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Education and debate

Understanding health care in the south Caucasus: examples from Armenia

Tido von Schoen-Angerer

Along with sociopolitical and economic problems, the medical poverty trap in the south Caucasus region exacerbates its health problems

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Health care in the south Caucasus has suffered as a result of the socioeconomic decline that followed the collapse of the Soviet Union and the ensuing—still unresolved—conflicts between Armenia and Azerbaijan over Nagorno-Kharabakh and between Georgia and its breakaway republics Abkhazia and South Ossetia. As in most parts of the former Soviet Union, these places have increasing cardiovascular mortality, a high burden of mental illness, and spreading infectious diseases such as tuberculosis, sexually transmitted infections, and HIV.^{1 2} However, the widespread underreporting in dysfunctional and collapsing health systems leaves considerable uncertainty about actual figures.³

Collapse of healthcare services

Access to health care and the role of the state as health-care provider are open questions in the south Caucasus. Instead of questioning and contributing funding to the extremely low government health budget of about US\$10 (£5.4; €8.1) per capita—as low as in many sub-Saharan countries in Africa²—the World Bank has explicitly encouraged health reform that aims to contain healthcare spending and reduce the state's role in healthcare delivery.⁴ It promoted introduction of user fees for public services in Armenia

and Azerbaijan and of health insurance in Georgia. Although efforts to reform a vast and hugely inefficient system are laudable,⁵ they are insufficient to compensate for the lack of state health funding, which exacerbates the medical poverty trap.^{6 7}

Healthcare services are in a state of almost complete collapse. This is obvious in the state of many health facilities, especially in rural areas, where collapsing buildings remain unheated during extremely cold winters; even the most basic supplies of drugs and materials are lacking; and healthcare staff are expected to provide services for monthly salaries around \$10 for nurses and \$30 for doctors, if they get paid at all. Not surprisingly, health staff supplement their meagre wages through “under the table” fees.⁸ State funding is not even sufficient to assure guaranteed free services for vulnerable groups⁹: in a household survey of 259 families done in 2003 in two rural regions in Armenia, 42% of sick household members reported that they did not seek care, mainly because of cost.¹⁰ Hospital admission incurred catastrophic costs: most families had to go into debt or sell property. In Tbilisi, Georgia, 49% of sick household members surveyed did not seek care, mainly because of cost,¹¹ and in Azerbaijan the figure was 37%.¹² Armenia and Georgia had the poorest access to health care in a comparative assessment of eight former Soviet republics (Georgia, Armenia, Kazakhstan, Ukraine, Moldova, Kyrgyzstan, Russia, and Belarus).¹³

Community insurance models, such as the drug revolving funds (community insurance schemes covering basic drugs) initiated by Oxfam,¹⁴ cannot solve the access problem as they cannot raise enough money from the impoverished population to protect against catastrophic costs from chronic diseases or hospital admission. The role of the state and public spending on health urgently needs to be increased, to beyond the targets set out by the World Bank's poverty reduction strategies.¹⁵

Approach to medicine and public health

Clinicians in the former Soviet Union have developed distinct treatment approaches and do not share the Western paradigm of evidence based medicine.¹⁶ Diagnostic criteria are often different, and many drug treatments and physical therapies (x rays, electric fields,



Stigma and isolation are two of the main problems for people with mental illness and their families: woman with psychotic disorder in her home (credit: German Avagyan 2003)



Fig 1 The south Caucasus region

etc) are unheard of in the West.¹⁷ Generally, treatment methods from Soviet times tend to involve many—often obsolete—drugs, long treatments, some of the highest use of injections in the world, and lower thresholds for admission to hospital and surgery.^{18 19}

Doubtless there is reason to acknowledge an important medical tradition and its many accomplishments. However, overdiagnosis, avoidable operations, and overprescription of drugs are not only harmful, putting patients at risk of adverse reactions and leading to drug resistance,¹⁶ but they also make health care even less affordable and contribute to the medical poverty trap. The objective is not to make medicine everywhere the same or to insist on international norms but to make medicine more patient friendly and accessible.

Beginning with the suspension of the Hippocratic oath at the beginning of the Russian revolution in 1917, the Soviet state interfered and “de-professionalised” medicine, emphasising the doctor’s duty to defend the interest of the state rather than of the individual.²⁰ When the Soviet empire collapsed, some doctors welcomed the opportunity for change,²¹ but many others, especially those with sanitary-epidemiological training (the Soviet equivalent to public health), have remained nostalgic about the old methods, which assured efficient disease control but neglected human rights.

Today, disease control and the public health functions of the state are ambiguous and highly problematic: while the preference for a controlling and penalising public health approach is ever present, there is a lack of means and too much corruption to enforce it. All too often, control mechanisms have become perverse instruments to extort bribes, rather than delivering a public good.

