Cancer and palliative care in Mongolia

Despite a difficult starting point, processes of change are underway in the health services of Mongolia. In April 2011, I had the opportunity to study at first hand the establishment of palliative treatment of cancer patients. My impression is that access to morphine and an emphasis on communication have ensured a better quality of life for terminally ill cancer patients. Cooperation between authorities, the national medical community and international aid donors has been decisive.

Målfrid Holmaas Bjørgaas
malfrid.bjorgaas@lyse.net
Mobile palliative team
Stavanger University Hospital
and
Håbet Health Centre

Until 1990, Mongolia was closely linked to the Soviet Union. The last 20 years have been characterised by post-communist crisis and corruption, but also by new directions and an increasing openness to the international community. The population has been estimated at three million (1). Approximately one million live in the capital Ulaanbaatar. The others live on the steppes, most of them as nomads.

The health services were established by the Russians. The Communists were good at structures. Buildings and personnel are there, but the quality of the health services provided appears to be wanting (2). Table 1 shows some health indicators, compared to the equivalent Norwegian figures (3).

My background

During the period 2005–2007, I worked in Mongolia for the Norwegian Lutheran Mission (4). At the time, several existing aid projects were being phased out, and my main task was to plan new projects in the field of primary health services. In cooperation with national and regional health authorities, three provinces in the Western region were selected as locations for the Strengthening Primary Health Care Project (5, 6). From 2008 until today, the project has facilitated courses in cancer and palliative care, as well as several other general medical topics.

In April 2011 I returned to Mongolia, as part of my leave of absence from the position of Senior Consultant of the Mobile Palliative Team. In the following, I will describe some of the impressions that remain after my conversations with contacts in the national and regional health administrations and GPs in the Khovd province, who attended courses held under the auspices of the project.

Late diagnosis

In 2005, more than 80 per cent of all cancer patients were diagnosed at stage 3 or stage 4 (7). Table 2 shows the distribution of the three most common forms of cancer (7). The high incidence of primary cancer of the liver is assumed to be caused by endemic hepatitis B and hepatitis C, as well as poor nutrition and high consumption of alcohol (7). My own observations of diagnostic opportunities and reporting routines indicate that many cases of liver metastases without a confirmed primary neoplasm are also likely to have been included in this group.

The National Cancer Center in Ulaanbaatar is responsible for diagnostics and treatment. In practice, endoscopy is unavailable and so is mammography, and x-ray tends to be the only option. Ultrasound examination is widely used, but my impression is that indications and interpretations

Table 1: Indicators for Mongolia and Norway, figures from the WHO, 2009 (3)

Indicators	Mongolia	Norway
Proportion of the population < 15 years (%)	26	19
Proportion of the population > 60 years (%)	6	21
Life expectancy (years)	69	81
Infant mortality < 1 year per 1 000 live births[1]	24	3
Death risk for the age group 15–60 years/1 000 inhabitants	225	67
Public spending on health per inhabitant (USD)	64	6 018

[1] Figures for 2010

Ger (Mongolian: home), a traditional Mongolian family tent. Photo: Målfrid Holmaas Bjørgaas

tend to be based more on magical thinking than on medical logic. There are no screening programmes. Laboratory capacity is poor, and the population has little knowledge of symptoms and risks (7).

Therapeutic options are poor or absent at the regional and provincial level. Cancer surgery is in practice unavailable outside the capital, and even there, the capacity is very limited. Those who have the resources go abroad. According to the cancer plan, treatment indications at the National Cancer Center are haphazard, and the quality of the treatment provided is low. Because of a lack of funds, hardly anybody is provided with chemotherapy (7).

Palliative care

As can be imagined, under such circumstances all patients will quickly require palliative care. Seven out of ten patients die within one year of their diagnosis (7).

