



Turkmenistan, Ashgabat (2008) © MSF

TURKMENISTAN'S OPAQUE HEALTH SYSTEM

April 2010



I Introduction

The people of Turkmenistan are being failed by their health care system, by their government, and by the international community. The system that is supposed to ensure their health is instead designed to conceal problems. This is not a case of individual practitioners failing to do their jobs but one that is far more systematic.

It is undeniable that communicable diseases such as HIV/AIDS, tuberculosis (TB) and sexually transmitted infections are more prevalent than reported figures would suggest. It is equally clear that public health risks are not being effectively addressed and that prevention mechanisms are not in place. Misinformation about how to avoid contracting and spreading disease is rampant. However, rather than encouraging workers in the health care system to actively counteract this through it and encouraging people to seek help, serious health care issues are being driven underground. As a consequence, it is all but impossible to gauge the real state of the health of people in Turkmenistan today.

In December 2009 Médecins Sans Frontières (MSF) took the difficult decision to close the last of its programmes in Turkmenistan. MSF had been present in the country for more than ten years and had had unique opportunity to witness the challenges facing the health care system. Unlike most of the countries in which MSF works, Turkmenistan's health crisis is not characterized by large-scale outbreaks of infectious disease, malnutrition or violence, nor by a complete absence of health care provision. Instead it is through systematic denial and manipulation; a system of smoke and mirrors reinforced by fear.

The purpose of this report is to shed light on some of the key issues in Turkmenistan's health care system and to raise concerns about the role of international actors in the country. Anonymised examples from MSF's experience of working directly with the country's health care system illustrate the extent to which the capacity to make real change or improvement was constrained.¹ Instead, international organisations help perpetuate the problems by giving a veneer of legitimacy to figures and practices that are not only ineffective, but often dangerous.

Key Findings

- Access to health care for the population of Turkmenistan is restricted by fear of the social and political consequences of illness for both health care practitioners and patients and by stigma.
- International standards and protocols exist mainly on paper, and are not routinely or consistently implemented in the country's health care system.
- Failure to acknowledge or address communicable diseases such as TB, HIV and sexually transmitted infections is most likely compounding upon and expanding existing problems. TB, particularly in its multi-drug-resistant form, is perhaps the country's most serious public health threat, and poses a high risk of creating a serious crisis in Turkmenistan.
- Despite the appearance of greater openness since the accession to power of former Health Minister Gurbanguly Berdimuhamedov, real change has not taken place. Instead, greater engagement with the international community is serving only to mask the continuation of old practices, including the manipulation of health data.
- International organisations risk being complicit in the entrenchment of problems by transmitting government misinformation as fact and by failing to address openly and firmly the problems that they are witnessing in the health care system.

¹ Examples and testimonies in this report are based on the direct experience of our expatriate health staff in country.

II Médecins Sans Frontières in Turkmenistan

MSF worked in Turkmenistan for more than ten years and remained, until its departure in 2009, the sole accredited international NGO with a permanent presence outside the capital. The decision to leave was not taken lightly. MSF's commitment to the people of Turkmenistan and its conviction that there is a need for transparent, international support in the health sector remains unchanged. However, over time the organisation recognised that rather than obtaining greater confidence from the government and freedom to provide assistance, its activities were becoming increasingly restricted.

MSF began its work in Turkmenistan in 1997 providing assistance to approximately 10,000 Afghan refugees in Tagta-Bazar. In 1999 MSF received accreditation with the Ministry of Foreign Affairs and signed a memorandum of understanding (MoU) with the government to begin a pilot DOTS² programme to treat TB in the two etraps (districts) of Dashoguz Velayat (region): Konya-Urgench and Turkmenbashi. By July 2002, a training centre had been opened in Dashoguz and all medical facilities in Dashoguz Velayat were covered by DOTS programmes, making Dashoguz the first velayat in Turkmenistan to have successful complete coverage of DOTS. This programme was handed over to the Ministry of Health at the end of 2003.

In 2004, following an assessment of needs in Lebap and Mary velayats, MSF began a children's health care project in Magdanly in Lebap. Over time the project expanded to include obstetric/gynaecological care and laboratory support. MSF also provided extensive formal and informal training and infrastructure support. This intervention, while successful in achieving improvements in the hospital and surrounding area, was problematic in many respects. From the beginnings the terms of the agreement were significantly more restrictive than MSF was accustomed to, including a "hands-off clause" that did not allow MSF's international staff to directly treat patients. Access to patients and data was restricted³ and MSF's capacity to implement internationally recognised protocols was limited by standing orders that were impossible to counter.

In 2008 MSF obtained an initial agreement from the Ministry of Health and Medical Industry (MoHMI) to begin a pilot programme to treat multi-drug resistant TB in Turkmenabad. Based on regional trends, data that had been submitted by the government to the Global Fund to Fight AIDS, TB and Malaria and an MSF drug sensitivity survey in the country, MSF determined that TB, especially the drug resistant forms, was

Turkmenistan's single most serious health issue. However, in May 2009, after nine months of negotiation, the MoHMI finally rejected the plan, determining that there was no need for MSF support as all health gaps were to be filled by the end of 2009. This was in spite of repeated requests from the MoHMI for technical support in their Global Fund applications, along with the knowledge that the Round 9 application then in progress, if accepted, would not see patients treated until 2012.

Despite ongoing lobbying and negotiation, MSF was unable to make progress in coming to an agreement about future interventions.