Sexually transmitted infections

The situation of sexually transmitted infections illustrates the ethical issues in disease control and some of the differences in clinical approach. In Armenia, doctors are still required to report the names of people with sexually transmitted infections to relevant authorities, and the criminal law adapted in 2003 can enforce up to two years’ imprisonment for avoiding treatment of venereal diseases. As in Russia, the concept of confidentiality is still poorly understood among doctors and accorded little priority.²² Sex workers are regularly rounded up by police for forced testing and treatment.²³ Syphilis, one of the most strictly controlled diseases

during Soviet times, is still treatable only in specialised, inaccessible centres, which receive government funding for lengthy inpatient treatment (even latent syphilis is treated). Current guidelines for treatment of sexually transmitted infections have not yet abolished many old, complex methods such as autotransfusion of radiated blood, immunotherapy including interferon, “pyrotherapy,” thymus substances, and substances derived from cerebral cell cultures.²⁴

Discussions with patients and healthcare providers reveal that anonymous treatment is available, but under the table payments are high; doctors thus have a financial interest in maintaining the threat of name reporting and treatment enforced by the police and the image of sexually transmitted infections as diseases that are hard and lengthy to treat. During Soviet times coercion was strong enough to detect cases and bring patients into care. Today, the climate of fear and intimidation prevents patients from coming forward for fear of repercussions and—as in Azerbaijan²⁵—reported sexually transmitted infections are but the tip of the iceberg. In addition, prevention is not given priority, and local doctors are slow to adapt to proved methods of prevention and control.

In an attempt to encourage people to present to healthcare services for testing and treatment for sexually transmitted infections, Médecins Sans Frontières set up services to provide free and anonymous treatment. Clinics were set up near a big market in Bagratashen and Sadakhlo at the Armenia-Georgia border and in Giumri, the second largest city, both of which had high rates of prostitution. Initially, national health authorities were not in favour of the project.

The services supplied by Médecins Sans Frontières are better attended than the nearest specialised centres, and interviews indicate that patients value the services for being both free and anonymous (box 1). The Armenian health staff of the independently functioning clinics have embraced the new approach, but one venerologist employed at the clinic had to be dis-

Box 1: Views on care for sexually transmitted infections in northern Armenia, December 2003

- “In a state hospital you pay the state fees and extra for the doctor. It is impossible to pay these fees, so there is no point going. Look at how we are living here!” Local Armenian woman
- “Last year I was examined by the venerologist at the local [state run] policlinic and was diagnosed with syphilis. The doctor offered me two options: either to agree for payable treatment or police will bring me for treatment with disgrace. The treatment cost was 200 US dollars!” Local woman
- “People who get sexually transmitted infections in Armenia are stigmatised, both by the community, but especially by the medical community. We want to tell doctors that it is not necessary to shout these people’s names all over the street. That doctors shouldn’t judge.” Local healthcare worker
- “The fact that this clinic is anonymous attracted me. If I go to state services, all the people who are surrounding me will be informed about my disease, the police will too, and I will have problems after that.” Armenian woman presenting to the MSF clinic

missed because he continued to provide information about patients to the police in order to make them “aware of what is going on in their district.” Clinic doctors have raised concern that single dose treatment with drugs such as cefixime and azithromycin, as recommended by WHO, might be insufficient.

National authorities must understand that respecting patients’ autonomy through an anonymous and voluntary approach is not only necessary and possible; also it is a more efficient approach to disease control that can increase health seeking and result in more accurate health statistics. Change across the Armenian healthcare system for treating sexually transmitted infections is feasible but will require political will, which has been lacking so far: the minister of health hasn’t responded to a call by Médecins Sans Frontières and other organisations in March 2003 asking for policy change with regard to sexually transmitted infections. A radical shift in approach is needed to abolish reporting of names, establish simple and realistic treatment protocols, put greater emphasis on prevention, and work across sectors with the ministries of the interior and justice to overcome the penalising approach. With HIV rates rising exponentially across the former Soviet Union, these basic issues must be resolved urgently.

Slow steps forward in psychiatry

A distinction should be made between a controlling public health approach and blatant abuses of human rights. During Soviet times psychiatry was used to punish dissidents.²⁶ Emphasis was on large mental institutions—as was also the case in Europe and North America until only a few decades ago. Mental health services were affected disproportionately to other health services when the Soviet Union collapsed, and hospital conditions deteriorated further. In 1995, in the psychiatric hospital of Vardenis, Armenia, on winter mornings after there had been electricity cuts (resulting in no heating) at night, dead bodies were carried outside, thrown over the hill, and left for the animals. Nurses handed out the same drugs to all patients indiscriminately, and patients were beaten when they became agitated.

Since then, many improvements have occurred in the region, thanks to the initiatives of different organisations (such as the Geneva Initiative on Psychiatry) and greater awareness by local health authorities, but the situation is still dire for many patients. In a context where most people live with their extended family, stay in hospital becomes indefinite when families refuse to have the patient return home. We found that people with mental problems living outside institutions in Armenia are often more vulnerable than those living inside (box 2).²⁷ Entire families are isolated from the community because of stigma; patients are hidden away, their health care reduced to renewal of drug prescriptions—if there is money to pay for them. Mental diagnoses often continue for life without review, and lack of confidentiality further contributes to the extreme stigma that people with mental illness experience in this context.²⁸ Clinical psychology and social work in the Western sense were non-existent during Soviet times, and there is still little experience and hardly any resources.

