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**contact**

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# **(RE)TRAINING DOCTORS FOR COMMUNITY MEDICINE**



## **TO MEET THE HEALTH NEEDS OF THE MAJORITY**

# INTRODUCTION

Human resource development for health, based on the commitment of health professionals to practise in their own country, especially among underserved rural populations, remains an important challenge. Medical schools in developing countries may graduate many nurses and doctors each year, but the majority of these will choose to practise in urban centres or abroad. The University of the Philippines, for example, the country's largest government-supported medical school, sees an average of 90% of its graduates leave the country to train and work abroad.

There are various reasons for this "brain drain." For one, the health profession attracts many students, in developing countries as elsewhere, on the promise of money to be made, not the desire to serve. Parents will invest in an expensive medical education for their child, knowing that it will increase that child's chances of finding work, hopefully abroad, which will in turn help support the family.

But there are other reasons. The Western orientation of most medical curricula leave the newly graduated health professional ill-equipped for true community-based work. Outside of the hospital or urban centre, without access to the technology to which they have become accustomed during their schooling, young medical school graduates find themselves in unknown territory. Communication skills for the training of village health workers may suddenly be more relevant than a sophisticated drug or machine. The health professional, after years of medical training, is unprepared!

Existing community-based health programmes offer important opportunities for training health professionals to work among the underserved.

But because these programmes often depend on external funding, they generally offer poor pay and little job security. They trust that health professionals will be attracted to community-based work on the basis of their commitment to serve the people, not on promises of professional advancement and lucrative salaries.

In the midst of this situation, there is a growing realization that health professionals in developing countries must be "encouraged" to choose to serve their people. It is too much to expect medical students to opt for work among rural or underserved populations on the basis of their commitment alone, without specific encouragement and without adequate preparation for such work.

This *Contact* issue features two initiatives developed in response to this realization. The Community Medicine Development Foundation, Inc. (COMMED) is a Filipino non-governmental organization begun in 1986 by young health professionals who were dissatisfied with their medical education as preparation for work in the community. COMMED now offers an alternative residency programme to train community-based medical practitioners. The second initiative is a government programme to train general practitioners in Nigeria, to enable them to serve with competence and satisfaction in the low-technology environment of the district hospital.

Both of these programmes were designed, on the basis of experience, to contribute to the development of a comprehensive health care system. Although each programme is uniquely tailored to a national context, the goal of both is to respond to the health needs of the underserved—the majority.

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## COVER

Photo: Nemuel Fajutagana, KAPPS-CCBHD Photobank

Villagers in Llorente, Eastern Samar, a rural area in the Philippines served by doctors of the Community Medicine Foundation, Inc. (COMMED).

# CURRICULUM DEVELOPMENT FOR COMMUNITY-BASED MEDICAL PRACTITIONERS: THE COMMED EXPERIENCE

By Erlinda Senturias, CMC Executive Secretary

## INTRODUCTION

The current health situation in the Philippines, observed and experienced by ten Filipino medical students during a community integration programme, prompted the formation in 1986 of the Community Medicine Development Foundation, Inc. (COMMED). COMMED was the response of these students, upon their graduation, to the problems they had identified in their medical training while living with poor rural people. These were:

- the inadequacy of their formal medical education to deal with health problems in the community;
- the need for a continuing upgrading of skills and medical knowledge of physicians in community-based practice; and
- the need to further develop a community of physicians actively involved in community-based medical practice.

COMMED members are committed to serving the people in the rural areas of the Philippines. They believe that health is a basic human right and that physicians have a social responsibility to promote health among their people. COMMED seeks to improve the health care system in the Philippines in two ways: by fielding physicians in remote, underserved areas around the country and by developing an alternative residency programme in community medicine, to attract more physicians into the practice.

## Why community medicine?

Because the Philippine health care system has failed to reach out to the majority of Filipinos.

- The government allots only 33 centavos (1.3 US cents) per day for the health needs of each Filipino.
- 60 out of 100 Filipinos who die of illness receive no medical treatment.
- Of 42 000 *barangays* (villages) in the country, only 8280 are served by Barangay Health Stations.
- There is only one doctor for every 8825 people.
- There are only 2440 rural health physicians serving the entire Philippine countryside.

Because existing health care services are inaccessible and unaffordable to the majority of Filipinos.

- 49.5% of the population lives below the poverty line.
- The average Filipino family of six requires a daily income of P163.45 (US\$ 6.64) to live decently, but the legal daily minimum wage is only P96.42 (US\$ 3.91).

## DEVELOPING COMMITMENT AND COMPETENCIES

Dr Nemuel Fajutagana, a founding member of COMMED and presently COMMED's executive director, stresses the need to develop commitment and competencies among potential community-based medical practitioners. The two-year alternative residency programme was born of this need.

Naturally, the training provided during the residency places its greatest emphasis on field

experience in the community. The curriculum follows a cyclical scheme of academic, clinical, and field-practice blocks:

- five academic blocks of three weeks duration each;
- five clinical blocks in a teaching hospital of three weeks duration each; and
- eight community field-practice blocks of eight weeks duration each.

*In an interview with Kabalikat, a publication of the Philippine Council for People's Development (December 1988), COMMED doctors Tess Umipig, Dennis Batangan, and Nemuel Fajutagana explained why they chose community medicine. Contact also recently interviewed Nemuel Fajutagana. Excerpts from the two interviews are combined below, to present a comprehensive picture of COMMED's beginnings.*

**Dr Fajutagana:** I grew up in the province of Romblon in the lower middle class, on a farm. I also worked in construction. What motivated me most to go into community medicine was my time in college when I started to be open to the realities of the time. I joined a student organization. I also had exposure to various health programmes.

During exposure programmes we stayed with the people. We lived with them, we worked with them, and we learned from them. Through that we realized how much they need physicians out there. That made us decide to go into community medicine.

**Dr Batangan:** I'm from Nueva Ecija, a province in Central Luzon area. My parents are both practising physicians, so I was exposed to the medical profession at an early age. That perhaps started off my liking for the medical profession and my appreciation of the people. But my commitment to community medicine came from my college years. At the University of the Philippines during four years, I was able to get lots of ideas. And then when I was in medical school, I joined service-oriented organizations that made these ideas concrete.

What really made me go into community medicine was the feeling of need, a feeling that once aware of the problem you have to

do something, or else you cannot be at peace with yourself. In the future I cannot tell my children that I was there watching, not doing anything.

**Dr Umipig:** Before I connected with COMMED, I didn't want to go into community medicine, much less become a doctor. My background is middle, middle class, and I come from Manila. My parents prodded me to become a doctor, so I became a doctor.

What pushed me to take community medicine was my exposure to Samar, through COMMED. I saw the poor people. I saw the shacks, the wooden houses. I saw the children, the malnutrition. I saw the festering wounds of leprosy patients. I saw the patients who I knew had curable diseases but could not be cured because they were too far from the hospitals. And I saw the health services there. Even the rural health units are staffed not by professional staff like doctors or nurses, but by midwives. I saw that and felt pushed to go into community medicine.

**Contact:** You started COMMED with 10 members who were medical graduates. Graduates of one medical school?

**Dr Fajutagana:** No, ten graduates of different medical schools, in 1986.

**Contact:** And how did you find each other?

**Dr Fajutagana:** Basically, most of us were

All of the training programmes are "piggy-backed" on existing community-based health programmes that have expressed a need for a physician resident in the community. The physician wishing to undergo the training must first have a strong endorsement from the community where he or she will be based. The community members, together with the resident physician, then design and implement their health programme. At the end of the training, it is the community that accredits the health

professional as a practitioner of community medicine.

The COMMED training programme is designed to provide the community-based practitioner with the necessary skills to practise community medicine. The resident physician who successfully completes the training will be able to

1. assess the health needs and concerns of a population;

involved in student and social services. We were all in some way student leaders and would meet in that capacity. During the internship programme during the year following graduation, whenever one of us was not on duty, he or she would go to our "headquarters," which was just the room of one of our colleagues or classmates. We said, "whenever two or three are gathered together in COMMED's name, they will discuss things." We had a logbook in which we recorded our discussions, and anyone who was awake and free could have a look at the book and continue the discussion from where it had been left off. We did this for a year, discussing and discussing.