Dr. Oduntuya Davaasuren has translated guidelines and training material into Mongolian, and is responsible for palliative care in the training of doctors as well as in further education of health personnel. She is a pioneer who has made a considerable contribution to the establishment of political frameworks, planning frameworks and regulations (8). Since 2003, GPs have been licensed to prescribe morphine. Morphine is in principle given free of charge to those who need palliative care, but the budgets are insufficient and the deliveries unstable. I was told that in 2010, peroral morphine had been totally unavailable for four months because of an import ban. After that, prices went up. Five tablets of 10 mg rapid-release morphine currently cost approximately one US dollar. In comparison, a family may earn 50–80 dollars per month.

GPs in Khovd told me that paracetamol and non-steroid anti-inflammatory drugs tend to be available locally. The access to morphine has improved in recent years, but the doctors report that individually adapted analgesic treatment is difficult because of a limited range of forms of administration and unreliable deliveries. An emphasis on training appears, however, to have made the doctors more confident and generous in their prescription practices.

Further challenges

The cancer plan outlines four pillars for improvement: prevention, early diagnostics, cure and palliative care (7).

Prevention

In 2002, nearly one-third of the adult population were smokers, men outnumbering women by a factor of ten (7). Alcohol consumption levels are high, although con-

Table 2: The most common forms of cancer among Mongolian men and women respectively (7)

	Per cent
Men	
Liver	39
Stomach	19
Lungs	13
Women	
Liver	30
Cervix	17
Stomach	11

firmed data are unavailable. The soil and groundwater content of heavy metals originating from mining operations is increasing (7). Vaccination of infants against hepatitis B is mainly implemented (7).

Research predicts that vaccination against the human papillomavirus (HPV) can reduce the prevalence of cervical cancer by up to three-fourths (9). In a visionary spirit, the cancer plan includes vaccination of all girls against HPV as a goal for the future, but as of now this goal remains totally unrealistic, both financially and organisationally (7).

Early diagnostics and cure

With no opportunities for treatment, early diagnostics remain meaningless. There is work underway on treatment indications and standardised courses of treatment. Provision of training in basic surgical methods could prove effective (10). Further development of chemotherapy and radiotherapy is costly and will require the provision of skills and funding from the outside. Increasing public knowledge about warning symptoms and appropriate behaviour remains important (11). Training programmes have been initiated in cooperation with foreign partners, of which the Strengthening Primary Health Care Project is one example.

Palliative care

The plan for development of palliative care emphasises home-based services and interdisciplinary teams that can provide help locally (7, 8). None of these have yet been realised. To date, there is one palliative ward with 15 beds at the National Cancer Center, but my impression is that there is no direct interaction with the primary health services.

Communication and patient information are discussed among the professionals, but traditionally there is a reluctance to mention death, and this tends to be avoided in direct contact with the patient. Course participants in Khovd were of the opinion that the patients ought to receive information, but that their relatives often resist. However, the doctors claimed that in their experience, openness is better than silence. They told stories of opportunities that emerged because the patients were able to arrange matters that were important to them, such as moving a family event forward in time. I believe that with the spread of such auspicious narratives, changes will gradually follow. Health personnel need meeting-grounds to promote dialogue. The courses represent one such meeting-ground.

Success factors

Access to morphine represents a great improvement of the situation of Mongolian cancer patients. Skilled enthusiasts with good contacts in the Mongolian national health-policy community are crucial to promote change. Political frameworks and plans must be in place. Local authorities and health-policy administrations must be included in the processes at an early stage, so that they can establish an understanding of the need for change prior to any specific initiatives. This will allow for ownership of the initiatives that will be implemented at a later stage (12).

Financial and professional aid provided from the outside must follow the pace of local management and motivation. Facilitation of dialogue between all parties involved is required. Palliative care in Mongolia is an example of how the provision of a relatively modest amount of resources can produce change.

Målfrid Holmaas Bjørgaas (born 1963)
is a Specialist in Family Medicine and a GP in Sandnes. She also has an additional position as Senior Consultant of the Mobile Palliative Team at Stavanger University Hospital. From 2005–2007 she worked as a project consultant in Mongolia for the Norwegian Lutheran Mission and was resident in Ulaanbaatar.
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