Abigail MacLeod

COMMUNITY MEDICINE

ELECTIVE REPORT (SSC5c PART 1): COMMUNITY MEDICINE AT AIC DISPENSORY – KAJIADO, KENYA

15/04/12 to 20/05/2012

OBJECTIVE 1 – *What are the prevalent health and obstetric conditions present in the Masai community? How do they differ to the UK?*

During my placement it was clear people only came to clinic when they had to. The busiest day of the week was market day when the Masai would come and get their supplies. The diseases diagnosed at the clinic varied greatly to that in the UK. Patients commonly presented with general malaise, myalgia and headaches and the main three differentials that they were tested for were Brucellosis, Malaria and Typhoid. This contrasts with the UK where such individuals would be tested for hypothyroidism, anaemia, infective mononucleosis etc. These diseases relate greatly to the Masai way of life. They do not always cook their meat thoroughly as their kitchens consist simply of a wood fire in a badly lit hut. This can therefore be a risk factor for Brucellosis. Malaria is prevalent in the Rift Valley of Kenya especially in rainy season but people still do not understand the importance of using mosquito nets. Mosquito nets are only given out free to pregnant women and children under 1 year, thus there are still many at risk individuals. Typhoid is also common due to the environment that the Masai live in. They live in manyattas that have no running water or electricity and so there are no facilities to wash hands before cooking, after using the toilet (which they do by digging a hole in the ground) or after handling raw meat. The manyattas are made from mud, animal dung and wood. They are dark and very smoky from cooking on a wood stove with little ventilation.

Tuberculosis is also common. We saw three cases in the time we were there but were told by the nurses in the clinic that there are many more people infected especially in those also suffering from HIV who go around untreated. There is no prophylactic treatment for people who come into close contact with infected patients and due to the cramped, non ventilated housing conditions that the Masai live in there is a high risk of transmission to other members of the family. Unfortunately we did not get to see many obstetric patients, as the maternity hospital had not yet been opened when we arrived. However we did get involved with the antenatal treatment of women and were shocked by the high incidence of syphilis within the Masai. The Masai still adopt polygamy and the men are not restricted to marital relations solely between their wives. In consequence sexually transmitted diseases are diagnosed

regularly when Masai women come in for their antenatal tests at the beginning of their pregnancies.

OBJECTIVE 2 – *How are community medical services organised and administered? What limitations are present? How does it differ from the UK?*

There are government and private hospitals that are the main source of secondary medical care in Kenya. The government hospitals offer reduced prices but many are cautious to use them, as there are rumours of the medical care being substandard. Within the community they're equivalent to our general practise clinics are clinics run by charities and other organisations. These are rarely run by doctors and our placement clinic was generally nurse-led, with doctors seen only occasionally during once-monthly specialist clinics. Limitations are numerous, but the main impediments are poor infrastructure with often patients unable to attend clinic due to flooding cutting off clinic access developing overnight in rainy season. Money is also a massive issue, with limited government funding and the Masai having to pay for all their treatment. There is also a lack of doctors, the nurses do their best knowing lots about the main conditions seen in Kenya but when rarer cases come in such as a case of potential nephrotic syndrome and congenital heart disease in a 14 year old boy they do not have the training to know how to diagnose and manage these patients.

OBJECTIVE 3 – HEALTH RELATED: *Explore how they manage conditions amongst a large population without the resources we are used to in the UK?*

They have minimal resources within the clinic and with not many people finishing school it is often hard trying to make sure people understand how to take their medication and for them to continue for a certain length of time. How they deal with this to try and ensure treatment is completed for infectious disease is giving them IM penicillin injections and getting them to come in once a week for 4 weeks as they are not reliable at taking oral medications.

There is a lack of access to drugs for the treatment of common diseases. When a patient has an asthma attack they only have 2 drugs to treat this – salbutamol and IV aminophylline. They also had regular power cuts which stop certain lab tests from being performed. This had a detrimental effect on one family where 2 children needed HIV testing after the death of both of their parents but they had to wait yet another day before they could no if they were positive or not.

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OBJECTIVE 4 – PERSONAL/PROFESSIONAL DEVELOPMENT
GOALS: *To enhance my communication skills within a different culture and to experience adapting to how medicine is performed in a developing country with minimal resources.*

Working in rural Kenya gave me a real insight into the nation's differing cultures. There were communication problems even between Kenyans as many of the different tribes have their own languages and don't know the widely spoken Swahili and English that the rest of the population speak. Even within the clinic only 3 of the healthcare workers could speak Masai and therefore communicating with them was difficult. When I had consultations myself I worked with an interpreter which was very useful and a good experience for my future working life. Also the Masai are a very proud tribe where its counted as weakness to show pain so even the little children with major burns did not cry and so it was hard to tell sometimes how much pain a person was in. Also during our placement we had a charity come and perform cataract surgery. This was a big organisational task but due to the lack of doctors operating assistants were taught how to perform the procedure and the doctors only performed the operation on the more complex cases. In my opinion I would not be happy with anyone less than a doctor performing surgery on me but with so few resources and the chance of restoring their eyesight the Masai were not bothered by this but this maybe because they are not informed to know that they were not doctors performing the operation.

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