**Contact:** What a great idea! Where did it come from?

**Dr Fajutagana:** It was everybody's idea, since under the circumstances, with all of us working in different hospitals, we could not meet. Even if one person was asleep, the discussion would go on and whatever group was involved would take minutes and record them in the logbook.

**Contact:** So COMMED was born of your ongoing observations as a group?

**Dr Fajutagana:** Our discussions were like the discussions of brothers and sisters. We had already had a certain amount of experience and exposure. Finally we realized that we were graduating, and we asked ourselves, "Where do we go if, after seeing the reality in the community, we don't want to go back to the hospitals." We realized that if we went back to the communities immediately we would also face problems because we had been trained in the hospital environ-

ment. We would be dealing with organizing for health, with traditional medicine, and with social and political problems. We saw that we had not been trained for this, and this was not our "turf." If we really wanted to be relevant to our communities then we had to decide what to do.

This was during our Board examinations—the national licensing examination for doctors. We were still meeting, because we had decided to draw up a proposal for a continuing exposure programme and we had a deadline for the proposal. Meanwhile, we were all frantically reviewing for our exams. Our proposal was for a four-month programme. It would be our final opportunity to find what we wanted to do in relation to community needs. Our assignment was to go to our communities and observe.

We wanted to design a programme, but we realized that we weren't prepared to do this. We had to first go visit a programme as observers. So we all went. Our assignment was to observe things such as common problems, the role of the doctor in the community, the different levels of the programme, and the training that was given.

We returned after two months. We processed all of our reports and shared our feelings about what we had observed and what we felt we wanted to do as a result. Then we returned to the communities for another two months. Then finally, when we came back together, we had an idea about how a programme should be. The alternative residency programme was the result of this four-month exposure process.



Photo: Nemuel Fajutagana, KAPPS-CCBHD Photobank

COMMED doctors found that the skills necessary to promote health in the rural areas of their country were quite different from those they had been taught in medical school. Here staff of a local community-based health programme and COMMED physicians travel to a community meeting. The areas covered by this programme can only be reached by *banca* (dugout canoe) or by foot.

2. investigate a potential health problem in a community;
3. plan, implement, monitor, supervise, and evaluate programmes or strategies that deal with health needs or problems;
4. develop innovative programmes, projects, and models that respond to the social aspirations of the people as these affect their health;
5. coordinate the development of these programmes or strategies;
6. contribute to the body of knowledge of community medicine through scholarly activity and research;
7. provide health services and improve the health status of community members;
8. refer patients as necessary to higher level health care facilities;
9. practise and promote traditional medicine;
10. develop and promote the use of appropriate technologies;
11. maintain competence and efficiency in the use of essential drugs and other traditional healing modalities (e.g. acupuncture, shiatsu, ventosa, moxibustion);
12. develop curriculum for and train community health workers to promote community self-reliance in health care.

The curriculum framework is based on a biopsychosocial model tailored to the Filipino ethos. This means that the patient is seen as a biological entity, but also as a feeling and thinking individual who is a member of the Filipino community and environment. Health is perceived as part of everyday life, to be cultivated with other human values and activities. The responsibility for health development is to be shared by members of the community, and not left only to the so-called professionals. Health care is to be a meaningful on-going process of sharing and serving, rather than a curative service valued for its "quick fix."

COMMED is as much about forming attitudes as acquiring skills. In addition to his or her clinical skills, the resident physician who successfully completes the training will

1. have the ability to generate the confidence, trust, and respect of the community;
2. have the willingness to listen to patients, to explain their conditions and possible approaches to treatment, and to encourage their participation in decision-making regarding their own health;
3. regard the individual as a responsible and intelligent member of the community, so as to tap that person's potential to contribute to community development;

4. have the openness to seek and respect a second medical opinion;
5. strictly observe medical ethics;
6. recognize and respect the role of other health and non-health professionals, especially the community health workers and traditional healers in the health care system;
7. recognize and respect the socio-cultural dimension of health care;
8. analyze the interrelationship of the social, cultural, economic, and political determinants of health.

The COMMED programme prepares a physician for work in a number of health-related fields, for example community-based medical practice; administration and management of a community-based health programme; public health practice in a rural health centre, district health office or hospital; field epidemiology and other health-related research; and teaching of community health/medicine in a medical school or public health institution.

## EVALUATION

The first class of community resident physicians graduated in 1989. Six of the nine participants qualified. Four of these physicians became programme/project directors or coordinators of three community-based health programmes; three became health service/primary health care practitioners in three programmes; and one became a teacher in a medical school. An evaluation of this first programme revealed that the graduates felt that they had been adequately trained, except in the area of research.

The physicians who decided to remain in their communities after their training explained why they had made this choice: They now felt fully integrated into the community. The community itself had inspired them to stay. "We owe it to the people to stay after the residency programme," they said. "We have a *utang na loob* (debt of gratitude)." Their understanding of community medicine had been deepened, widened, and confirmed by their experience. Their vision of community medicine and empower-

ment of the people had been validated, and the training had developed in them a greater sense of responsibility to participate in the empowerment process.

Some resident physicians added that their community work gave them a sense of independence, economically and politically. They enjoyed the moral support they felt as members of the COMMED team, as well as the security and sense of belonging that came from having integrated with their communities.

After one or two more years in the community, four of the first COMMED graduates underwent further clinical training in obstetrics, internal medicine, and rehabilitation medicine. They then designed an approach for integrating aspects of specialty training in these areas into the COMMED two-year residency programme. Another physician went on to graduate training in community health management, and two took courses in traditional medicine.

In addition to those who have pursued higher studies, there are now 50 COMMED doctors at work in various rural communities.

## DIFFICULTIES SO FAR

The most difficult part of the training so far has been the harassment of COMMED doctors by the military. Community-based health workers in the Philippines, and their families, are commonly suspected of subversive activities, of being members of the communist front, or of providing services to the members of the New People's Army.

Nemuel Fajutagana speaks of being intimidated by a soldier with a loaded rifle in front of the soldier's commander, who claimed that there was nothing he could do if the soldier got out of hand. Dr Fajutagana also speaks of radio broadcasts by the paramilitary in the region where he was working, asking him to surrender his colleagues as "subversives." He remembers asking his colleagues to lock him in the health clinic when they left in the evening so that the military would not suspect his presence and come to harass him. The 50% drop-out rate among community health workers trained by COMMED physicians is attributed mainly to harassment from military and vigilante groups.

Dr Fajutagana adds, however, that there is a more recent development in COMMED's relations with the military. "The military will now come to our offices and ask about a COMMED report on a measles outbreak, for example. They ask, «Is this report true? We don't hear about these things from our regional command.»

Community work in rural areas inevitably brings COMMED doctors in contact with rebels and their supporters. "We are doctors," explains COMMED physician Arturo Pesigan, "and when we see a wounded man we don't ask whether he's a rebel or not." COMMED upholds medical neutrality, and services by COMMED physicians are provided to all those who need their help, regardless of religious or political beliefs or other affiliations.



Photo: K.H. Meiters, Missio

Military presence in the rural areas has a strongly negative effect on health development. The 50% drop-out rate among community health workers trained by COMMED physicians is attributed mainly to harassment from military and vigilante groups.

As a matter of protocol and precaution, upon entering a province, COMMED doctors introduce themselves to local officials and present their endorsements from the Department of Health. They also coordinate with the military to avoid being caught in encounters. Such contact is kept to a minimum, however, to avoid COMMED doctors being branded as military supporters by the local people.

*Excerpts from our recent interview with Dr Nemuel Fajutagana continue below in a discussion of the inadequacy of conventional medical training as a preparation for the practice of community medicine.*

**Contact:** Can you give an example of how you were ill-prepared by your medical training for work in the community?

**Dr Fajutagana:** Let me share one story. One issue that is inadequately covered in the traditional medical curriculum is health and culture, or medical anthropology. When you start in medicine you are never really introduced to your cultural context. You are given the feeling that your medical training is *scientific* and that it is the best. Almost as an absolute.

