Natalie Wright: ha10289, 100032491

SSC 5c Elective Report

Mongolia is a developing country in Asia bordered entirely by super powers Russia and China. As such, Mongolian culture has been very much affected by its neighbours. It was only in 1991 that Mongolia abandoned communism and China's 'one-child-policy' in favour of a democratically elected government. Since then, the Mongolian economy has seen (slow) growth, literacy rates have improved, and health service reforms have improved access to healthcare in rural areas.

Geographically speaking, Mongolia is vast, with endless plains and desert. It is also a country at altitude, which endures sub-zero temperatures, as low as -35 deg C, for eight months of the year. The population is small at only 2.7 million people, making it one of the least densely populated countries in the world. Mongolian people traditionally lead nomadic lifestyles – rearing cattle with very little scope for growing crops given the hostile climate. Over the last few decades, however, Ulaan Baatar (the capital city) has grown both economically and in terms of its human population. Consequently, a second, urban culture has emerged. Today, over 50% of the population lives permanently in Ulaan Baatar, while the remainder continues to live in rural areas.

The spread and low density of the population poses real problems when it comes to providing a decent infrastructure throughout the country. Electricity supply is limited to larger towns and areas surrounding Ulaan Baatar, sewage systems outside of the capital are basically unheard of, and very few roads are tarmacked. All of this means that life outside of Ulaan Baatar is very basic, distances between villages and towns are vast, and overland travel is exceptionally slow. Consequently, providing good healthcare across the country is very challenging – especially in more remote, hard-to-reach areas.

Mongolia's current healthcare system is not dissimilar to our own, here in the UK. There are so-called family doctors in smaller communities who provide basic primary care. If patients require a higher level of care, then they have to attend the nearest hospital. Most healthcare is provided free of charge with payments only generally made for prescription medicine. The problem with this model in Mongolia is that patients may live up to 500 miles from the nearest hospital. This makes acute medical care very difficult to provide and consequently, the mortality rate for medical emergencies such as myocardial infarctions, acute asthma exacerbations, stroke…etc is much higher than in similarly developing countries.

On the positive side, there is a great deal of medical expertise in the community in general. This is particularly true when it comes to obstetrics. Women often give birth in the community with close relatives acting as midwives. As such, childbirth is much less medicalised than in the West, with far fewer pharmalogical interventions. This system works very well until there are serious complications and, for example, an emergency C-section is required. In this instance, women may journey for several hours over bumpy

terrain to reach the nearest hospital. Predictably, Mongolian maternal mortality rates around childbirth are higher than in neighbouring countries.

Once a patient successfully attends hospital, the level of healthcare provided is actually very high. There is only one medical school in Mongolia, situated in Ulaan Baatar, where the vast majority of doctors are trained. Medical degrees take six years to complete with subsequent training in a specific area of interest. Many students are multilingual, speaking Russian as well as Mongolian. These students tend to undertake part of their training in a Russian hospital once they reach a more senior level of practice. This all means that medical knowledge tends to be up-to-date and comprehensive in hospitals. (Family doctors, by contrast, spend much less time studying and rarely undertake training abroad.)

However, what Mongolian hospitals have in terms of medical expertise, they lack in terms of resources. For example, at Arvaikheer Hospital in the Uvurkhangai province, there is only one oxygen tank per department. When you consider that in the paediatric department, the majority of patients admitted are suffering with pneumonia and have reduced oxygen saturations, this really does mean that there is a shortage of basic resources.

A further challenge of the provision of healthcare in Mongolia is that patients tend to present late. Given the distance that they have to travel to hospital, they often self-medicate at home for a lot longer than recommended before attending hospital. Consequently, when they eventually arrive, their illnesses tend to have progressed a great deal and are correspondingly harder to treat.

At Arvaikheer Hospital, there is a large ophthalmology department where ophthalmic surgeons have been trained in India to carry out cataract surgery. Cataracts are the leading cause of blindness in Mongolia, so this provision is essential. Patients with cataracts, however, often do not present to the department until the cataract has progressed to such an extent that they are almost completely blind in the affected eye(s). As a result, the cataract itself is large and dense, and the surgery to remove it is much more difficult than it would have been had it been identified sooner. The upshot of this is that cataract surgery complication rates are high, and when they arise, the department may not have the necessary equipment or skills to adequately manage them.

This example highlights a real need for better equipment, and further, international training for medical professionals. There are two main barriers to this unfortunately. The first is money, and the second is language. The answer to the first problem may be found in the form of international grants and bursaries; however, it is generally necessary to apply for these in English. Knowledge of the English language, therefore, is a pre-requisite in this case.

As part of my elective in Mongolia, I provided English lessons to medical staff at both hospitals I visited. This was by far the most rewarding part of my placement. The doctors were very enthusiastic and committed to learning English, and I felt that I was able to provide something of real value in return

for them taking the time to show me around their hospitals. I completed my elective in conjunction with the charity Medics2Mongolia, which is committed to providing medical students with free electives in Mongolian hospitals where they provide English lessons to medical staff in return for their experiences of medicine in a foreign country. I only fully appreciated the value of this project once I arrived in Mongolia and could see how something as simple as learning English has the potential to help solve many of the problems facing Mongolian healthcare. I wish the project all the best for the future and am very pleased to have been part of its launch in Mongolia.