Outside Europe

Primary care: a look at Kenya

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British Medical Journal, 1977, **1**, 1337-1338

When a person falls ill in Britain, he can if he wishes receive treatment in the first instance from a doctor with a university degree or a royal college diploma. In many countries a patient's expectation is lower. Outside the capital or other large city he is likely to see a medical assistant first, though since this person is probably working without immediate supervision from a medical practitioner the term "assistant" may be somewhat misleading.

Medical assistants under various titles constitute the first medical contact for many patients in countries with very varying degrees of technological development, ranging, for instance, from Tanzania, where development is low, to Russia, where it is high, with China coming somewhere between. Though in Britain fully qualified doctors man the medical front line they are not its sole occupants. Pharmacists, prescribing opticians, first-aiders, and trained nurses all have a role, for instance. But as the cost of providing full medical cover mounts year by year, and the demand certainly does not diminish, the question is increasingly asked whether even technically advanced countries can afford to go on as they are. Is expensive medical manpower effectively deployed? Are people obtaining a reasonably economical return from "health" services in the form of good health? Are there more effective alternatives? It is possible that the experience of countries whose primary medical care is largely given by medical assistants has something to teach more technically developed countries. For there are certainly problems which, if not peculiar to medical assistants, are of some relevance to the provision of primary medical care through them. A recent visit to Kenya enabled me to see some of them at first hand.

Clinical officers

In Kenya about 40% of the medical services are provided by missionary organisations. The Government provides most of the rest through the Ministry of Health, but there are also private practitioners of various kinds ranging from traditional herbalists to highly qualified Western trained physicians and surgeons, and Voluntary Service Overseas (VSO) has provided a number of nurses and medical auxiliaries. The range of qualification within the Government service is also wide—from rural medical aids, who got few if any "O" levels at school, to doctors with the highest qualifications. But in many places the main services of primary medical care are in the hands of people who used to be known as medical assistants and are now called registered clinical officers. They may work in dispensaries, health centres, or hospitals, often in remote places and without immediate medical supervision. These clinical officers are one group among a number of types of medical auxiliary workers, which include laboratory technicians, entomologists, nurses, pharmacists, radiographers, and physiotherapists. What is specially distinctive about them is the degree of clinical independence that their often isolated position necessitates.

Candidates for training as a registered clinical officer must have attained the equivalent of our "O" level at school, with good grades in several scientific subjects and English, but they have not gone on to "A" level. Most are aged about 18-20. At present about 100 are admitted each year to the training school at Nakuru 100 miles (160 km) north of Nairobi, which is run by the Ministry of Health. Theoretical and practical training is given in anatomy, physiology, pathology, and clinical medicine, so that by the end of the course the student has received a grounding in the sort of problems he will meet in what may be virtually independent clinical practice. The course lasts three years, and about 60-75% of students complete it. But, as in more developed countries, greater problems are apt to come after qualification than in selection and training.

On qualification the clinical officer has no option but a job in the Government service, to which he will be posted. In return for his training he is bonded to the Government for three years and must go where the Ministry of Health decides he is needed, though it may take into account his domestic circumstances. A married man, for instance, might not be sent to a district remote from his wife's family. In his post the clinical officer comes under the district medical officer, an employee of the Ministry, but a variety of choices will unfold before him in due course. To gain a clearer understanding of what these mean in personal terms to clinical officers it is helpful to have some idea of the conditions they may encounter in their daily work.

Poor resources

Over much of its area Kenya is a dry country with poor resources. About two-thirds is desert or subdesert, and in the opinion of some of the older inhabitants the aridity is increasing. This is not necessarily due to any permanent climatic trend, on which the evidence is inconclusive, but rather to changing practices in agriculture, forestry, and rural life generally. The widespread destruction of woodland is causing anxiety, for though trees do not bring rain the forest helps to conserve moisture. Thus one of the fundamental necessities for a healthy life in communities is often lacking, namely, a plentiful supply of pure water. Even some health centres, for instance, lack not merely piped water but any nearby source of water at all. The water has to be carried from a well some distance away. As well as a good water supply many parts of the country lack power for heat and light. Some health centres must rely on

British Medical Journal
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paraffin stoves to boil water and have no electricity or other central source of light after dark. Finally drugs are scarce and sometimes entirely lacking. In the West a sceptical attitude about our ready recourse to drugs has lately grown up, but their value is abundantly plain where diseases caused by bacteria, protozoa, and helminths are ubiquitous.

Like many countries, among them Great Britain, Kenya also has a population problem. The Government acknowledges its existence and is ahead of much public opinion in doing so. Family planning officers under the aegis of the Ministry of Health advocate the benefits of limiting the number of children as well as spacing them adequately. They tour the country districts as well as towns, and need to be devoted advocates of a policy that is commonly and sometimes deeply unpopular.

Objections to contraception are apt to be expressed in physical terms—"The pill causes heavy bleeding," and "intrauterine devices disappear into the body where they can't be found." But at heart many women believe that contraception is "against God" or "against Nature." This was a prevalent belief in Britain until only 30 years ago and is still not extinct, so that Kenya does not have far to go before its policies, as we have seen happen here, may be expected to have an appreciable effect on the birth rate. In fact the drive in that direction receives a degree of Government support in Kenya that has often been lacking in Britain.