Later on, however, doctors will experience problems relating to people, and they will not have been prepared for this by considering cultural factors during their training. For example, as a doctor working in health services you provide people with drugs, but when you go home the people will turn around and consult their traditional healers to ask if they should take the drugs, and the traditional healer will say "No." So eventually you find that their cupboards are full of unused drugs.

Situations such as this are critical. Are we being effective in dealing with such traditional concepts? One time I was visiting an area where there was a measles outbreak, which happens regularly in the remote areas of the Philippines and can result in 50 to 100 deaths in just three *barríos* (villages) over just a few months, for example. In such a village, I found people hanging dolls outside their homes in their windows. At first, they didn't tell me why they were doing this.

**Contact:** They didn't want to tell you?

**Dr Fajutagana:** No, at first they didn't want to tell me because they thought that because I was a doctor I would tell them that this was a useless practice. But later they told me that the dolls were a protec-



tion against measles. They hung the dolls in the windows so that the measles would attack the dolls and not enter the house. Similarly, they plant flowers outside their homes so that the spirits will play around in the flowers and not enter the houses.

For a doctor who is unprepared for traditions like this and who has not considered cultural factors in health, the tendency is to attack the culture and the traditional beliefs and tell the people that such things are stupid and should be stopped. But such a reaction would be ineffective.

So I thought about it, and finally the tradition of the dolls and the flowers helped me to introduce to these people the concept of prevention. Their concept was, in fact, prevention. They wanted to prevent the outbreak of measles.

**Contact:** So what did you say to them?

**Dr Fajutagana:** I told them to continue with their practices and that prevention is good, but there were other preventive measures that they could take. At that point, I could introduce alternative concepts in prevention that might be new to them, such as immunization and maintaining a healthy environment, as they were already doing with their flower gardens. And so I continue in that line. I reinforce the things in common between their desire to prevent illness and the reason behind a vaccine, for example. The basic idea is to prevent death and illness. In this way, people listen to you because what you have to say is close to them and draws upon what they already believe.

You see, in the Philippines there is a strong tendency among doctors to blame the patients rather than themselves. Doctors tell patients that they've come too late, that it's their own fault that they are ill. Doctors tell mothers that they don't really care about their children if they don't have them immunized. But this is simply not true. A mother doesn't want her child to die, but she might be familiar with only one preventive aspect—the traditional. She needs to learn about the

other aspects rather than be blamed. I tell my colleagues that we keep on blaming patients and we don't blame ourselves.

**Contact:** You mean that you say this to your COMMED colleagues.

**Dr Fajutagana:** No, I say this during lectures or while sharing with other doctors and students in the medical field. I say this because when I was a student I had the same tendency: I blamed the patient. Now it's time for us to blame ourselves also.

**Contact:** And how do your medical colleagues respond?

**Dr Fajutagana:** Well, the responses vary. For clinicians, such a statement might be a realization. It is new information for them and makes them think about the shortcomings of conventional medical training.

At one point, we organized a consultation on traditional medicine to which we invited traditional healers. We were asking them a lot of questions. In the end they said, "You know, you always ask us about our practices, or you want to know if we will refer our patients to doctors. And we always tell you that when we have a case that we think is not for us as traditional healers, we refer them to the doctors. But the doctors, they never refer patients to us. Even if they cannot heal their patient or find an explanation for an illness with laboratory tests, for example. They will never refer a patient to a traditional healer. Are you willing to do that?"

You can imagine that this created a stir, even among the COMMED doctors. It's a very difficult question.

**Contact:** So what did the doctors say?

**Dr Fajutagana:** Well, they were very quiet. In the end, we had to allow a moment for reflection. In COMMED, too, we had to think about this, even though we were already pushing traditional medicine, though from a different perspective. We then realized that the people were doing it already, that it was not up to us to push but rather to learn. →

We had been saying that people should use traditional medicine, but, in fact, 70% of the population is already using it.

**Contact:** One of COMMED's aims is that "physicians who successfully complete the training will be able to practise and promote traditional medicine." This seems to be what you are talking about. So how do the doctors respond when they learn that they have to be able to practise traditional medicine themselves?

**Dr Fajutagana:** I should explain that the dynamics within COMMED in regard to traditional medicine are changing as a result of our experience and this kind of self-examination. Before, we studied traditional medicine because of its curative possibilities, which was actually seeing it from a very biomedical point of view. Now we are looking at it in a wider perspective, as something that will complete, or enrich, the existing system. Traditional medicine is naturally more holistic because it deals with health as a way of life. It deals with how you relate with spirits, other people and beings, and nature, for example.

We are now looking at traditional medicine because of its preventive and holistic im-

plications, not just because of its curative possibilities.

**Contact:** I imagine that it takes a certain amount of humility to adopt such an outlook.

**Dr Fajutagana:** That's the new direction. Initially, we saw that it was so difficult to get health services to the people. There was no access. So we treated traditional medicine simply as an alternative system. Now we are looking at it more deeply, as a cultural entity.

This leads to a vital component that we are trying to develop: the Filipino identity of the medical practice. And the only thing that will make the medical practice truly Filipino is the adding of these cultural factors such as Filipino spirituality, the Filipino identity. For the Filipino who is a doctor, that's the whole thing.

We have a very nice definition of this in our language. It is not so nice in English but translates something like "Filipino medicine is the sum of the knowledge, skills, and attitudes that are our heritage." Our heritage includes all of these things. How we define nature, how we define our relation with the environment and other people, and how we define our own spirituality. ★



Photo: Tase Umipig, KAPPS-CCBND PhotoBank  
in Calbayog City, Western Samar, community-based health programme staff, community health workers, and COMMED physicians learn herbal plants together during their training in herbal medicine.

Another difficulty faced by COMMED, as by most NGOs, is insufficient funding. Without funding, it is difficult to provide training.

COMMED programmes have succeeded so far despite these difficulties, yet COMMED has not yet gained official recognition of the community-based approach. COMMED met a negative response to its proposal to integrate community medicine into the University of the Philippines curriculum as an alternative to the conventional doctor's two-year residency requirement.

## VISION FOR THE FUTURE

Ultimately, of course, the community-based approach to medicine must be institutionalized in the Philippine national health programme. Since this is not a government priority, however, there will most likely be a long wait for it to happen. In the interim, "it's up to us in the health and non-governmental sectors to find alternative systems that can operate in the community setting," explains Dr Batangan in the University of the Philippines *Newsletter*. "And in that sense there's no limit to your vision until you see that it is the majority who are being served."

COMMED physician Tess Umipig, in *Kabalikat* (December 1990), explains, "We see a situa-

tion that is not getting better—poverty, oppression—and from this we see the need to be strong. A health NGO must link up with other development NGOs to raise the standard of living of the people. The COMMED concept has expanded and developed. Now we view COMMED not only along the lines of community work, but also along the lines of advocacy. This means that we are working to convince more doctors to go into community medicine."

"We began with a concept," continues Nemuel Fajutagana. "From that concept we became a reality. Now, we have a strong alternative training programme for doctors. COMMED is evolving. What is clear is that we will maintain our orientation, primarily as an alternative institution developing the community medicine programme. We will continue to propagate the idea that doctors should also work in the countryside, in marginalized areas of our country. The rest will depend on how other aspects of development work proceed. COMMED will move with these development efforts."

"We have seen our place in development. And we achieved this through dialogue with the people and with other programmes. What is beautiful here is that we evolved with the other sectors, not only with doctors. We developed with the people." ★

# TRAINING DOCTORS FOR WORK AT THE FRONT LINE OF HEALTH DEVELOPMENT

By Dr C. Andrew Pearson, former Director of Training,  
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## THE PROBLEM

Developing countries experience a problem for which no certain answer has yet been found. It is possible, at great expense, for any country of reasonable size to open a medical school and teaching hospital and to train first-class doctors to international standards. It is not possible, in free societies, however, to then force these doctors to work just where they may be most needed.

Some governments do require one to three years of national service in district hospitals or primary health centres, but nearly all the doctors then leave, either to pursue training in a specialty in a national teaching hospital or overseas, or to make their living in private practice in urban centres. They are thus lost to the general hospitals and primary health programmes at the front line of health development that provide 90% of health care for the people.

