

Primary Health Care in Rural Mongolia: Health maintenance from a
Community Empowerment perspective
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Introduction

The health situation facing many of Mongolia's rural areas is dire. They suffer from a decaying health infrastructure, declining human capital and deleterious lifestyle choices. My research in Mongolia sought to catalog new challenges to health maintenance, understand the underlying causes and the opportunities for improvement. This analysis draws on the framework of social empowerment to identify the many layers of causation and how they interact from community perspectives (Israel et al., 1994). Competency at the local community level managing environmental and individual challenges has decreased since the democratic transition of 1991; a rural community's situational and individual characteristics for this are explored (Janes, 2004). I begin this analysis by describing the pre-democracy health system and the convergent forces leading to its disuse. I follow with an examination of the dramatic, simultaneous, degradation of the environment and health system service capacity. The community has been unable to cope with these changes which have led to loss of social networks, decreasing education and increasing competition for scarce resources. The break down in organized civil society following 1991 precipitated a corresponding break down in social services and the environment that in turn lead to a greater strain on civil society, creating a vicious circle of isolation, poverty and ill health.

The development of a new society

The Mongolian health system during Communism fostered dramatic improvements in health status. The rapid gains in life expectancy observed from the 1960s to the 1980s (from 49 to 66) are testament to this fact; the Asian Development Bank (ADB) assessed the national

health system in 1991 and reported “good coverage and good access of the population to health services in Mongolia” (Rossabi, 2000, p168). This was especially true in the countryside, where the Communist government made numerous attempts to support rural infrastructure and development. Using media propaganda and work holidays for students, rural areas received a continuous influx of both human and infrastructural resources. In addition, strong, centralized control for resource allocation at most local levels provided support for social services, like health. As Janes notes in his article on maternal mortality in rural Mongolia, during Communism if a mother had to be admitted to a maternity ward for observation, the collective leaders would ensure provisions for her family (2004, p241). When the Soviet States disintegrated, the heavy subsidies that allowed for such a system disintegrated too. The organizations, like the World Bank and the ADB, who came in to fill the gap eliminated the previous system completely, labeling it “unsustainable” (ADB, 1992).

The new system attempted to resolve the complex tensions between the current market economy and society’s expectations from a previous socialist state. However, these tensions have never been fully resolved. Though the Mongolian health system committed to provide highly equitable and accessible healthcare, it has actually become restrictive and unresponsive. In Renchinlumbe, where I carried out my research, this was demonstrated by a limit of one *bag feldsher* (rural health worker) per *bag* (sub-county administration level). Previously, many *bags* in this large *soum* (county) had two *felsdhers*. The *soum* health system was unable to deal with this deficit. The Ministry of Health’s Strategic Master Plan mistargeted the symptoms of the problem, and changed *soum* hospital duties, rather than addressing the root causes (Mongolian Ministry of Health (MOH), 2005). *Soum* hospitals have become outpatient focused and referrals are encouraged. However, given a lack of outpatient reporting or its requisite infrastructure

hospitals are still reimbursed based on their inpatient days served. This has created a confusing and often conflicted health system with no clear role.

The fault does not lie entirely with the national health system for the creation of a conflicted structure. The foreign donors responsible for supporting almost 30% of sector-wide spending also have shaped the environment of rural health systems (Mongolian MOH, Health Indicators 2004, 2005). Donors have invested most heavily in infrastructure. However, there has been very little success in integrating the needs of the community with this development. One example is in the provision of radios from the ADB to the *bags* in Renchinlhumbe. It has provided a needed link between the rural citizens and those in *soum* or *aimag* (state) centers but by basing distribution patterns using GPS coordinates, to provide theoretically equitable access to all those in the *bags*, one of the most powerful uses of the equipment was co-opted. Now, when someone has a medical emergency they are more likely to seek out the radio operator than the *bagfeldsher*.