MSF's conclusion was that its effectiveness had been dramatically reduced and, worse, that the organisation was increasingly complicit in masking problems in the health care system rather than addressing them.⁴ Moreover, MSF had noted that it was not only that the government was limiting its activity in Turkmenistan but that, over the course of time, the organisation had begun to engage in a form of self-limitation. Repeated rejections of MSF's requests for assessments along with refusal of permission to intervene in areas of critical need, and concerns for the safety of national staff, all resulted in an increased tendency to shy away from sensitive issues and to refrain from speaking openly about problems witnessed in the course of MSF's work.

While MSF has taken the decision to leave, international organisations such as the World Health Organisation (WHO) and UNICEF remain. It is MSF's belief that they too play a role in perpetuating problems in the Turkmen health care system. In fact, as this paper will illustrate, it is clear that such problems, particularly communicable diseases, are under-reported, and that there is no real visibility regarding their extent or severity. MSF repeatedly witnessed the tendency of organisations to overlook gaps, to fail to follow-up on government commitments, and to provide legitimacy to government data by diffusing it internationally without comment or caveat.

It is impossible to know how serious or pervasive Turkmenistan's health problems really are. It is clear, however, that patients are not receiving the treatment to which they are entitled, and that the government of Turkmenistan's public health response is inadequate.

² DOTS is directly observed treatment, short-course, and is the WHO-recommended strategy for detection and cure of non-resistant forms of TB.

³ These restrictions increased over time, rather than the reverse. In 2009 MSF international staff were barred access to the operating theatre, following a training for MoHMI staff on a standard and internationally recognised surgical procedure. Disagreements with regard to the admission of patients from other etraps resulted in further limitations, including the refusal to allow MSF Turkmen national staff to access certain wards or to provide treatment and, reportedly, verbal threats.

⁴ Within Magdanly hospital, as some of the examples in this paper will illustrate, this manifested itself in a tendency to circumvent orders or systems. While this had the positive effect of ensuring that patients received treatment who might not have done otherwise, it did not necessarily result in them receiving the best possible treatment, nor in accurate reporting for epidemiological purposes. In some cases, for example, when admission to the hospital was refused, MSF found a way to treat on an outpatient basis. While this resulted in the patient being cured, inpatient treatment would have been the correct course of action.

III Manipulation and its Repercussions

Since its independency in 1991, the Turkmen state has put a higher priority on the appearance of health and prosperity than on the substantial reforms necessary to actually improve the health status of the population. This has had negative repercussions at every level of the system and has resulted in inadequate treatment of patients and a lack of management of public health risks. In recent years there was much talk of health care reform, particularly in the areas of TB and mother and child health,⁵ as well as more openness and collaboration with the international community. However in MSF's experience any changes have been essentially cosmetic.

Creating the Appearance of Prosperity

Turkmenistan rarely warrants mention in the international media, but when it does there is often comment on the contrast between the marble and gold façades that gild the most visible parts of the country and the poverty and hardship that is suffered by many members of the population, 30 percent of whom live below the poverty line.⁶ This tendency is replicated in the health care system, where there has been large-scale investment in infrastructure – including an eight-story oncology hospital in the capital, Ashgabat, and state-of-the-art diagnostic centres in regional capitals – but where few patients have access to such resources, and technology is not matched with the ability to interpret findings.⁷

Vital to maintaining an appearance of prosperity is for Turkmenistan is the international representation of itself as a country with its public health situation under control. Therefore here, too, appearance has been given priority, to the extent that it is quite impossible to obtain realistic data on anything from maternal and infant mortality to communicable diseases. For analysts attempting to understand Turkmenistan's health situation, the lack of reliable data remains one of the most crucial barriers.⁸

The most obvious area of obfuscation is in the area of communicable diseases, such as HIV, sexually transmitted infections and TB, particularly multi-drug resistant TB (MDR-TB). Equally sensitive, however, are infant and maternal mortality rates. Highlighted in the United Nations' Millennium Development Goals (MDGs), these indicators are taken as a barometer not merely of women and children's health, but of the health and development status of the whole society. They have been a

primary focus of health and development actors in lobbying the Turkmenistan government and have been at the centre of many of the country's recent health reforms. It is notable that these are also the only mortality data that the government of Turkmenistan has reported to international bodies, despite their accuracy being highly suspect. Furthermore, emerging diseases such as avian flu and H1N1 seem not to exist within Turkmenistan's borders.

Accessing information from outside of the country has proved difficult, but closer proximity has not necessarily improve visibility. Even from within Magdanly Hospital, MSF was unable to obtain basic data, to such an extent that, in 2005, the team conducted an informal bedside survey in order to better understand and address infant mortality.⁹ While taking into account that there are higher number of limitations in using this method, the results clearly showed a far higher level of infant mortality than other countries in the region. Furthermore repeated attempts to conduct basic assessments in the area were continuously denied, making it impossible to obtain better visibility on the health situation.

Manipulation of data

MSF's experience in Turkmenistan overall and in Magdanly in particular made it clear that the difficulties in obtaining data were not due to lack of capacity, but rather because of a deliberate obscuring of information. Furthermore, it was not that figures were adapted to present a more optimistic view of the situation, but rather, that the reality was adapted to ensure that the statistics would meet pre-determined targets.