In African countries, various strategies have been adopted to get around this problem. Finding no way to attract sufficient of their own nationals into the public service on a career basis, governments have recruited doctors from countries where there is a surplus of health professionals and salaries are generally lower, such as India, the Philippines, or Cuba, though the quality and motivation of such doctors is often questionable.

On the other hand, governments may sidestep the entire problem and leave the general hospitals to cope as best they can, while concentrat-

ing on developing good primary health care services with non-physicians—clinical officers, nurses, midwives, and other community health workers.

Such a solution can be effective up to a point, but that point does come. Patients do require surgery to save life, or caesarian section to deliver a baby. They do require investigation for a pyrexia of unknown origin, for example, or treatment for one of the many serious conditions that cannot be handled by primary health care services. The first referral hospital is essential, and if it is not up to standard, the primary care services soon lose credibility. The need for good doctors at the district level cannot be ignored.

## CHURCH HOSPITALS ALSO FAIL TO ATTRACT NATIONAL DOCTORS

Church hospitals have done, and are still doing, tremendous working in filling the gap in national health services. Despite criticism of church hospitals as consumers of funds that might be better spent on primary care for a great number, there is no denying that to many communities they are a beacon of hope.

They have been generally sited at a point where routes converged and where the first lone doctor could serve the greatest number. Many of these hospitals also pioneered highly effective primary health care services in the community beyond their compound walls. However, it is not just the government hospitals that fail to attract national doctors. Church hospitals, too, are often unable to attract

national doctors to work with missionary doctors, often expatriates, and to take over when they retire.

## TACKLING THE PROBLEM IN NIGERIA

In 1975, after 23 years at Ilesha Wesley Guild Hospital in Nigeria, I came up against this problem. During those years, the hospital had grown from 75 to 200 beds and developed an extensive primary care service. In practically all areas—nursing, tutoring, administration, and maintenance—nationals were in charge, or trained and waiting to take over. There we felt we had succeeded. But with doctors we had failed. Despite many efforts at long-term recruitment, offering financial terms similar to those provided by the government, no doctor would stay for more than a year or two.

The hospital's reputation in the country was high. Students from Ibadan medical school were sent to us to obtain experience in paediatrics. The hospital was included among the institutions recognized as offering the year-long internship required after qualification, and many young doctors came for that. Among the doctors we approached were many with a Christian commitment, anxious to serve. Yet our recruitment of nationals failed. We asked why doctors were unwilling to come on a long-term basis to what was a high standard, but relatively rural, hospital. Replies varied:

"The hospital is too far from the city."

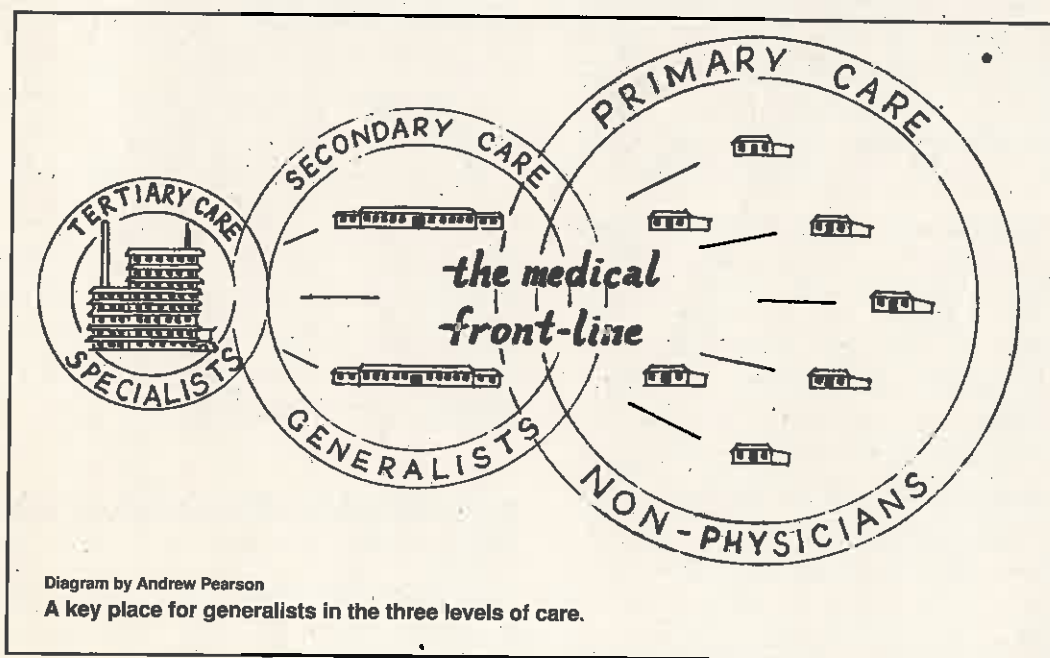
"Facilities for my wife and children would be inadequate."

"I must return to the teaching hospital to do my specialty."

It became clear that there was something lacking in the medical education system, despite considerable efforts to make the curriculum relevant to the country's needs. During their studies, students were trained by professors and faculty members specializing in the tertiary care disciplines. These teachers naturally became role models for their students, who wished to become specialists and perhaps professors in their turn. At no point were the students taught by generalist staff in secondary care. Professors and faculty members of the Department of Community Health, who lectured on primary health care, lived in the city like everyone else. Under such circumstances, it was unrealistic to expect students to wish to succeed in their careers by doing things differently.

## AN UNEXPECTED OPPORTUNITY

Just as it was becoming apparent that Ilesha Hospital was to be taken over by the government, I was invited to join the staff of the medical school in Ibadan, under the Department of Community Health. The post required residence not in the city, but at the branch campus in Igboora—two hours out into "the bush." The



purpose of the work was "to help direct medical students towards a generalist vocation."

My family and I felt God's hand in this unexpected opportunity. As one door closed for us, another opened. We accepted the assignment and over the next ten years witnessed a fascinating development.

## **DEFINING THE DISCIPLINE OF GENERAL PRACTICE**

At this time, there was no department or unit of general practice in Ibadan medical school, or any other medical school in Nigeria. Students all spent a compulsory six weeks at the branch campus during their fourth year "community health" posting. They came in groups of around 35 and were provided with simple but adequate accommodation. The campus facilities included a small complex for tutorials and lectures, a library, a laboratory, and an office for medical records and administration. The clinical practice facilities included a 10-bed health centre, the local 36-bed district hospital, and several local government primary health centres in the surrounding villages.

The students were introduced to environmental public health, health education, clinical care of under-fives, and maternal health care. They learned how to care for patients, using simple diagnostic and treatment facilities available at the health centre and district hospital. At the district hospital, a student would work with the doctor as first assistant in operations such as hernia repair and caesarian section and in treating patients for trauma and sepsis, hopefully realizing in the process how much could be done with simple technology. However, he or she would also learn at what point to refer more difficult cases to the teaching hospital in Ibadan (if the patient could feasibly make the journey).

In the health centre clinic, the student served as an "apprentice doctor" and was thus faced for the first time with patients who had not already been diagnosed. The young doctor was encouraged to examine each patient carefully, knowing that most would have common conditions such as malaria, measles, or scabies, but that there would be occasional patients with serious illnesses such as previously undiagnosed diabetes, early leprosy, lobar pneumonia, senile cataract, supracondylar fracture, or acute meningitis. The students were also ad-

vised that not every patient would have an organic disease and to watch for reactions to stress (common in rural as well as urban areas) and for patients needing simple reassurance and nothing else. They were reminded to be scientific in their use of the available laboratory tests, to keep good records, and to treat with short courses of essential drugs when necessary—the fewer drugs the better. Whenever appropriate, preventive health education was to be given to patients as a priority.

The clinical aspects of community health described above were taken as "general practice." As the students worked with the doctors on a generalist basis, they began to identify with them and see them as role models. They saw that they could live reasonably well in a rural area and that there *were* alternatives to mains water and power. The students also saw that the medical work involved high clinical standards, a broad range of practice, and considerable job satisfaction in seeing patients through from first consultation to cure. The doctors involved were seen to be held in high regard by the community. Many of the students resolved to become generalist doctors themselves. Through this programme, attitudes began to change.