Donors have actively resisted investing in rural communities. Unlike the Communist government, which viewed having a stable rural economy as central to maintaining a stable nation, the current donors are more problem-focused. The rural communities are isolated and sparsely populated so programs there are viewed as lacking power and cost-effectiveness. Additionally, some NGOs surveyed this summer view urbanization as an irreversible trend, though there has been no sound research done on this topic. Others provide epidemiologic evidence of the importance of focusing on areas with the most serious outbreaks of disease, often found in urban or especially the new peri-urban areas made up of mostly rural citizens forced to leave their countryside homes. Finally, the rural communities are quite unique in structure and this lack of understanding makes them a more challenging population to work with. This lack of

investment in a stable rural population has been the primary driving factor in the increasing migration to urban centers.

Consequently, the *soum* hospitals must manage the health of populations under increasing stress. Here, the Strategic Master Plan from the Ministry of Health has been helpful, developing the capacity of referral hospitals at *aimag* centers and even developing a new class of mid-level referral at some select *soum* centers (Mongolian MOH, 2005). However, these services have not been successfully integrated into communities. One of the greatest challenges has been lack of human resources. There is little incentive for health workers to work in the countryside. The majority of students graduating from medical school are from either the capitol city or from poor rural families and, therefore, saddled with debt. Even though the state offers a fiscal incentive to work in the rural areas, many are afraid to do so for reasons like failing schools, lack of continuing education, etc. The incentive is also insufficient for a student who had to pay for tuition and living expenses over 6 years, which makes it difficult for many rural students to return home. In addition, the new tasks for health management in the countryside require a range of skills not taught in school. In Renchinlumbe and Ulaan Uul the hospitals had no one trained in management, statistics or adequately in public health. Furthermore, *soum* hospitals lack diagnostic capacity outside of general physical assessment.

Access to services is perceived by community and provider alike to be quite low at the rural level. This perception was supported by Service Availability Mapping, a tool used by the WHO to assess access to services (World Health Organization, 2004). My survey also found a distinct difference between what is supposed to be offered at the local level and what is actually available. Basic tools like hemoglobin monitoring for those at risk of anemia are unavailable. The microscope was inadequate for anything except the most basic protozoan exams, magnifying

up to only 5x. This lack of even basic diagnostics and limited treatment capacity is another reason the community perceives the services offered at the *soum* hospital to be inadequate. This is supported by the hospital's own frustration at lack of support from the national health system.

The community's response

The decreasing investment to Renchinlumbe, in combination with increasing transportation costs, has made this *soum* increasingly impoverished. This has led to intense competition for resources among the still functioning social services. Health service providers particularly have failed to campaign effectively for funds, and over the past four years the *soum* hospital director has failed to obtain any funds for public health projects from the *aimag* health director. This adversarial system also manifests in the relationship between the school-lead health education program and the local health providers. They report constant frustration when attempting to collaborate with the school's health education teacher. Fears that a percentage of the money allocated to the school will instead be directed to the hospital in order to compensate for their participation. The Care Center at the government (equivalent to the US welfare office) also has failed to develop partnerships with anyone despite the Ministry of Welfare's apparent emphasis on this. As a result organizations in Renchinlumbe consider themselves quite isolated.

This lack of responsibility to higher authority has created a system susceptible to widespread corruption. For example, the *soum* to the immediate south, Ulaan Uul, had no existing government; they had apparently left after squandering their entire annual budget by May. This greatly complicates working in these areas, as governors have tremendous authority over all official projects operating in their *soum*. It is also only through the governor that official requests for public health funds can be made. This is one of the reasons many NGOs and donor

organizations develop parallel systems of implementation for health projects. However, if organized, there are measures in place to counter this corruption. The governor's advisory council, which can be organized at the request of either the governor or the *soum* council, can be used for oversight and community representation in the implementation of public projects. However, no *soums* in which I worked had such a council in existence. In addition, the *bag* directors could be more involved in implementation at the *bag* level. These political measures are essential to further develop community-based programs in these *soums*.