While there has been greater availability of data to international organisations and analysts since President Berdimuhamedov came to power, the previous system of quotas for everything from mortality to communicable diseases has continued.¹⁰ The government puts pressure on health care workers to meet these quotas, but the necessary resources are rarely provided to ensure that these targets can be met. For example, in Magdanly in August 2007, the hospital received a fax with instructions to start TB DOTS diagnostic services. It was only with the support of MSF teams, who constructed, equipped and supplied a laboratory department for the purpose, that patient services could be offered from March 2008 onward.

In MSF's experience, health care workers are not encouraged to reduce stigma and barriers to treatment. Rather, at every level, they are under pressure to actively prevent cases from reaching the treatment facility in case they might harm the statistics. If the cases reach the treatment facility staff are under pressure

⁵ See for example Rechel, Sikorskaya and McKee, "Health in Turkmenistan after Niyazov", London School of Hygiene and Tropical Medicine, 2009, <http://www.lshtm.ac.uk/ecohost/projects/turkmenistan%20files/Health%20in%20Turkmenistan.pdf>.

⁶ Economist Intelligence Unit, www.eiu.com

⁷ Turkmenistan.ru internet newspaper. Health Oasis in Kopetdag Foothills, January 28, 2007. http://turkmenistan.ru/?page_id=5&lang_id=en&elem_id=9247&type=event&sort=date_desc. And Eurasianet.org. Turkmenistan: Public Health Remains in Critical Condition. January 8, 2010. <http://www.eurasianet.org/departments/insightb/articles/eav010810.shtml>.

⁸ Rechel, Sikorskaya and McKee, 2009, see fn 5, supra.

⁹ Over a period of four months, MSF staff asked a series of questions of women in the maternity ward to obtain a reasonable estimate of retrospective infant mortality.

¹⁰ One example is the 2006 Safe Motherhood decree, which demanded a fifty percent reduction in maternal mortality.

to either prevent the patient from staying or from appearing in the registry books at all. Laboratory technicians are also under pressure to not report 'too many' positive results for infections considered to be sensitive. As a result, laboratory test results have been manipulated, including the deliberate dilution of reagents and falsification of results.

[There was a high-level complaint] of the lab reporting parasites in stool found in patients. Instructions were given to bring back all these positive reports to the lab, for the lab to re-write all of them as negative. He said that the lab should never give positive reports on patients from his department because it makes morbidity registers look bad when the commissioners come to do their ward visits. January 2007¹¹

Patient admitted with vomiting and nausea, no diarrhoea. Stool sample showed massive parasites. When treatment was provided to patient, grand-mother said that she was sure that her grandchild had not produced a stool since admission and she therefore does not believe the result. She collected two more samples during the following days under supervision of MSF-nurse that were negative, so first stool was definitely not from this patient. When looking for a plausible explanation. I learnt that by "Prikaz" every patient has to give a stool sample and that MoHMI is in trouble if these are not produced. As a consequence, stool samples are split or "imported" into the hospital in case the patient does not have a stool. Apparently, this happened in this case. July 2007

MSF repeatedly witnessed and heard of members of staff at all levels routinely giving and receiving orders to manipulate STI diagnostic results in order to keep the records within the quotas. This was based not on written instruction but rather on verbal orders from regional or national superiors:

Screening of a pregnant woman for syphilis. We had two positive tests in September in maternity and staff received a phone call with warning not to confirm any more cases of STIs [sexually transmitted infections]. After that phone call we don't have any more syphilis cases officially confirmed by the laboratory. September 2008

It is perhaps as much a result of these quota systems as of any reforms to the health system that Turkmenistan shows, in virtually every category, consistent improvement in its health statistics. According to official reports, from 2000 to 2006 infant mortality is reported to have reduced from 59 to 45, while

mortality in children under five years of age has decreased from 71 to 51 and life expectancy at birth has risen from 62 to 63.¹²

The tendency of international organisations to report the government's health data as fact is dangerous not only for the country's population, but also regionally. For example, countries like Uzbekistan, which provide much more credible data to the international community (see Figure 1, below), have received significant negative attention on the basis of their reported TB prevalence. By contrast, Turkmenistan has merited barely a mention.¹³ As a result, the failure to address public health issues is rewarded, while efforts at transparency are punished.

Figure 1¹⁴

| Communicable Diseases -> Tuberculosis (as of 24 March 2009). Estimated TB prevalence, all forms (per 100 000 population per year) | | |
|--|--------------|------------|
| Periodicity: Year Applied Time Period: from 2000 to 2007 | | |
| | Turkmenistan | Uzbekistan |
| 2000 | 130 | 139 |
| 2001 | 115 | 148 |
| 2002 | 110 | 144 |
| 2003 | 103 | 152 |
| 2004 | 98 | 149 |
| 2005 | 91 | 144 |
| 2006 | 85 | 134 |
| 2007 | 75 | 140 |

¹¹ MSF staff ensured that positive test reports from the department were taken to MSF expatriate staff so that patients could receive treatment, even if their official laboratory reports were falsified.

¹² WHO WHOSIS, accessed March 1, 2010, <http://www.who.int/whosis/en/index.html>.

¹³ This applies not solely to TB but also to other diseases. WHO HIV/AIDS epidemiological fact sheets, for example, report that Uzbekistan has increased from 1,400 reported HIV positive patients in 2001 to 16,000 in 2007, while Turkmenistan has fewer than 500. www.who.int/hiv/countries/en/

¹⁴ WHO, Global TB Database, accessed March 6, 2010, <http://apps.who.int/globalatlas/dataQuery/>

IV The Impact on Patient Care

Working within Magdanly Hospital and, when access was possible, in the surrounding health posts and health houses,¹⁵ MSF witnessed countless examples of inadequate patient care. The easiest explanation is to blame the health care workers directly for poorly applying protocols and being self-interested and negligent. To do so, however, would simply be overlooking the way that the system denies the health care workers the tools they need to do their jobs, and encourages poor practice within the system.