Nevertheless, once the young doctors were free to choose their career, after the one year of required service in the National Youth Corps, some went off to the city to enter private practice. Others—the majority—felt that their basic medical training had to be followed by postgraduate training in a specialty. They therefore returned to the high-technology teaching hospital and narrowed down their interests to a chosen field. The further they went along this road the less they felt able to be at home again in the low-technology district hospital, close to the community, with its broad clinical demands.

By exposing medical students to general practice through this programme during their undergraduate years, a seed had been sown. A further step was necessary, however, before it could grow and mature.

## **POSTGRADUATE TRAINING IN GENERAL PRACTICE**

The next step, therefore, was to work out a postgraduate general-practice vocational

training programme tailored to the needs of Nigeria and other developing countries. The aim of the programme would be to give doctors a way to prepare themselves for a generalist career in district-level hospitals with primary health care outreach and, at the same time, give them a status no lower than their classmates who had opted for specialist careers in teaching hospitals.

In the development of the programme, we consulted widely with senior private practitioners, sympathetic specialists in Ibadan, medical schools, government doctors, and the registrar of the Nigeria Medical Council, and with the medical students themselves. We also studied models used in developed countries such as Britain, Canada, and Australia for aspects relevant to our situation. There was no model available to us from Africa or any other developing country.

We started with two assumptions: first, that the discipline of general practice should be seen as extending beyond the boundaries of private practice and, second, that general practice would include some hospital-based work, as well as primary health care. Thus any doctor working as a generalist—whether in a health centre, a private clinic, or a low-technology general hospital, whether in an institution that was supported by government, a private volun-

tary agency, or industry—would be seen as a general practitioner.

The curriculum, therefore, would include more general surgery and operative obstetrics than would be the case in a comparable curriculum in a developed country, such as Britain. On the other hand, the techniques of providing simple primary care would be shared with community health personnel, and the doctor's role would include the training and follow-up of such community-based health resource people.

When the doctors completed their postgraduate training, they would then be qualified and competent to take career posts in district hospitals. Even when far from specialist help, they would be able to treat 90% of the patients coming to see them, which would greatly reduce the number of patients needing referral. When these ideas were discussed with the medical students, they said, "Yes, this is what we need. If there were a programme like this, we would choose it."

## SETTING UP THE PROGRAMME

By 1977, a proposed curriculum had been hammered out. This happened just in time for the development of the programme to be tied into a number of events, in which Nigeria was uniquely fortunate.



Photo: Andrew Pearson

On the job training for a general practitioner registrar in a Catholic hospital.

1. In 1977, the private practitioners of Nigeria regrouped to form an active association. They were requested by the Nigeria Medical Council to develop a training programme. They heard about the curriculum that we had developed, studied it during 1978, and then gave it provisional approval as the curriculum for the general practice training.

2. In 1979, the Government of Nigeria sponsored the formation of a National Postgraduate Medical College to oversee all postgraduate education for the country that was already taking place in the teaching hospitals. The college set up faculties for each specialty—surgery, obstetrics and gynaecology, public health, etc.—and a faculty Board for each to set and oversee examinations. A Fellowship of the Medical College (FMC) was awarded to successful candidates in each specialty—FMCS for Surgery, for example.

3. An interim Faculty Board for General Practice was also set up, and senior GPs awarded honorary Foundation Fellowships. These went to a wide variety of generalist practitioners in the private, government, and voluntary agency sectors and in the university general outpatient departments.

4. In 1980, the first Nigerian national conference/workshop in Training for General Practice was held. Foundation Fellows and other practitioners, interested academics and registrars, and medical students with an eye to their future gathered in Ibadan, together with international participants from Britain, Canada, and Egypt.

The objectives and curriculum were debated, defined, and agreed. A course structure for a

four-year training programme was adopted, in part so that it would be similar to those of other faculties. The first two years of training would take place in an accredited medium-sized general hospital, with at least two senior doctors or consultants. The last two years would take place in an approved smaller centre with more involvement in primary health care. At the same time trainees would undertake a clinical research project appropriate to general practice. The examination system mirrored that of other faculties and included an examination in sciences basic to the discipline at the beginning of the programme, an examination at the conclusion of the first two years, and a final examination at the end of the four years.

### **TRAINING OUTSIDE THE TEACHING HOSPITALS**

The major difference between the Faculty of General Practice and other faculties lay in the selection of the hospitals that were accredited for the training. At the preference of the Faculty Board, these were mainly church-related hospitals, together with a few government hospitals. The hospitals had vacancies for doctors and were prepared to pay salaries at the national rate and to provide on-the-job training. Private hospitals were added for Part II of the training period. The entry of the church-related hospitals proved crucial to the programme; and in participating in the training the church-related hospitals found a new role.

The requirements for accreditation were not excessive: simple, but adequate, buildings; a sound nursing service; x-ray and laboratory facilities; concise medical record-keeping to



Photo: WHO by R. da Silva

The Eruwa District Hospital is typical of facilities participating in the general practitioner programme. As an accredited training centre, the hospital provides on-the-job training to medical students from Ibadan University.





Photo: WHO by R. da Silva  
Nigerian fifth year medical students with the author, who was, at the time of the photo, Senior Medical Officer, Eruwa Hospital.

ensure continuity of care; primary health care outreach; good relations with the community; and at least two senior doctors or consultants, practising as generalists and willing to take on the additional training responsibilities. One doctor's response to the introduction of the training programme was typical:

I have been out here many years and was thinking the time had come to go home, but this prospect will make me think again. If my work is not just routine service but helping to train the next generation, then it will be doubly worthwhile. I will stay.

The programme took off in 1981 with just four hospitals and 12 GP registrars (or trainees). Within five years, these numbers had risen to 25 hospitals and 70 registrars. The programme proved popular and met a real need. Once they were part of the structured training programme, rural hospitals no longer found it difficult to attract young Nigerian doctors. They were queuing up to get in, even though these hospitals were up to five hours by road from the nearest city.

As time went on, there were problems. The exams were not as easy as some young doctors had hoped, and some failed. Others found the research project undertaken during Part II of the training too time-consuming when combined with the busy daily work of the hospital. In other cases, it was the hospital that lost one or more of its key senior doctors and could no longer offer training. Hospitals that had de-

pendent on a rotation of well-qualified doctors from Holland, for example, suffered when these doctors became unavailable, and the hospital's training accreditation had to be withdrawn. Yes, there were setbacks. Yet considering the difficult economic situation through the 1980s, it is amazing how much was achieved.

#### **A HOPEFUL OUTLOOK**

Over 25 of the doctors who started have now qualified as FMCGP (Fellow of the Medical College in General Practice). Some have gone to church hospitals and some to the newer medical schools as consultants in general practice in departments of community health (training the next generation). Several have joined government general hospitals. Many have set up private practices offering a good standard of service, often in remote rural areas.

Interestingly, a high proportion of those who first opted for the programme were committed Christians. Many of those who went into private practice did so because of their Christian convictions. They wished to get away from the rigid bureaucracy of the public service, yet feared that the church hospitals were vulnerable to government take-over. Though "going private" might involve a long struggle, they felt they would be able to express their faith through their healing ministry more fully. In their practice, prayer would have a proper place alongside medical and surgical treatment. One doctor employed a retired bishop as a counsellor. Another had a chapel in his hospital for staff

and patients. Yet another set up a mobile unit to tour villages giving health education using slide sets available from TALC (Teaching-aids At Low Cost) and providing simple treatments free. This doctor also maintained a demonstration farm aimed at educating the local farmers on how to improve their agricultural techniques and increase local consumption of high-protein foods. These last examples, especially, stand in contrast to the general view of private practice as the choice of doctors for purely financial gain.

While counting its success stories, the programme has nonetheless failed to achieve adequate recognition and close cooperation from the Ministries of Health in the 30 States that make up the Federation of Nigeria. These are the authorities who control the district general hospitals, often many hours drive away from a State capital. Changes to make the best use of this new cadre of doctors in the public service have been slow in coming.