With a decaying social services infrastructure, and corruption rendering ineffective what remains, the community with which I worked perceived rapidly deteriorating social safety nets. As they act on these perceptions some flee the countryside for monetary reasons; some are forced to move due to poorly managed rangelands or decreasing access to markets. This has led many rural populations to live in a state of constant flux. Another demographic change in the *soums* is an increase in the number of children in households over the past 5 years. The health providers reported that over the past 3 years a dramatic reduction in the number of people they have on birth control or in family planning. These providers hypothesized that one reason for this was the monetary compensation of 3000 *tugrugs* (1,200 *tugrugs*=\$1) per child instituted by the ruling *MAXH* government. However, the changes I observed tended to be more complex.

First born males are routinely pulled out of school by the fourth grade and sending children to national, *aimag* or *soum* capitols was also very common. Often, a girl successful in school is invested in by sending her to school in Ulaanbaatar, another child, male or female, would be sent off to live with a relative in the *soum* or *aimag* capitol. The oldest male would usually be kept to manage the flocks. It was perceived by a majority of male herders that education beyond the 4th grade for them was pointless. This distribution of children throughout

several communities may provide a form of social safety net but has also led to continued stress on traditional social networks.

The trends observed above also have had a distinct effect on the health of the community. For example, the lowering rates of education among males make them a difficult population to engage in health education activities. There is also a commonly accepted, though poorly understood, trend among most Mongolians to self-medicate before seeking treatment. Most Mongolians expect medication be given at the time of treatment as that is the accepted mode of medical care. Thus, with limited access to treatment in *soum* hospitals, the providers have been attempting to focus on behavior modification and prevention instead. This has led to the perception among much of the community that the health system is impotent. Increasing the difficulty of this exchange is the poor quality of patient-caregiver interaction. For example, while I was there a community member turned to me for help in identifying the disease she was lead to believe by hospital staff was killing her granddaughter. Upon consulting the physician I learned that there was no treatment for the girl's ailment but that she would recover, the disease was not fatal. When I asked the grandmother why she did not discuss this with the physician she reported having attempted to do so and had been rebuked for this. There were other cases similar to this both in rural and urban areas (O'Rourke, et al., 2001). These trends all work to degrade the potential resistance of the community to the negative effects on health, that the social, environmental and individual factors mentioned earlier, create.

Community Empowerment

By using a Community Empowerment framework, I am able to incorporate many of the different factors that affect the ability of community members to maintain their own health. This model includes structural/environmental factors, individual factors as well as the dynamic

interactions between them. By working from a community perspective, the relationships between these factors can be explored. This model also focuses on control, an idea essential to understanding health maintenance. The model's conditioning variables are constructs that involve the interplay of these three factors and act as a buffer against the environmental and individual challenges to health maintenance. These buffers are areas of strength or possible focus within the community for future health interventions.

At the model demonstrates, there is a significant loop and feedback loop relationship between the systemic, individual and dynamic variables leading to the decreased ability to maintain health. The donors and national health system have created conditions where confusion and lack of commitment breed challenges to health service access. These combine with infrastructural challenges to directly impact the perceived ability of rural communities and individuals to maintain their own health. The responses by the community I observed to these conditions were ultimately responsible for the isolation and poverty affecting the communities. The ill health observed in all areas is directly linked to this pathway and it would appear that without significant investment and change the pattern will continue, further degrading the conditions in which this community lives. The strength of the Community Empowerment approach is in seeking to understand the conditioning variables that create varied responses between different communities. Building on the factors that have buffered this community, or other communities that have been effective in dealing with the many challenges they face, is the first step in effectively intervening. This allows some community control over what is often considered an impossible situation and can work to provide an increased sense of internal empowerment, not only improving their own ability to maintain their health but in assisting in the improvement of their entire community's.

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