Refusal of Care

The pressure on health care workers to meet specific targets for health indicators often resulted in individuals being denied care. MSF was constantly negotiating with hospital staff to allow the admission of critically ill patients, as the hospital staff feared that a poor outcome or complications would impact negatively on their statistics, bringing with it severe repercussions. This was particularly the case for patients who came from outside the catchment area of the hospital, despite it being stated on paper that critically ill patients must be admitted.

2 admissions on behalf of MSF initially refused by the MOHMI doctors due to poor prognosis. Both survived and the cooperation in case management of those kids was excellent after initial doubts and fear. May 2007

Other patients were discharged from hospital early to avoid having to record a hospital-death.

MSF medical doctor was informed that it was the consensus of the Turkmen medical doctors to discharge a baby as soon as possible for the following reasons: poor prognosis (as proven by the death of the other twin), the parents come from another district, and therefore, should the patient be sent home, the patient will surely die but the death would not be reflected in the hospital's statistics. November 2007

Baby was born at gestational age of 26 weeks. On the second day the child had a respiratory arrest requiring short-term intubation and ventilation. MOHMI staff subsequently discharged the child in the afternoon and the baby died at home. June 2008

1 years 5 month old child, severely malnourished. Outpatient department referred case to paediatric ward. Medical doctor of paediatric ward refused admittance as the child was a 'lost cause' and would probably die anyway. MSF

doctor found a solution to treat the child on an outpatient basis. September 2007

A particularly difficult problem encountered in MSF's maternal and health programme was on how to define live births. The Soviet definition of a live birth used previously in Turkmenistan stipulated that infants born before 28 weeks of gestation weighing less than 1000 grammes or measuring less than 35 centimetres in length were not considered live births unless they survived seven days. This method of measurement was used previously in Turkmenistan, and consequently, many infants' deaths went unrecorded. The WHO definition of a live birth is any infant that shows evidence of life, and this international definition was officially adopted in Turkmenistan on January 1, 2007.

However, official ministerial expectations of the infant mortality rate did not change. This increased the pressure to have as few infant deaths as possible. One way to keep infant deaths low was to not attempt resuscitation after birth, so that the case would be classified as a stillbirth rather than a death. MSF worked closely with the hospital staff to demonstrate that with proper care many of these infants could survive and be successfully discharged from hospital.

Poor quality of care

MSF witnessed many examples of poor medical management of patients and a lack of understanding of basic principles. This is not surprising given the inadequacies of the medical education system. Reforms during Nijasow's government led to a loss of the country's medical educators (Russian speaking) and reduced the availability of training materials, scientific publications and WHO protocols.

4-year-old child came for consultation for "runny ears" for 2 years. Delayed speech development, impaired hearing. Symptoms started 2 years ago, since then smelly discharge from both ears, perforated ear drums with large defects on both sides. So far, never received systemic antibiotic treatment. Previous MoHMI treatment given: Crushed and diluted Amoxicillin tablets were instilled into the ear every month for a couple of days. MSF started treatment with oral amoxicillin. Both ears healed nicely, much improved hearing and no discharge any more. July 2007

A 2-year-old boy was admitted to inpatient department with severe dehydration caused by vomiting and diarrhoea since two days, weight loss of 2 kg in 5 days. Weight 12 kg. Discussion with MoHMI doctors about rehydration therapy. MoHMI was seriously telling me that 400 ml total fluid intake per day was enough and the maximum to be given in this case was 500 ml. Reasons given: Danger of overhydrating, Central Asian children are not used to so much fluid, children die if they are rehydrated aggressively. I explained patiently three times the calculation method of

¹⁵ Access to health houses and health posts was sometimes restricted by poor weather or road conditions, however, access was also constrained by government intervention, as when MSF was denied permission to visit health houses for a period of time.

daily fluid requirements depending on weight, indicating that this child needs at least 1,2 l [maintenance] fluid intake per day not counting the losses. I explained how to calculate deficit and how to estimate and monitor losses, and how to rehydrate properly. He still argued that this is not feasible for children of this area. I copied literature for him, brought training materials – he still argued that WHO protocols do not apply to Central Asian children and that he as a doctor as well as the patient would get serious problems if they followed these rules. Head of therapeutic departments, who came along and was involved in the discussion, confirmed this opinion and said, WHO protocols had been proven to not work in Turkmenistan. MSF managed to explain [to] the mother to give the child at least 1500 ml oral fluids in frequent small portions. Luckily the vomiting stopped and the patient recovered within 3 days – mainly due to MSF-nurses' and the mother's effort. August 2007

As far as MSF was able to establish, continuing professional education to maintain levels of competency and ensure up to date scientific knowledge is not mandated or facilitated. In Magdanly hospital, most of the staff were natives of the area who received medical training in Ashgabat, Turkmenabad or in nearby Uzbek medical colleges many year ago. Predominantly Soviet-educated with little if any continuing medical education, they had little or no exposure to up-to-date evidence-based on either practice or scientific literature. This resulted with MSF witnessing many repeated examples of poor or dangerous practices.

