ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective/SSC supervisor will assess this.

What is the prevelance of asthma in Kenya; and what are thr risk factors associate with exacerbation in the semi-nomadic pastoral communities.

Asthma is one of the most common chronic conditions worldwide. According to the WHO, it is estimated that around 10% of the Kenyan population, around 4 million people, are affected; with a higher prevalence in urban areas. Whilst on placement we witnessed one individual present with an exacerbation of asthma, at a dispensary in Maralal. The initial management was different to that in the UK: IV hydrocortisone, IV aminophylline and SC adrenaline. Once the patient had recovered we had the opportunity to discuss how he manages his asthma on a daily basis. The clinical officer educated the patient on inhaler technique, as we would in the UK. The challenges in controlling asthma in these communities were identified as follows: compliance with medication, beliefs about the effectiveness of inhaled medications and lifestyle factors. The clinical officer explained to us that the majority of his asthmatic patients refused to take the inhaled medication as they did not believe it to work and would insist on prescription of oral steroids instead. Addressing these gaps in understanding within these communities is important in ensuring that asthma is being controlled effectively. Similarly to the UK there are lifestyle factors which increase the risk of an individual having an exacerbation. The lifestyle factors to consider within this community are: confined housing conditions, cooking with charcoal stoves in unventilated rooms, working alongside livestock and working in dusty conditions. It is important to identify the triggers that may cause an exacerbation relevant to the community you are serving. This individual was presenting with his third asthma attack in the prior five months, and despite this having been explained previously, no lifestyle modifications had been made. Within these communities education is imperative to successfully managing common health problems. However, having the money to be able to live a healthy lifestyle is fundamental, and a limitation in this community – similarly to many others worldwide.

What is the provision of maternal healthcare, with regards to birthing practices, in pastoral communities in Kenya, compared with that of the UK

The literature states that around 50% of women in rural Kenya, and only around 8% of women in pastoral communities were assisted by a skilled birth attendant (SBA) during delivery. The alternative is to deliver at home, usually under the supervision of a traditional birth attendant (TBA). A TBA would usually be a respected member of the community; however these individuals would usually not be trained to the government standard of best practice.

During our placement we were exposed to two separate environments concerning maternal health. The first was our time spent on the maternity and labor units at Narok County Government Hospital. The majority of the women at this facility has chosen to attend, and deliver with an SBA present. However there were also cases of women who were admitted with obstetric complications after attempting to deliver at home. When discussing this with the obstetric consultant, he informed us that there had been a dramatic increase in the number of women in this district attending the hospital, since the introduction of free maternal healthcare by the government. However, he also

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expressed his concern for the women who were continuing to deliver at home, as a result of their cultural traditions. The second exposure we experienced was spending time across two primary healthcare dispensaries. Both facilities has a labor and delivery room which was accessible for free to the women in these communities. However both facilities were only able to assist in uncomplicated vaginal deliveries; and if complications were to arise they would have to refer to the nearest hospital. The difficulty with this, especially at the rural clinic in Inyonyorri is the distance and access to the nearest hospital, a minimum of one hour's drive. This would also require the family to pay for the transport, which could often by difficult in this area.

The clinical officer at the Samburu clinic advised a woman who had just delivered her fifth child at home to consider the benefits of delivering in a facility with an SBA present. This individual expressed that she would only deliver at home, on account of it being the cultural norm and have had no problems previously. Despite the introduction of free maternal healthcare cultural barriers do exist, preventing women from utilizing these facilities.

In comparison only 2.1% of women in England and Wales in 2016 delivered at home, according to the office of national statistics, the majority of these women being aged 35-39. This could be attributed to the medicalisation of childbirth in the UK, and that more women feel comfortable being in an environment where the skills and resources are available if a complication were to arise. Comparatively in the UK if a woman decided to have a home birth then a trained midwife would usually be present to assist.

To identify limitations in the provision of primary healthcare in semi-nomadic pastoral communities in Kenya

This elective placement was primarily set in primary healthcare facilities, serving individuals of pastoral communities. Neither of the dispensaries I visited were government led, and we therefore felt it would be an important exercise to explore any limiting factors in the provision of healthcare at these facilities. To do this myself, and my colleague, designed a questionnaire directed at the healthcare providers of these dispensaries. The study showed a disparity in what the healthcare professionals felt were the limitations to providing optimal care.

The first dispensary visited was an ICROSS facility serving the Maasai community; led by either a nurse or community health worker. The primary concern was the availability of certain medications for dispensing – especially antibiotic suspensions for children. The most common presenting complaint we observed here were: URTI, diarrhea and infected wounds – all of which were prescribed an antibiotic. If the antibiotic was not available then a prescription was written to acquire it elsewhere, where they would likely have to pay a fee. In comparison, the second catholic missionary dispensary, serving the Samburu community, was led by a clinical officer. Here we identified a multitude of limitations; including language barriers as the clinician did not speak the local dialect. Other concerns included: lack of compliance with medications, understaffing and patients inability to pay for their medications. Highlighting these limitations allows us to think about ways to improve provision of healthcare in these facilities in the future.

To improve my communication skills, when faced with language barriers and cultural differences; and to immerse myself into a new culture.

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I feel what I have gained most from this elective placement is improvement of my communication skills to overcome language and cultural barriers. Respect for cultural differences is a priority when managing different groups of people and working amongst the pastoral communities in Kenya I have learnt about traditional Maasai customs and how this affects deliverance of healthcare. Spending time in maternal health facilities has taught me the differences in community dynamics, preference of place of delivery and birth attendants present. It had taught me the importance of both respecting traditional cultures, whilst trying to educate individuals on promoting better health. I have witnessed healthcare providers educate on topics such as family planning and sanitation effectively by explaining the importance of these aspects, whilst maintaining an understanding and respect of cultural beliefs. These skills I hope to transfer into my own practice when communicating with patients from different backgrounds. Being immersed in a community where I do not speak the language has taught me to be patient and graceful when trying to communicate. Using prompts such as gestures and diagrams have allowed me to communicate more effectively when leading a clinic in Sambutru county. It has also taught me the discomfort of being in an environment whereby you do not understand the language. I believe that this is an important experience, as it allows you to empathise with non-English speaking patients who are in this situation in the UK.

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