At a village meeting held in the shade of a spreading acacia tree one afternoon to hear a report from the chief and a medical student on ways of reducing infant mortality an elderly woman expressed in traditional terms her disapproval of family planning. She didn't believe in it, she said, because it was against God. When she was young babies used to be fewer and to be spaced out more, she said; now they were more frequent. Asked if God had changed the peoples' fertility she said, No, the trouble was too few beds. Husband and wife started marriage sleeping on separate beds, but when the first baby arrived it was put in one bed and the parents then shared the other. And she concluded, "If you put a cat beside meat you can't keep it away." This homely metaphor evoked laughter, patient argument, and some expressions of agreement. It certainly summarises one aspect of fertility—that an improvement in material circumstances helps to control it.

Countering isolation

A clinical officer's professional life, therefore, may be marked by considerable isolation and material deficiencies. How he responds to the challenge depends on the help he receives and the temptations to which he is exposed as well as on his own personal qualities.

At the end of his three years' bond a clinical officer is free to leave the Government service if he wishes, and some do. Some set up in private practice with ill-defined status but perhaps lucrative reward. Others obtain posts in pharmacies or in companies of various kinds. But many do remain, sometimes no doubt because they have both a safe job and a growing family. The risk that their difficult working conditions and relative isolation may induce apathy is recognised, and measures taken against it may be grouped in three main categories. Firstly, a good district medical officer maintains frequent contact with the clinical officers under him, visits them at their health centres, tries to obtain better working conditions for them, and encourages them to keep up with their reading. Secondly, continuing education by lectures and refresher courses is offered (of which more below). Thirdly, progression up the professional ladder even to full qualification as a medical practitioner is possible.

This last is a particularly interesting development. A registered clinical officer who left school with only the required "O" level can gain practical experience in his job, and then, if found suitable, enter a course leading to qualification as a licensed medical practitioner. This is a grade that at one time was mainly filled by Asians and now persists as a lower qualification than that of a university degree. However, the erstwhile clinical officer with ability need not stop there. After gaining experience for some years in the grade he can enter a course leading to a medical degree, and thus become a fully qualified medical practitioner. Several have in fact successfully made the long journey to full medical qualification in this way.

Continuing education in various forms—visits from the district medical officer, lectures, courses, periodicals—is as vital to efficiency at clinical officer level as at other levels. This lesson, now understood in developed countries, is appreciated also in Kenya. And that country is singularly fortunate in having its Government's arrangements for continuing education greatly extended by the Flying Doctor Service.

The popular image of the Flying Doctor Service is of pilot-surgeons flying off to remote airstrips to do emergency operations in the bush. There is something in this, but it is only part of the picture. The African Medical and Research Foundation, which runs the Flying Doctor Service, is a charitable body which also receives Government funds. It is as deeply committed to teaching the prevention of disease to lay people and the continuing education of medical assistants of all kinds as to the treatment of patients. Its educational work takes three main forms. Firstly, teachers are flown to remote places to give general instruction and advice. Secondly, experts in some particular skill—for example, anaesthesia—hold special courses up country lasting several days. Thirdly, it publishes books and journals devoted to medical education at a practical level—specifically, *Afya* for medical auxiliaries of all kinds, *Medical Digest* for doctors and others, and the *Defender* for lay people. Undistorted by both commercial and official pressures, the foundation's work is one of the most effective health agencies in the country.

In summary, therefore, the provision of primary care by registered clinical officers works as well as it does despite the handicaps of isolation and a harsh environment because they have opportunities for advancement, continuing education is available in a variety of attractive ways, and medical officers maintain contact with them at district level. Certainly these counterblasts to apathy in the service or resignation from it vary in quality from one district to another. But a reasonable inference is that they are essential to the success of a primary care service in the circumstances found in Kenya and in many other countries.

What is the cause of and the treatment for senile itch?

Itch may occur in the elderly patient for numerous reasons. If a primary skin disease is not responsible—for example, eczema, urticaria, drug eruptions, and scabies—then an internal cause should be sought. A good history, careful examination, and a few investigations (full blood count, electrolytes, liver function tests, thyroxine, urine examination, and a chest radiograph) should discover most endogenous diseases responsible for itch. Senile pruritus can be diagnosed with confidence only after carefully excluding all other causes of itch. Its cause is not completely clear, but it seems as though the reduced activity of sebaceous and sweat glands and skin atrophy (part of the aging process) is partly responsible. Such skin lacks water-binding lipids and, as a result of increased water loss, will crack and often itch. Excessive use of soap and detergents will make matters worse as will exposure to conditions of low humidity. If the diagnosis is true baths should be limited. The addition of aqueous cream *BP* or a bath oil, such as Oilatum Emollient, should help to prevent excessive degreasing of the already dry skin. Emollients such as oily cream *BP* or emulsifying ointment *BP* may be used often between bathing. If there is an eczematous element a dilute local steroid may help. I have found hydroxyzine (Atarax) 10 mg three times daily a most useful systemic preparation for helping the itch, but trimeprazine (Vallergan) 10 mg at night time is an often quoted alternative. If, however, the itch does not abate despite the above measures then I would re-examine the diagnosis.