MSF Expat was present in all Caesarian sections over 14 days. In none of the sections, sterile operating techniques were strictly followed. Of most concern is that the chief nurse is sorting the sterile instruments without sterile gloves on. This means that all instruments are unsterile when operation starts. Surgeons are not aware of proper technique how to put gloves and keeping their hands sterile. May 2007

Pregnant woman with pre-eclampsia; very high blood pressure in late pregnancy; foetal heartbeat reported as normal; no blood pressure surveillance carried out, and no labour induction took place; next morning baby in womb was dead. November 2006

Based on MSF's direct experience and observations, there appears to be rampant misdiagnosis of common conditions and a vast overuse of antibiotics and multiple intravenous administration of medication for complaints as simple as the common cold. There is little understanding of correct fluid management and children in respiratory distress are given large boluses of Ringer Lactate. There is persistent use of blood products without indication, and transfusions are frequently performed without screening for HIV or Hepatitis C. Cases of blood transfers by syringe from adult relatives directly to children without any screening at all were also witnessed. The

powerful anti-seizure drug phenobarbital was used for 'raised intracranial pressure', which sometimes amounted simply to a child crying with colic. Phenobarbital was also observed to be administered routinely to children who had been delivered by forceps. All of these practices were observed despite the fact that international treatment guidelines have been officially adopted. Even worse, MSF saw cases of misdiagnosis and incorrect treatment.

2-year old child received blood transfusion upon indication of fever signs, while Hb was 16. MoHMI denies that the transfusion occurred knowing that MSF would recommend against the blood transfusion. Three witnesses however confirmed it took place. November 2006

Over the course of five years, MSF medical teams conducted formal trainings weekly and bedside training sessions daily on diagnostics, therapeutic management and care for virtually all prevalent health conditions among pregnant and lactating women and in newborns, infants, children and adolescents. Emphasis was consistently on the concept of evidence-based medicine and other international standards of patient care. Despite these efforts, MSF's success in changing local practice remained hit and miss. This was largely because there was no systemic encouragement for staff to implement or follow international protocols and so opportunities to correct poor practices were often lost when the use of unsafe practice or abandoned treatment protocols simply went 'underground'.

A Culture of Fear

MSF observed medical staff in Turkmenistan reduced to delivering sub-standard care through a culture of fear. Frequent staff reshuffling creates anxiety and uncertainty and staff become fearful of making any change, no matter how positive the outcome might be for the patients under their care. This culture of fear has filtered down from the highest political levels.

A medical doctor from Turkmenabad who came to Magdanly for consultation was later sacked because an official from Ashgabat determined that he made a "wrong diagnosis". Two members of local staff received fines, reportedly for not reporting this case earlier to the Sanitary Epidemiological Service.¹⁶

Although MSF could not independently corroborate them, reports were received that high maternal mortality rates result in imprisonment of the doctor in charge, and MSF knew of numerous individuals who had been imprisoned in the course of their work. It was also reported that the head of the Narcology Hospital was fired for reporting cases of HIV.

¹⁶ MSF Monthly Medical Report, April 2009.

The punitive nature of the system affects the behaviour not only of health care workers, but also of their patients. In Turkmenistan, as elsewhere, shame and social pressure play an important role in preventing patients from seeking assistance for diseases which are stigmatised in society. However, in Turkmenistan MSF found that the official repercussions of having contracted infectious diseases such as syphilis, HIV and TB are so severe that patients will resort to extreme measures to avoid having this recorded. For example, if a positive syphilis result is recorded in a patient's 'Sanitary Book', the result will be exclusion from many types of employment, including in the education and health care sectors. Patients are not guaranteed the right to confidentiality of their medical records, and all employers have access to the information in the sanitary book. The consequences therefore can lead patients to avoid seeking care, or can push them to pay bribes to health care workers in order to receive testing or treatment without it being documented.

Lab diagnosis showed Trichomoniasis, a sexually transmitted disease, and there was a big hunt for the patient as according to Prikaz (official decree) all Trichomoniasis cases are to be admitted and notified, thus stigmatizing the disease. The patient went in hiding to avoid registration. October 2008

According to MoHMI lab records, 121 male urethral swabs (for STI) were examined, and all results were negative. Unfortunately, it was confirmed that the lab never received these samples. The forms were simply completed and returned to the Venereology Department. It has been suggested that the patients pay for these negative results.¹⁷ April 2009

To give health care workers their due, on many occasions efforts were made to ensure that appropriate care was given, despite significant pressure. In these cases, however, diagnostic records were found to have been creatively altered to match expectations.

A 14-year-old boy with complaints of prolonged fever, rash, vomiting, abdominal pain and 7-8x per day black stool. Initial diagnosis was measles. Child deteriorated, then treated in line with typhoid diagnosis. Records however say Acute Viral Diarrhoea. December 2006

A case of brucellosis¹⁸ was seen in a 4-year-old girl from Magdanly town who was admitted in the Infectious Disease ward. A laboratory test was conducted and... a sample went to SES, which took three days to process. SES

result was officially documented as negative but verbally communicated as positive to the Chief Doctor of the ward. The correct treatment for brucellosis was conducted.

January 2007

It is indicative of the commitment and integrity of many health care workers that cases like these exist. The fact that data is 'doctored' in this way, though, raises serious concerns about the real prevalence of disease and the state of public health in Turkmenistan.

¹⁷ MSF Monthly mission situation report.

