Elective Report

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Introduction

Mongolia is a unique country. From the aeroplane window we were welcomed with breathtaking views of sparse plains covered in red sand, gentle rolling hills, rugged snow topped mountains and shockingly blue skies. Infrequently scattered across the changing landscape were white Gers, which are nomadic tents and the traditional homes of many Mongolians.

We started our elective at Nalaikh district hospital, an hour bus ride from the capital, Ulaanbator. Nalaikh is a rural small town consisting mainly of dirt roads and little running water. The hospital was built during the time of Soviet aid, in the centre of the town. Its rundown exterior towered over neighbouring small buildings, dilapidated flats, outhouses, Gers and the occasional farm animal. The interior of the hospital was a stark contrast to its overpowering shell. It was meticulous, spacious, well-lit and roomy. The wards were spotless but minimal, with basic beds, no furniture and little in the way of medical equipment. The medical cabinet was similarly sparse. Drugs for inpatients were prescribed by ticking boxes on a very limited list of drugs, which fit comfortably onto one side of A4 paper.

Uvurkhangai hospital was more rural, but not dissimilar to Nalaikh hospital. Both serve well to demonstrate difficulties at hand in Mongolia. Mongolia is a poor country (classed as a Lower Middle Income Country, OECD, 2011) with rudimentary infrastructure and basic health facilities. Yet, it is also rich in natural resources, potential and hope to embrace a western-style democracy and healthcare standards. Whilst there, the doctors in both hospitals demonstrated tremendous resourcefulness, resilience and outstanding clinical knowledge.

Describe the pattern of health provision in Mongolia and contrast this with other countries, or with the U.K.

Both hospitals were funded, built, stocked and maintained in the time of Soviet aid. Following the decline of the USSR, the country faced an abrupt cessation of financial assistance and had to face a rapid transition from a centrally-planned economy to a market one. In the 1990's Mongolia was thrown into a deep and long economic recession that lasted nearly a decade. Health care infrastructure, medical resources, fuel and other amenities suffered greatly (Manaseki, 1993).

During the Soviet era Mongolia did not manage to attain the socioeconomic development required to sustain a westernised health care system. Soviet assistance at its height was one third of Mongolia's GDP. The country currently receives official development assistance (OECD, 2011) with a GDP per capita of $3,522 (2009). Its total expenditure on health was 4.7% of GDP as of 2009, compared to the United States' 16.2% (World Health Organization, 2009).

There are two main problems facing current Mongolian health care system: a lack of funding and marginal preventive medicine. Mongolia is also a large country with sparse human habitation. The rural hospitals serve small populations in districts that cover vast distances, posing problems with access. In Uvurkhangai, Preeclampsia occurs in 30% of pregnant women, nearly all of whom reside a notable distance away from the main hospital. There seemed to be no formal process of screening women hypertension or proteinuria. The reason for this was largely explained to be due to problems with appointments and follow up. It is typical for ger-families adopting the nomadic lifestyle, to rehouse upwards of four times a year. Hence, it is continual challenge to establish continuity of care in this large group of the population.

The pattern of disease / illness in Mongolia, discuss this in the context of global health.

In both hospitals, the day would start off early with a flood of patients registering to be seen. Many had travelled from distant settlements, across difficult terrain. Altercations were common, with individuals arguing and pushing to get appointments. In clinics, patients were frequently interrupted by others, impatiently entering the consultation and reluctant to leave before being seen.

Most consultations focused on the treatment and cure of immediate injuries and physical illness. Unfortunately, due to diet, lifestyle and quality of living, the majority of treatments provided only brief relief to more complex problems. This was a frustration expressed by many doctors. Cardiovascular risk is a key example of problems faced through lack of public health awareness. Hypertension is very common in the country; by a person's fourth decade, cardiovascular disease is almost endemic. This is especially the case with the nomadic Mongolian population. Many attribute this pattern of disease to the staple drink, milk tea, which contains yaks milk, butter and salt. Mongolian nomads start drinking this in early life, often following weaning. People can drink large quantities throughout the day, as a replacement for water. The high salt and fat intake is compounded by a heavy meat and dairy diet. Vegetables do not feature frequently in dishes outside of the capital city.

Seasons also shape Mongolian life and wellbeing. We visited at the end of spring, which is a crucial time for Mongolians. Weather at the beginning of spring can be cruel and unforgiving. If is often dry, dusty and windy. It is the time when weaker animals die and it is believed when people die also. This is particularly the case following a prolonged, harsh winter. The dry climate and difficult terrain contribute to a lack of vegetation, leading to a diet with limited fruit and vegetables but rich in red meat, dairy products and animal fat. Limited food

sources cause a number of vitamin deficiencies amongst children. Cases of rickets, osteomalacia and neural tube defects were not uncommon.
An issue Mongolia faces is neglect of preventive medicine, thought to be partly the result of the soviet model. Stalinist purges on religion led to a ban on Tibetan – Buddhist medicine and instead Mongolia had a policed westernised healthcare system. With the loss of traditional medicine, Mongolia lost thousands of years of accumulated self-care knowledge which strongly centred on a biopscyhosocial balance, health, wellbeing and nutrition. Many health professionals feel that the country lost an appreciation for awareness from one's health at this time, as well as community responsibility (Baabar, 1999).