In due time, it is hoped that the States will find that a team of two or three of these "front-line" doctors in a 120-bed hospital have the broad clinical skills to provide an excellent service, and the administrative skills to supervise the handling of essential finance at district level and coordinate the primary care services in the area around. Consultant level salaries and maybe rural bonus payments may need to be offered. This alternative would be cheaper than trying to recruit multiple specialists in surgery, obstetrics, medicine, paediatrics, etc., who cannot deputise for each other to give 24-hour cover and who soon become frustrated when they find their skills cannot be fully used.

### **CAN OTHER COUNTRIES SOLVE THEIR DISTRICT-LEVEL MEDICAL RESOURCE PROBLEM THIS WAY?**

Other developing countries have begun to look at ways in which they can provide a generalist postgraduate training to prepare doctors for a career in secondary/primary care, whether in public service, church-related institutions, or the private sector.

In 1986, the Government and University of Papua New Guinea, for example, initiated a



Photo: Andrew Pearson

Some of the pioneer trainees in the Nigerian programme in 1983, most of whom are now qualified as "consultant general practitioners."

study of such a possibility for that country, but were ultimately prevented by economic setbacks.

In 1990, in Ghana a survey was conducted among private practitioners and doctors working in university, government, and voluntary agency hospitals of attitudes towards GP training. Survey results indicated a consensus that vocational training for general practice was desirable and that the hospitals of the Christian Health Association of Ghana (CHAG) could make a significant contribution. With the West African College of Physicians poised to provide the necessary administrative and examination structure for such a programme, training may go ahead along similar lines to the scheme in Nigeria.

Before the end of 1992, Zambia hopes to launch a Masters programme for District Health Specialists—M.Med (DHS), where the four-year training will take place mainly in accredited church-related hospitals. Ten Lusaka-trained doctors have applied for the first places. Other countries as diverse as Nepal, China, Western Samoa, and the Philippines are also assessing possibilities.

The scheme is not an expensive one, since it makes use of existing institutions. Some strengthening of staff may be necessary. A church-related hospital should not be afraid of getting involved if approached. Accreditation will make it easier to recruit national doctors. The hospital may have an established vacancy, with salary and housing attached, or the gov-



Photo: WHO

Nigeria, as other developing countries, needs the skills and expertise of its people at home. Dr Adetunji Doherty (left) is a «bush» doctor, but also acts as veterinarian and sanitary engineer at Ikiri Rural Health Centre, Nigeria. His wife, Ewesu, is a nurse who formerly worked in a London hospital. Together they run the health centre.

ernment may be prepared to pay in return for the training given.

The hospital may already possess a reasonable library, to which a few books could be added. Setting aside a room for tutorials should not be difficult. Personal supervision of the registrar, particularly in the surgical theatre or delivery room, requires time at first, but less so later, and the additional patients treated should increase fee revenue. Making time for clinical meetings, journal clubs, or the occasional weekend workshop will be an extra, but a potentially exciting one. Training in administration and hospital maintenance will be acquired along the way. If an increased emphasis on primary care outreach is necessary to complement the registrar's training, it will be to the advantage of both the hospital and the community.

## A CHALLENGE TO CHURCH-RELATED HOSPITALS

At the time of this writing, in the medical schools of Africa, excluding Egypt and South Africa,

about 2000 doctors are produced annually, a figure likely to move up to 4000 before the end of the century. In order to make the most efficient use of this vast resource, by attracting as many as possible into secondary/primary care where they are most needed, something must be done urgently. It is no use just wringing our hands as the best and brightest of the young doctors move up the ladder of tertiary care in the only postgraduate training that is open to them, i.e. in the main specialties. The gap in postgraduate training must be filled with GP training such as that described. Only then shall we see doctors specializing in the broad field of secondary/primary care and ready to make a successful career at that level.

There is no doubt that the «mission hospitals»—with their reputation for high level motivation, good clinical and practical skills, devoted nursing service, honest administration, economical maintenance and innovative primary health care outreach—are the best placed to provide the major part of such training. This is the new challenge before them, and they should be ready to respond if given the opportunity. ★

# STATEMENT FROM THE WHO/UNICEF CONSULTATION ON HIV TRANSMISSION AND BREASTFEEDING

*In view of the controversy surrounding the subject of HIV transmission through breastmilk, we feel that Contact readers would wish to be fully aware of the most recent statement from WHO/UNICEF in this regard. We therefore reproduce the statement, together with its accompanying recommendations, below in their entirety.*

In view of the importance of breastmilk and breastfeeding for the health of infants and young children, the increasing prevalence of human immunodeficiency virus (HIV) infection around the world, and recent data concerning HIV transmission through breastmilk, a Consultation on HIV Transmission and Breastfeeding was held by WHO and UNICEF from 30 April to 1 May 1992. Its purpose was to review currently available information on the risk of HIV transmission through breastmilk and to make recommendations on breastfeeding.

Estimates based on the various studies conducted to date show that roughly one-third of the babies born worldwide to HIV-infected women become infected themselves, with this rate varying widely in different populations. Much of this mother-to-infant transmission occurs during pregnancy and delivery, and recent data confirm that some occurs through breastfeeding. However, the large majority of babies breastfed by HIV-infected mothers do not become infected through breastmilk. Recent evidence suggests that the risk of HIV transmission through breastfeeding a) is substantial among women who become infected during the breastfeeding period and b) is lower among women already infected at the time of delivery. However, further research is needed to quantify the risk of HIV transmission through breastfeeding and determine the associated risk factors in both of these circumstances.



Studies continue to show that breast-feeding saves lives. It provides impressive nutritional, immunological, psycho-social, and child-spacing benefits. Breastfeeding helps protect children from

dying of diarrhoeal diseases, pneumonia, and other infections. For example, artificial or inappropriate feeding is a major contributing factor in the 1.5 million annual infant deaths from diarrhoeal diseases. Moreover, breastfeeding can prolong the interval between births and thus make a further contribution to child survival, as well as enhancing maternal health.

It is therefore important that the baby's risk of HIV infection through breastfeeding be weighed against its risk of dying of other causes if it is denied breastfeeding. In each country, specific guidelines should be developed to facilitate the assessment of the circumstances of the individual woman.

## Recommendations

1. In all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected, promoted, and supported.
2. Where the primary causes of infant deaths are infectious diseases and malnutrition, infants who are not breastfed run a particularly high risk of dying from these conditions. In these settings, breastfeeding should remain the standard advice to pregnant women, including those who are known to be HIV-infected, because their baby's risk of becoming infected through breastmilk is likely to be lower than its risk of dying of other causes if deprived of breastfeeding. The higher a baby's risk of dying during infancy, the more protective breastfeeding is and the more important it is that the mother be advised to breastfeed. Women living in these settings whose particular circumstances would make alternative feeding an appropriate option may wish to know their HIV status to help guide their decision about breastfeeding. In such cases, voluntary and confidential HIV testing accompanied in all

cases by pre- and post-test counselling could be made available where feasible and affordable.

3. In settings where infectious diseases are not the primary causes of death during infancy, pregnant women known to be infected with HIV should be advised not to breastfeed but to use a safe feeding alternative for their babies. Women whose infection status is unknown should be advised to breastfeed. In these settings, where feasible and affordable, voluntary and confidential HIV testing should be made available to women along with pre- and post-test counselling, and they should be advised to seek such testing before delivery.

4. When a baby is to be artificially fed, the choice of substitute feeding method and product should not be influenced by commercial pressures. Companies are called on to respect this principle in keeping with the International Code of Marketing of Breastmilk Substitutes and all relevant World Health Assembly resolutions. It is essential that all countries give effect to the principles and aim of the International Code. If donor milk is to be used, it must first be pasteurized, and where possible, donors should be tested for HIV. When wet-nursing is the chosen alternative, care should be taken to select a wet-nurse who is at low risk of HIV

infection and, where possible, known to be HIV-negative.

5. HIV-infected women and men have broad concerns, including maintaining their own health and well-being, managing their economic affairs, and making future provision for their children, and therefore require counselling and guidance on a number of important issues. Specific issues to be covered by counselling include infant feeding practices, the risk of HIV transmission to the offspring if the woman becomes pregnant, and the transmission risk from or to others through sexual intercourse or blood. All HIV-infected adults who wish to avoid childbearing should have ready access to family planning information and services.