Box 2: Stories obtained from mental patients in Armenia, December 2003

- A 26 year old woman lives with her mother in a 10 m² room in a refugee hostel in Tchambarak, a little town in the mountains. Winters are long, with temperatures below –30°C. The only things they have are two old beds with one blanket each, a little table, an old television, and a bookshelf. They receive a monthly pension of \$8 and once a day a meal, provided by a charity soup kitchen. Although she is psychotic, the daughter had never visited a psychiatrist, nor had her mother, who is also suffering from mental problems. During working days, the daughter now visits the MSF day centre in Tchambarak, where she knits and draws, and where she can feel at home.
- A 15 year old girl has learning difficulties and has signs of autism. Her parents are not really poor but have decided that they do not want to spend any money to buy medication or to let her visit a psychiatrist. For them, she is a punishment from God and the less she is at home the better.
- A 56 year old woman was diagnosed with schizophrenia in Russia, where she last had a consultation with a psychiatrist 15 years ago. Her son lost his eyesight at the age of 13 when a shell hit their house during a bombardment. Since then he has been “nervous” and sometimes behaves aggressively. He has not left his bed for more than 10 years. The mother takes medication and gives the same to her son as she does not see how else she can help him.

The Armenian ministry of health has recently recognised the importance of deinstitutionalisation. Médecins Sans Frontières started a joint pilot project with the ministry offering free psychiatric care through a multidisciplinary team approach (including psychiatrists, psychologists, and social workers) in a newly created mental health centre in Sevan and ergotherapeutic activities in day centres. This approach is more patient centred and more holistic and many patients show considerable improvement. Attendance by patients with schizophrenia is good, but few people with depression, anxiety, or personality disorders attend, probably because of fear of stigma. Many obstacles to deinstitutionalisation still exist: psychiatrists have a very low threshold for hospital admission as they are held legally responsible for any misdoing by their patients. The lack of alternative housing such as supervised apartments prevents discharge of patients when families refuse the patient or have—illegally—sold the patient’s apartment. Still, improving outpatient mental health care is a precondition for reducing institutionalisation.

Conclusions

Access to health care in the south Caucasus is a priority issue. As long as most people are too poor to afford user fees or insurance, the role of the state as a health-care provider should be strengthened rather than weakened.

The current healthcare system is jeopardising health and rights of people in the south Caucasus: controlling and penalising people, and prescribing avoidable and unaffordable treatments to patients, should become things of the past.

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Summary points

The widespread collapse of the healthcare system and unaffordable out of pocket costs have led to poor access to health care in the south Caucasus

Important differences in the clinical approach between the former Soviet Union and the West should be acknowledged, but many practices are harmful and contribute to making health care unaffordable

The preference for the Soviet style, which controls public health approaches in a collapsing and corrupt healthcare system, raises ethical and efficiency questions

Foreign assistance to the region must focus not only on reform but also on funding essential services and should no longer advocate market mechanisms in the healthcare system

Placing the interest and rights of the individual patient at the centre of attention is key to achieving changes in public health and clinical approaches

Contributors and sources: TvS-A is a paediatrician and has worked for Médecins Sans Frontières in Armenia and in Nagorno-Kharabakh in 1995-6 and again since 2001 and has travelled widely in the south Caucasus.

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One hundred years ago

Quackery and baldness

Bald heads have long been happy hunting grounds for quacks; there is no kind of advertisement with which readers of newspapers and magazines are more familiar than those vaunting the virtues of "hair restorers" of one kind or another, and inviting the public, as Hamlet did his mother, "to look upon this picture, and on this." In the one is shown an individual whose pate is a "bare ruined choir"; while in the other, his head is covered with a fell of hair which, if roused and stirred by a dismal treatise, would look like Birnam Forest on its way to Dunsinane. It would be unwise to accept those pictorial representations with too easy a faith. Advertisers use many dainty devices to push their wares, and the use of faces as well as names can be bought for a price. Sometimes, indeed, your advertiser will, like Molière, take his property where he happens to find it. Only the other day an enterprising vendor of a specific for obesity had to stand, figuratively, in a white sheet for having, with more ingenuity than

righteousness, used the portrait of a lady of a certain age to illustrate the condition of a patient before the use of his nostrums, and the portrait of the same lady when a young girl to show the effect of the treatment. The incurability of what may be called essential baldness in the present stage of knowledge is admitted by all scientific practitioners. Sabouraud says, uncompromisingly, that we cannot cure baldness, nor restore hair to denuded scalps. Our helplessness in the matter is due to our ignorance of the etiology of the disease. Among the causes that have been assigned are time—the subtle thief of youth, which steals the hair with other juvenile adornments; brain-work—an etiology which commends itself chiefly to bald-headed men; the "arthritic" diathesis; dissipation; a sedentary life; cutting the hair too short or wearing it too long; a too carnivorous diet; the use of heavy, unventilated hats; that universal scapegoat alcohol; and the inevitable microbe. (BMJ 1904;i:205)