¹⁸ Brucellosis is a serious bacterial infectious disease. In pregnant women, if not treated, it can result in a miscarriage. In this and cases like it, MSF made efforts to find the patient through other means in order to ensure adequate treatment

V Public Health and Epidemiology

Turkmenistan is far from exceptional in its hesitance to report cases of infectious diseases, and it is known that many countries seek to minimize or underreport. However Turkmenistan arguably goes farther than most, to the extent that in 2004, according to the London School of Hygiene and Tropical Medicine, 'secret instructions' were said to have banned all mention of infectious diseases like TB, measles, cholera, dysentery and hepatitis.¹⁹ Moreover, although increasingly international standards and protocols have been introduced by the government, in MSF's experience, these are rarely applied or applied consistently. The result is a patchwork of prevention and treatment practices, unwillingness on the part of health care professionals to diagnose or treat infectious diseases and of patients to seek assistance, and the manipulation of statistics to avoid the appearance of problems.

Non-implementation of International Standards and Protocols

The failure to prevent, diagnose and effectively address public health issues appears to be evident at every level of the health care system. While the government publicly endorses evidence-based medical protocols, it fails to ensure their implementation. The following is a summary of some examples with which MSF struggled in Magdanly.

- Turkmenistan endorsed the Integrated Management of Childhood Illnesses (IMCI) in 2004. However, neither under the previous government nor the current one has this led to the application of evidence-based clinical practices in paediatric care. The medical knowledge and understanding of health professionals is worryingly low and harmful practices are still widespread in paediatric care, made all the more shocking by their consistency.
- The National Safe Motherhood Programme was adopted in 2007, but despite the involvement of international agencies in supporting its development and implementation, in MSF's experience, large gaps still exist. While pregnant women are theoretically entitled to free antenatal care services, numerous user fees are still in place. Consultation fees (formal and informal), associated laboratory testing including screening for sexually transmitted infections, and even the cost of basic ferrous and folic acid supplements remain significant barriers to care for many women. Family physicians tend to have a low level of knowledge, and there are frequent instances of medication being prescribed and administered to pregnant women that are contraindicated in pregnancy. Furthermore, indications for Caesarian sections are poorly understood, surgical techniques are outdated, and medical staff are under pressure to keep the number of C-sections performed low.

¹⁹ Rechel and McKee, Human Rights and Health in Turkmenistan, London School of Hygiene and Tropical Medicine, 2005, p. 41.

- On paper, TB is taken seriously in Turkmenistan. In 2008 Prikaz #288 was adopted, implementing DOTS in Ashgabat, and since then further prikazes have been put in place to facilitate the implementation country-wide. However, in practice, old prikazes remain in effect, such as #313, which provides for 'seasonal treatment' of TB – a holdover from the Soviet era. After "2M rest," patients who complete DOTS treatment (both those who have sputum converted and those who have not) are automatically registered for seasonal treatment – Isoniazid and Rifampicin – given in the months of March/April and September/October. Patients are enrolled in this plan for up to five years. This dangerous practice puts patients at risk of drug resistance to the two most important TB drugs, Isoniazid and Rifampicin.

These examples are indicative of the lack of capacity within the health care system to implement improved practices and protocols effectively. While some of the blame can be laid on lack of adequate training and inadequate resources invested in the health care system, there are other factors that militate against any real health care reform.

Denial and Lack of Response to Pandemics – H1N1 and HIV/AIDS

The government's response to emerging public health risks is simply to deny any possibility that they might exist in Turkmenistan. While this does not prevent the implementation of some preventative measures, the follow-up is notably half-hearted. International organisations have contributed to this by uncritically reporting health statistics provided by the Turkmen authorities and failing to press the authorities to implement and adhere to international standards.

This was particularly evident in Turkmenistan's response to the advent of H1N1 or 'swine flu'. On November 4, 2009, the governmental newspaper Neutral Turkmenistan reported that there were no cases in Turkmenistan and stressed that serious measures were being taken to prevent the outbreak of the disease, including strict controls on travellers and special detection equipment at airports.²⁰ The government's official position is that there have been no cases in the country, and without independent information it is impossible to refute this. However its advent has revealed real fear in the population about health status and a lack of trust regarding the transparency of the government. This has surfaced in international articles and blogs, often with very strong allegations of government cover-ups.²¹

²⁰ Perhaps most widely reported was the government's decision to not permit Turkmen Muslims to attend the Hajj in 2009.

²¹ Influenzastan, a five part series. <http://www.neweurasia.net/tag/swine-flu/>. See also Washington Post, In Ukraine, H1N1 pandemic sets off panic and politicking, November 21, 2009. <http://www.washingtonpost.com/wp-dyn/content/article/2009/11/20/AR2009112004023.html?sid=ST2009112004284>

The management of H1N1 also serves as an illustration of the failure of international actors to effectively address public health issues in Turkmenistan. The government public education campaign (published in Neutral Turkmenistan) included recommendations for prevention, including taking vitamin C and adaptogen drugs or cyclopheron, α -interferon as a nasal ointment and oxaline ointment. Research done by MSF indicated that these were protocols used for influenza during the time of the Soviet Union, but certainly do not correspond with WHO protocols for treatment.²² However, when this was discussed with WHO in a meeting on November 13, there appeared to be no plan to raise this with the authorities.