Explore the practice of traditional Mongolian medicine / Buddhist – Tibetan medicine existing in Mongolia today

Traditional medicine in Mongolia is shaped by two spiritual concepts; shamanism and Buddhism. Despite soviet restrictions, these beliefs have done much to shape Mongolian culture and social practice.

Two of a shaman's main functions are to cure sickness caused by soul straying and accompany souls of the dead to the next world. The shaman has special medical and religious powers as an intermediary between a spirit and human world. They communicate with spirits during drunken trances, often lasting for many hours.

Tibetan Buddhist spiritualism appears to have less of an influence in the management of illness. Despite 80% of Mongolians belonging to the Buddhist Mahayana faith (as practiced in Tibet) Buddhism was nearly destroyed in 1937 when communist government wiped out 700 monasteries and massacred 30,000 monks. Until 1921, traditional Buddhist- Tibetan medicine had been the sole basis for healthcare and mainly practiced by Buddhist monks (Loizzo, 2009). Post 1990s, investment and expansion in this area has benefited the country in terms of preventative medicine and also in preserving culture and national identity.

In isolated settings, throughout soviet rule, shamans still played a significant role in the management of health issues, largely implementing Tibetan Buddhist influenced practice. Traditional medicine was fascinating to study from a western perspective, but also frustrating practically. In Nalaikh district an endocrinologist from Spain struggled to teach basic life support to medical figures of disseminated communities. She found participation was limited and students were reluctant to learn new concepts. The crux of the problem was a strong belief in the concept of karma. Karma suffices when traditionalist medical figures explain the cause of death. I had first had experience of this problem when a middle aged man died of a myocardial infarction out in the steppe and also when family member tried to explain the reason their children suffered from Rickets.

Funerary rites are also beginning to change, especially in the remote Mountainous region in Mongolia's West Country. Up until the early 20th century Mongolians typically disposed of their dead in a process similar to the tradition of Sky Burial common in Tibet. Russians

forbade the practice, and as such Mongolians reverted to cremation or burial. Sky Burial involves leaving the body out in an elevated area, where birds and wild animals can dispose of the body. In the post-communist era, there has been an increase in Sky Burials as this act is seen to be the best way to return a body to the natural world, whilst the soul can be reincarnated into another living object.

Help establish and participate in the English teaching programme

The most enjoyable aspect of working in the hospitals was establishing the English teaching programmes for the doctors. This was achieved in partnership with the charities medics2mongolia and GoHelp. Enthusiasm for the project was touching and encouraging. It marked a significant difference in the general approach to learning, as compared to the resource rich U.K. The overall aims of the project are split, depending on the level of English and the lesson groups Doctors were assigned to. The basic groups have the final goal of writing a medical CV in English, whilst the advanced group are focusing on submitting applications for international finding, bursaries, equipment, presentations at international conferences and publications in English.

A number of medical students across the UK and from Australia will be visiting the hospitals throughout the year on their electives, implementing lessons and carrying on with the projects. Our spare time was spent establishing the aims and objectives of the project, assessing the need and level of English, gaining access to translators, translating documents and sourcing ambassadors for the project at different hospitals.

GoHelp has an office in Mongolia and community projects across the country, a few of which are in Nalaikh. Whilst there, we also helped with first aid teaching to children at the local book house project.

Conclusion

On a national level, a number of projects are being implemented to help support and reform the system, such as the GoHelp – M2M teaching project. Numerous satellite projects are also supporting the revival of traditional medicine and entrenchment of preventative care. Examples of this are the endocrinologists work in Nalaik and other projects such as the Nippon Method. This was a successful project and effective general health promotion strategy. The project supplied families with pharmacy kits of traditional medicines alongside health education. Doctors and families involved were trained via broadcast on national television. The confidence of Mongolian doctors improved with understanding traditional medicine and 64% of participants noticed a general improvement in their health (WHO, 2007).

Mongolia's medical system currently faces a difficult challenge. The country has limited resources and medical coverage is poor. Socioeconomic struggle and poor healthcare infrastructure present pervasive problems. Despite this, whilst in Nalaikh and Arvaikheer, I

was encouraged by the work ethic of the doctors and their passion for reinstating preventive and promotional health.

I was privileged to experience medical practice in two remote and challenging environments in Mongolia. We gained exposure to the struggle of practicing medicine with a lack of resources and also witnessed an unforeseen demand for fusion with traditional medicine. The experience broadened my outlook and expanded my clinical knowledge in an unpredicted way.

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