6. In all countries, the first and overriding priority in preventing HIV transmission from mother to infant is to prevent women of childbearing age from becoming infected with HIV in the first place. Priority activities are a) educating both women and men about how to avoid HIV infection for their own sake and that of their future children; b) ensuring their ready access to condoms; c) providing prevention and appropriate care for sexually transmitted diseases, which increase the risk of HIV transmission; and d) otherwise supporting women in their efforts to remain uninfected. ★



WCC Photo  
"In all populations, irrespective of HIV infection rates, breastfeeding should continue to be protected, promoted, and supported," affirms the WHO/UNICEF statement.

# THE BABY-FRIENDLY HOSPITAL INITIATIVE

*Adapted from World Immunization News, March-April 1992, Vol. 8 No. 2, and BFHI News, the Baby-Friendly Hospital Initiative Newsletter, June 1992*

Why believe in the right of mothers to breastfeed? Because widespread adoption of this practice would save the lives of over one million infants each year, to give one good reason. It would also save many infants from preventable diseases, primarily diarrhoea; it would decrease the number of women who develop breast and ovarian cancers; and it would reduce spending by families, hospital programmes, and governments on artificial breastmilk substitutes.

The reason for the general decline in breastfeeding, says UNICEF's 1992 *State of the World's Children*, is that more families are living in cities, more women are going out to work, and advertising is more aggressively persuading mothers that bottlefeeding is modern and sophisticated.

In fact, breastmilk is the world's most sophisticated food, continues the report. It is so nutritionally complete that an infant normally needs no other food or drink for the first four to six months of life. It is hygienic and inexpensive, and it protects infants against common infections.

Artificial milk is, in any case, an inferior food for an infant, but under certain conditions it is also dangerously inappropriate. Low income families—in both developing and developed countries—generally cannot afford the expensive product, are unable to read the instructions on the tins, or lack easy access to clean water, sterilizing equipment, refrigerators, or fuel for boiling water.

Bottlefed babies in poor communities are approximately 15 times more likely to die from diarrhoeal disease and four times more likely to die from pneumonia than babies who are exclusively breastfed.

If while in hospital the mother has been encouraged to bottlefeed and has been given free supplies of milk powder by the hospital, it will be difficult for her to return to breastfeeding once she is home—even if she then realizes that her family actually cannot afford to bottlefeed their baby.

To help more children get the best possible start in life by helping their mothers to breastfeed, UNICEF and WHO have drawn up a code of practice for all maternity units. All hospitals that

## Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practise "rooming-in"—that is, allowing mothers and infants to remain together—24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

comply with the "Ten Steps to Successful Breastfeeding" (see box) will be designated as "baby-friendly."

The Baby-Friendly Hospital Initiative (BFHI) recognizes that hospitals and health professionals exert a tremendous influence either for or against the successful initiation of breastfeeding. The Ten Steps outline what practices these institutions can adopt to ensure that mothers breastfeed, thus providing the best care possible for mothers and their newborns.

For more information on the Baby-Friendly Hospital Initiative (available in English, French, Spanish, Chinese, Hindi, Korean, and Turkish) or to receive *BFHI News*, write to Baby-Friendly Hospital Initiative, UNICEF, 3 UN Plaza, New York, NY 10017, U.S.A.

## PROFILE OF A BABY-FRIENDLY HOSPITAL

*Adapted from an article by Michael Lim Tan, first published in Health Alert, (Issue 123, November 1991) and reproduced in Mothers and Children (1992, Volume II, Number 1), a bulletin of the Clearinghouse on Infant Feeding and Maternal Nutrition, American Public Health Association, 1015 15th Street NW, Washington, D.C. 20005, U.S.A.*

As in other government hospitals, the wards at the Jose Fabella Memorial Hospital, Manila, Philippines, are actually large halls, each with about a hundred beds. At Fabella's maternity wards, the patients are not patients in the medical sense of the word; they are mothers and their newborns. Picture a hundred mothers, with a hundred babies, in one ward. Then imagine an extraordinary silence, despite those one hundred babies. There are few babies crying. Most are sleeping contentedly or breastfeeding. The serenity is symbolic of the quiet revolution going on at Fabella, that of creating a baby-friendly hospital.

The 71-year-old institution is a hospital for the poor. But the babies born at Fabella stand a better chance of survival than those born at the Philippines' more expensive private hospitals. Credit this to a rooming-in policy that Fabella first fully implemented in 1986. The success of Fabella's programme has since captured the attention of UNICEF, WHO, and other international groups.

Rooming-in involves immediate contact between the mother and her newborn. The newborn, still wet with the fluids from birth, is put to the mother's breast even as she lies on the delivery table. The baby receives its first immunization, not with a needle but with the mother's first milk, colostrum, which is packed with nutrients and immunoglobulins. The suckling action also stimulates contractions in the mother's uterus and helps to expel the placenta. The contact is also important in creating the bond between mother and child. I watched the eyes of a tired

mother light up when her child latched on. There was pride and wonder as the child instinctively sought her breast and began to suckle.

It is only after this first feeding that the baby is washed. The mother is brought to the ward, to be followed shortly after by the baby. If there are no problems, the mother stays for a day or



Photo: UNICEF

The encouragement of doctors, nurses, and other health professionals can make all the difference in enabling mothers to breastfeed successfully. At Jose Fabella Memorial Hospital both health professionals and volunteers are trained to provide mother support.

two, feeding her baby on demand. "Breast-feeding chairs," specially designed to reduce backache, are provided for the mothers. Fabella's director, Dr Ricardo Gonzales, explains that this is part of the hospital's working philosophy of providing comfort in care, as well as dignity and safety.

The newborn child is never put in a nursery, even if the mother is sick. There is a special isolation room for a mother with an infectious disease, to separate her from other mothers

and babies but keep her own baby at her side. Her own child is usually producing antibodies against her infection, and the breastmilk gives the child additional protection against other diseases. Even mothers who deliver by caesarian section breastfeed within 24 hours if there are no post-operative complications.

Such a rooming-in policy helps to ensure that the mother will breastfeed successfully. Studies in many countries have shown that the main reason why many mothers "cannot" breastfeed is that breastfeeding was not initiated within the first hour after delivery. Nature's cycles are often disrupted by hospital procedures.

Premature babies at Fabella are put in an intensive care ward with incubators, but, again, the mother stays close, ready to give milk when needed. There is also a milk bank, supplied with milk collected from the mothers. In most cases, the premature babies are eventually able to breastfeed. In a "breastfeeding corner" next to the intensive care unit, I saw mothers busily nursing their premature babies. One nurse proudly showed me a baby who had been born two months ahead of time, weighing only 900 grams. It had put on another 200 grams since birth and was now able to take breastmilk from a glass pipe. The child and mother would soon be ready to return home.

Promotion of breastfeeding must be continuous. At Fabella, prenatal counselling includes advice on breastfeeding (although about 30% of the mothers who deliver at Fabella have not had such counselling). All mothers are helped to breastfeed by hospital staff members and "Lactation Brigades"—volunteers circulating throughout the wards to provide mother support. This is in sharp contrast to scenes of a few years ago when baby milk company representatives visited the maternity wards to promote bottlefeeding.

Another innovation at Fabella is that of helping mothers to help each other. Because of the shortage of beds, three or four mothers some-

times end up sharing two beds. In one ward with 84 beds, there were about 120 mothers and their infants. This problem has been turned into an opportunity—two beds are joined together and the hospital puts first-time mothers together with second- or third-time mothers. The mother with more experience ends up advising the first-time mothers nearest her.

There are only two hospitals in the Philippines where a rooming-in and breastfeeding policy is fully implemented—Fabella and Baguio General Hospital. If Fabella and Baguio General have been so successful with rooming-in, why are other hospitals not doing the same?