Moreover, WHO remained silent in the face of government claims that there were no cases in the country, despite their knowledge that there was an outbreak of respiratory disease (with flulike symptoms)²³ and that no testing was being done – diagnostic tests had not arrived in the country and no laboratory technicians had been trained. As of March 21, 2010, the government of Turkmenistan continued to report the complete absence of cases of H1N1 in the country, as taken from WHO external records.²⁴

HIV/AIDS remains the most 'invisible' of diseases. The change in leadership did not affect its core message, which is, that there are no cases of HIV in Turkmenistan. However, now it is now delivered with the reassurance that, "if there were HIV positive individuals in Turkmenistan, then they would, of course, receive treatment according to international standards."²⁵

A study released in 2008 of blood services in four Central Asian health systems reported serious problems in the testing and use of blood products,²⁶ adding that the greatest increases are found among injecting drug users, a problem that Turkmenistan shares.²⁷ Unlike these countries, however, Turkmenistan has not reported any new HIV infections in the last three years and has not performed sentinel surveillance.

*By the end of 2006, Turkmen authorities had reported a cumulative total of just two HIV cases, one of which developed AIDS and died. Almost no other national data are available... Unofficial reports indicate a substantial and unaddressed epidemic in progress.*²⁸

²² Patients who have severe or progressive clinical illness should be treated with oseltamivir. Treatment should be initiated as soon as possible. See WHO, Clinical management of human infection with pandemic (H1N1) 2009: revised guidance, page 6, November 2009.

²³ Warden Message US Embassy Ashgabat, Turkmenistan November 3, 2009 http://turkmenistan.usembassy.gov/warden_information.html

²⁴ <http://www.globalhealthfacts.org/country.jsp?i=110&c=216&cat=4&sn=1>

²⁵ Meeting with Mr. Serderov, Minister of Health, May 2009.

²⁶ Blood Services in Central Asian Health Systems: A Clear and Present Danger of Spreading HIV/AIDS and other Infectious Diseases. Global HIV/AIDS Program, World Bank. May 2008. <http://siteresources.worldbank.org/INTECAREGTOPHEANUT/Resources/cabloodbankstudy.pdf>

²⁷ World Health Organization, Regional Office for Europe. Turkmenistan – HIV/AIDS Country Profile. http://www.euro.who.int/aids/ctryinfo/overview/20060118_47.

²⁸ WHO Country information, updated 19 June 2008. http://euro.who.int/aids/ctryinfo/overview/20060118_47

The impossibility of Turkmenistan having had only two cases of HIV/AIDS, as per their official reports, is widely recognised. Surprisingly, however, this has received relatively little attention from the international community, and the government's neglect of the issue is rarely directly addressed. For every comment on the WHO website such as the above, there is a bland and reassuring statement from UNICEF such as the following:

*Although Turkmenistan is a country with a low level of HIV/AIDS (one case of HIV reported in 2004), the government recognizes that it must remain vigilant if it is to protect the country from becoming yet another casualty of this illness.*²⁹

As in the case of H1N1, government efforts to prevent the spread of HIV are insignificant. For example, in 2005 the government adopted a national programme on HIV, however in Magdanly, MSF observed that HIV testing was extremely difficult to procure. Rapid tests were not available in the hospital laboratory, and although MSF was told that the tests were being carried out at a laboratory one hour away, teams rarely saw transport of test samples or records of results being returned. In addition, although HIV prevention of mother-to-child transmission (PMTCT) training was provided in 2008 and 2009, and despite WHO reports that it had been rolled out throughout the country, resources have not been allocated to hospitals for its implementation. It was only in March 2009 that anti-retrovirals (ARV), essential agents in preventing mother to child transmission and in treating HIV, were added to the country's essential drug list. Tellingly, these agents were not explicitly referred to as treatment indicated for HIV infection but rather as 'immunomodulators'.

Management of Blood Products

Most dangerous, however, not only for the spread of HIV but also for other diseases, is the management of blood products. National health directives explicitly state that all blood is to be checked for Hepatitis A, Hepatitis B, Syphilis, Brucellosis and HIV. In practice, however, blood is often taken from relatives directly, without being tested. Although officially identified blood donors are to be tested every three months for possible infections, MSF observed that this was not systematically done and suspected that results were being falsified or not recorded. The more vigorous that MSF became in recommending alternative treatments, or at least practicing safe transfusions, the more frequent were the attempts to hide them from the organisation's staff.

²⁹ UNICEF. Turkmenistan – HIV/AIDS country profile. http://www.unicef.org/turkmenistan/hiv_aids.html

A boy came for a consultation because he has been sick for months, initially with jaundice and all the time tired. There is no diagnosis known to the parents. He got 9 blood transfusions – including one from a “successfully treated child”. Upon examination the boy has still jaundice and increased lab tests for liver functioning showed liver impairment suggesting suspect Hepatitis. No testing for Hepatitis was done. November 2008

Even hospital staff members among the donors asked that their positive status for such infections be hidden.

One doctor is found positive for Hepatitis B and C. He is a known blood donor. The doctor was telling us that they do not always follow the official transfusion procedure. That means his blood was not always tested before giving to a patient. Also concerning is the way of these transfusions: They take with one syringe blood from a donor and transfer it immediately to the recipient. That procedure is repeated by using the same syringe for this recipient all the time. Later we found that this doctor... has no record of any donor testing at all. March 2006

Throughout its intervention MSF struggled with the issue of transfusions and the lack of testing for HIV of blood products. Training was provided and concerns were raised at all levels in the hospital and in the local Ministry of Health. When this failed to make change, the issue was raised at higher levels. Concerned that its continued involvement would encourage the belief that blood products were being safely and responsibly managed, MSF finally withdrew its support entirely from this process on the grounds of medical ethics.

