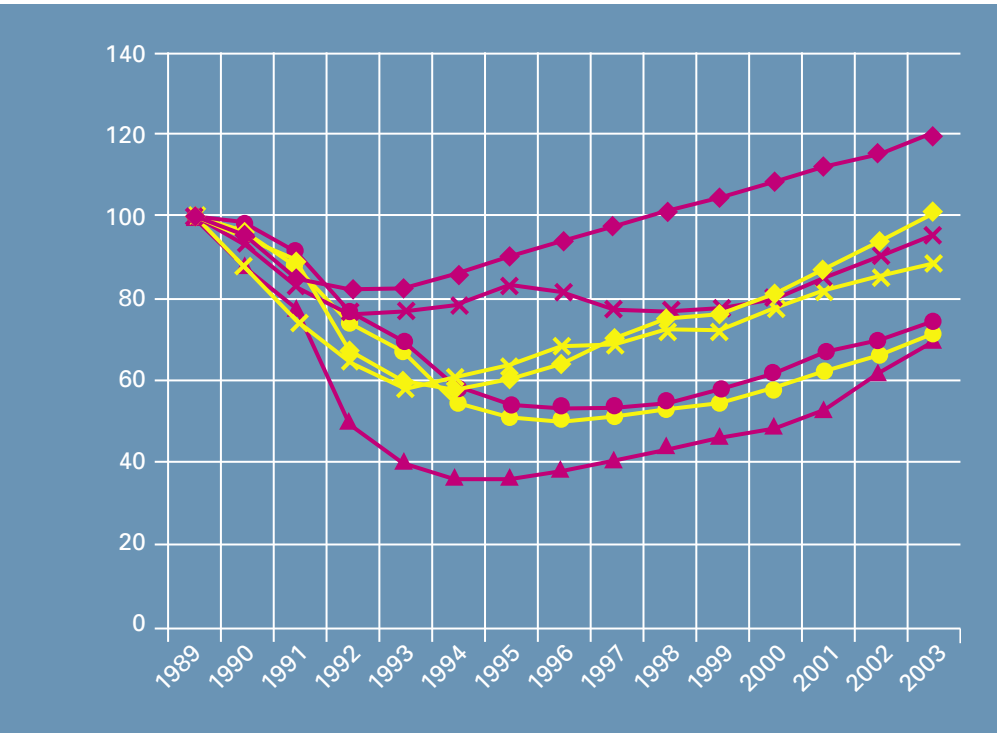
- *Central Europe*
- *Baltic States*
- *Bulgaria and Romania*
- *Other South Eastern Europe*
- *Central Asia*
- *Western CIS*
- *Caucasus*

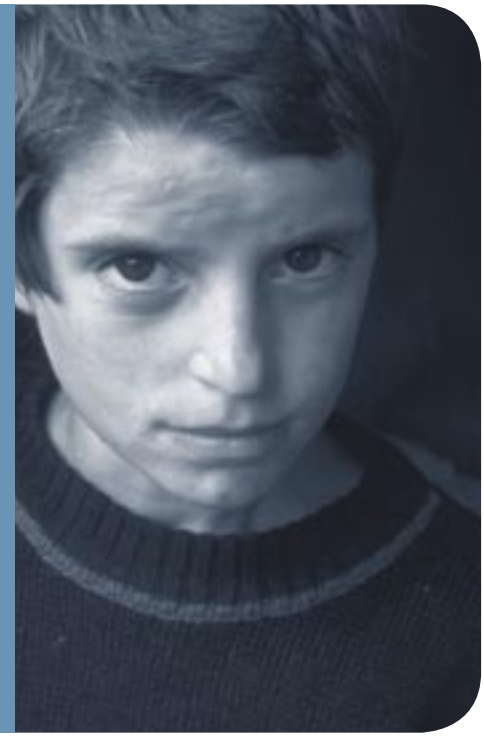
Figure 11: Public expenditure on health as a percentage of GDP: the Caucasus and Central Asia, 1993 and 2003 Source: TransMONEE database, WHO.

1993

2003

Note: Data was not available for Tajikistan for 1993; data for Kyrgyzstan and Tajikistan for 2003 refer to 2002





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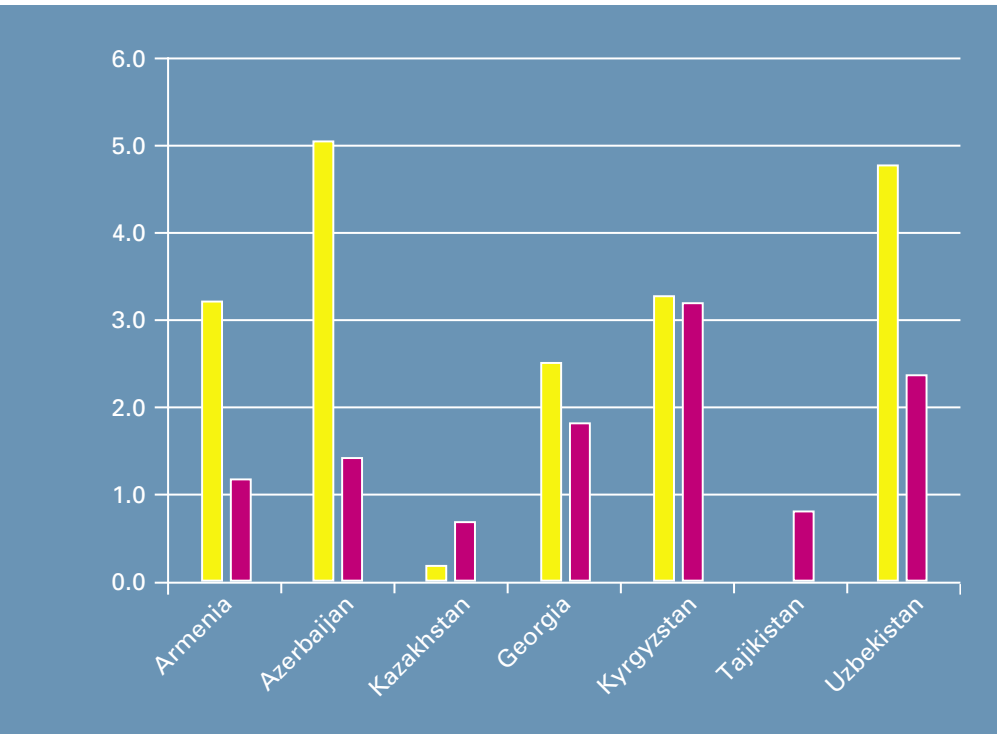

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Note:

Baltic States: Estonia, Latvia and Lithuania.

Caucasus: Armenia, Azerbaijan and Georgia.

Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

Central Europe: Czech Republic, Hungary, Poland, Slovakia and Slovenia.

Other South East Europe: Albania, Bosnia-Herzegovina, Croatia, FYR Macedonia, and Serbia and Montenegro.

Western CIS: Belarus, Moldova, Russia, Ukraine.

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