Tuberculosis

Unlike other diseases, the government of Turkmenistan not only recognises the presence of TB in the country but also has substantial programmes and plans for addressing the problem. This has included ambitious applications to the Global Fund for funding TB programmes in the country.

Indeed, in recent years Turkmenistan has been credited with ‘substantial progress’ in TB treatment and has been praised for publishing some health data including the incidence of TB.³⁰ However, information is still contradictory. Both, Turkmenistan and the WHO, report consistently declining prevalence rates, decreasing each year to 75 cases per 100,000 people in 2007, the last year for which data is available. However in their application to the Global Fund in 2009, the Turkmen MoHMI

cites a much higher prevalence of 115 cases per 100,000 people per year.³¹

Moreover, the government’s reported cure rate of 84.8 per cent for smear positive new cases clashes with their own reported resistance rates in their recent reapplication to the Global Fund, Round 9, quoting 20.9 per cent of new smear positive cases and 33.9 per cent of previously treated cases as MDR. These figures for drug resistance contrast with what is officially recorded in the WHO TB Surveillance reports.³² These surveillance reports refer to the drug resistance survey done by MSF in 2002 which report levels of 3.8 per cent and 18.4 per cent respectively for new and previously treated cases. The more recent figures submitted to the Global Fund indicate an extremely high level of drug resistance and demonstrate how severely the situation has deteriorated in a short period of time. These results demand urgent response.

MSF currently supports a TB programme in Uzbekistan on the border with Turkmenistan where approximately 40 per cent of new sputum positive TB cases are diagnosed as MDR/XDR cases and only 30 per cent are fully susceptible patients.³³ At the moment in Turkmenistan there is no national protocol for the treatment of MDR-TB and what MSF has witnessed in practice are ad hoc attempts to prescribe any second-line medications that are available. Patients who fail treatment are diagnosed as ‘chronic’, and it remains unclear what, if any, services are available to them and how infection control is managed. MSF expects rates of infection in Turkmenistan to be similar to or worse than those in Uzbekistan.

TB and MDR-TB is arguably the most urgent public health issue in Turkmenistan, but the government has been consistently unwilling or unable to take real steps towards addressing them. The most recent application to the Global Fund proposes to enrol the first patient only in year three of the programme, which means that patients would not start receiving treatment until 2012 at the earliest. Moreover the contrast between the amount of money allocated to construction projects in Ashgabat alone and the lack of national funding committed to TB treatment gives an indication of how low the issue ranks on the national agenda. This is evidenced by the fact that, despite having already been rejected twice for funding by the Global Fund, the government of Turkmenistan continues to apply for external funding rather than changing the prioritization of its own resources. At the same time, the president announced in January that in 2010, all together, \$23.6 billion of Turkmenistan’s state budget of a reported \$75 billion will be used to fund hundreds of buildings all over the country in the next two years.³⁴

³⁰ Rechel and McKee, “The Effects of Dictatorship on Health”, BMC medicine 2007, p. 9. <http://www.biomedcentral.com/1741-7015/5/21>

³¹ It has been assumed that one of the reasons for the failure of Turkmenistan to receive Global Fund support, unlike other countries in the region, is the lack of transparency in its reporting.

³² WHO, Multidrug and extensively drug-resistant TB (M/XDR-TB), 2010 Global Report on Surveillance and response.

³³ MSF Mycobacteriology Laboratory Nukus, Karkalpakstan, Uzbekistan 2008

³⁴ Turkmenistan News Brief, Issue 3 2010, <http://www.eurasianet.org/resource/turkmenistan/newsarchive/>

VI Conclusion

Over a decade of working in the country, MSF experienced the Turkmen health care system as critically flawed by a lack of transparency from the point of delivery to the reporting of data. While hospitals, health houses and health posts are wide spread, MSF observed that access to them is restricted by stigma and the fear of the consequences of illness. Increasingly, international protocols and standards are formally introduced to the country, but in MSF's experience these are rarely implemented. This has a significant impact on quality of care.

Indeed, practices witnessed by MSF in the country are likely to be creating more health problems than they address. The failure to effectively address or even acknowledge the existence of communicable diseases such as TB (including MDR-TB), HIV and sexually transmitted infections is most likely compounding and expanding existing problems. Furthermore, the failure to collect and disseminate epidemiological information in a transparent way means that the government and the international community have no accurate picture of the health situation of the population of Turkmenistan. Given the prevalence of drug-resistant TB in neighbouring countries, MSF fears a looming TB crisis in Turkmenistan. Without an immediate and significant intervention, this will lead to a major medical and health crisis in the country and could have broader regional implications.

The change of regime since Berdimuhamedov came to power has not resulted in improvements to the health care situation in Turkmenistan, and despite the appearance of greater openness, real change has failed to occur. Rather, a closer engagement with the international community is serving only to mask the continuation of old practices, the entrenchment of corruption in the system and the manipulation of data.

The role of the international community in situations like this is to insist on transparency and to push for implementation of international standards. This is not happening. Instead, by remaining silent in the face of government misinformation, international organisations are allowing themselves to become complicit in the problems.

Key Recommendations

Among the myriad problems encountered by MSF during its work in the country, the following issues need most urgently to be addressed:

- Rapid diagnosis and treatment of drug-resistant TB should be implemented immediately, with international experts as direct implementation partners.
- The failure to test blood products for Hepatitis A, Hepatitis B, Syphilis, Brucellosis and HIV must be urgently investigated, and national directives implemented without delay.
- International organisations must stop reporting data that is contradictory as fact and should take the responsibility of actively promoting transparency in the health system.

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