The Health Department actually requires all government hospitals to have a rooming-in policy. Fabella is, in fact, designated as a national lactation management training centre for government hospital staff. But implementation of rooming-in policies has been weak in most of the other hospitals. **Doctors and nurses, even if they are aware of the advantages of breastfeeding, believe that many mothers are unable to breastfeed. The advertising efforts of the commercial sector—directed at health professionals through promotions and incentives—would exploit this doubt.**

The vicious cycle goes on: a mother who bottlefeeds her first child, believing she cannot breastfeed, will bottlefeed all the children that follow. We now see second- and third-generation mothers who do not even try to breastfeed because their own mothers have said they cannot because "your breasts are too small" or "you're too sickly." Reversing this trend will be difficult, but efforts must start with the doctors and hospitals that have come to control the lives of the new mother and her child.

Because Fabella handles so many births, its policies can dramatically change popular perceptions of breastfeeding. Baby-friendly hospitals like Fabella are crucial in restoring the "breastfeeding culture" that gives mothers and children the best at birth and beyond. ★



## USEFUL PUBLICATIONS

The Voluntary Health Association of India (VHAI) is a federation of 19 state-level associations, linking over 3000 non-governmental organizations—including those related to various churches and religious groups—throughout India. VHAI works to promote social justice in the provision and distribution of health care. Its major activities are

- helping to build a people's health movement through networking, lobbying, campaigning, and public affairs-related activities;
- facilitating the evolution of low-cost, appropriate, people-oriented health programmes in harmony with the traditional knowledge and skills of the community;
- providing support services to community health programmes;
- researching various aspects of primary health care.

VHAI publications have been featured before in this column, and we should like to bring to your attention the most recent of these. The **State of India's Health Report** includes main chapters on nutrition, health and environment, family welfare, traditional systems of medicine, health systems and services, and health education. Shorter sections focus on disability, health finance, women and health, medical education, health research, health information systems, health technology, medical ethics, health and culture, and nursing education, among others.

Designed as an aid to policy makers, health planners, donors, and those implementing programmes, the report is available in hardback at Rs 300 and paperback at Rs 250 (with an additional Rs 20 for postage within India) directly from VHAI at the following address:

Voluntary Health Association of India  
Tong Swasthya Bhavan  
40, Institutional Area  
Near Qutab Hotel  
New Delhi—110 016  
India.

The World Health Organization (WHO) has just issued a catalogue of its publications related to **Hospitals in the District Health System**. The

catalogue provides bibliographic and descriptive information for 92 WHO publications offering practical and technical information designed to help strengthen the medical care provided in small hospitals. Grouped into six broad categories, the publications cover specific material in the areas of hospitals in relation to the health system, clinical functions, the management of common diseases, clinical support, general services, and hospital planning and design.

We draw your attention to a special offer included in the catalogue. To support the work of hospitals throughout the world, WHO is offering the seven manuals that comprise the **WHO Core Library for Doctors Working in Small Hospitals** at a price reduced by 65%. The library includes the following titles:

*Anaesthesia at the District Hospital*

*General Surgery at the District Hospital*

*Surgery at the District Hospital: Obstetrics, Gynaecology, Orthopaedics, and Traumatology*

*Management of Severe and Complicated Malaria*

*Respiratory infections in children: management in small hospitals*

*Manual of Radiographic Interpretation for General Practitioners*

*Cancer Pain Relief*

Realizing their value to doctors and nurses working in remote areas, *Contact* has had in mind to review the three manuals on anaesthesia and surgery at the district hospital for some time.

*Anaesthesia at the District Hospital* is a practical manual produced to assist doctors who lack formal training in anaesthesia and yet find themselves called upon to provide anaesthesia, particularly in the emergency care of the critically ill. The book concentrates on a selection of basic techniques, such as endotracheal intubation, procedures, and equipment capable of producing good anaesthesia despite constraints on personnel, equipment, and drugs. Particular attention is given to the use of draw-over anaesthesia as the technique of choice for inducing general anaesthesia when resources and staff are limited.

*General Surgery at the District Hospital* is a richly illustrated guide to general surgical procedures suitable for use in small hospitals that are subject to constraints on personnel, equipment, and drugs. Information is addressed to the medical officer who may not have formal training in surgery, yet has gained experience, under supervision, of all the relevant techniques.

Following an overview of basic principles, the book presents detailed information on surgical procedures for the face and neck, chest, abdomen, gastrointestinal tract, and urogenital system. Paediatric surgery is also covered. Most of the operations included are for saving life, alleviating pain, preventing the development of serious complications, or stabilizing a patient's condition pending referral. Simple but standard surgical techniques have been selected wherever possible, and procedures that require specialist skills or that could add unnecessarily to the doctor's workload have been avoided. Lists of essential surgical instruments, equipment, and supplies conclude the text.

*Surgery at the District Hospital: Obstetrics, Gynaecology, Orthopaedics, and Traumatology* is an illustrated guide to surgical procedures for treating the major complications of pregnancy and childbirth and for managing traumatic injuries, including fractures and burns. Obstetric and gynaecological procedures commonly required in small hospitals are also covered. The chapters on orthopaedics and traumatology provide details on both basic orthopaedic techniques and the management of specific fractures, dislocations, burns, and other injuries, as appropriate at the first referral level.

We highly recommend that *Contact* readers who stand to benefit from any of the books in the *WHO Core Library* take advantage of this valuable offer. Regularly priced at SF125 (US\$122.50) the seven-manual set, published in both English and French, is currently available for SF44 (US\$39.60). To order, please write to



Distribution and Sales  
World Health Organization  
1211 Geneva 27  
Switzerland.

## OUR READERS RESPOND

We have received considerable feedback on the *Contact* double issue (December 1991—February 1992), which focused on the international debt. The surprise and alarm expressed by some readers in regard to the extent of the debt crisis and its effect on the well-being of their countries and the world tell us that the issue was useful.

Dr K. Balasubramaniam, Pharmaceutical Adviser, International Organization of Consumers Unions (IOCU), however, felt that we had grossly under-reported the net flow of resources from the South to the North during the period 1983-1985, in the lead article by the Ecumenical Coalition for Economic Justice (ECEJ).

Using statistics from the UN World Economic Survey 1989, ECEJ had reported the flow as positive (US\$11.3 billion), whereas, points out Dr Balasubramaniam, IMF data quoted in *Third World Guide* shows a negative flow of US\$19.6 billion already in 1982.

ECEJ replies that, at the time of writing, the UN figures were the most comprehensive available; covering private direct investments, private loans and official flows, but not capital flight. Capital flight, which often takes place through illegal or disguised transactions, is difficult to estimate.

The ECEJ and *Contact* appreciate Dr Balasubramaniam's careful reading. If the desire to be comprehensive has meant an underestimation of the severity of the problem, this was not the intent!

Reader Eliazar T. Rose, New Hope Rural Leprosy Trust, Orissa, India, writes to us of the debt crisis as a legacy of colonialism but also a result of a culture of greed, from which no country or people is exempt. For many, including Christians, he feels, consumerism has become a gospel of its own for which the only answer is to distinguish true need from greed and to confront ourselves and one another when we see things out of balance.

In WCC language, such confrontation is called "challenging unjust structures." Inasmuch as injustice breeds ill health, the work of challenging unjust structures as they affect people's health is a vital part of our mandate. In fact, it is one reason for *Contact*.

Recently we received this letter:

*Dear Director,*

*For several years now our Council has been receiving 10 copies of your wonderful magazine for each house of religious women in our diocese. The content of your magazine has spread far and wide as sisters have worked with women in some of the most isolated areas of this part of Ghana. We cannot thank you enough for your regular mailing to us. Recently our Council received a gift, and we feel it is just right that we share some of it with you. Therefore, enclosed you will find a check for \$50. We know this will not go far, but we trust that God will make our small offering multiply as you continue to do His work in building a better world. Contact is truly a very valuable reference and guide.*

*God Bless You,*

*(signed)*

*Religious Women's Council  
Navrongo/Bolgatanga Diocese  
Bawku  
Ghana*

We have accepted the gift of the Religious Women's Council of Navrongo/Bolgatanga Diocese as a precious contribution towards the work of *Contact*. We realize the sacrifice that was involved. We also feel that the affirmation by our readers of the value of *Contact* is worth far more than any feeling we may have of our own self-worth.

You, our readers, know that *Contact* is available free of charge to individuals and groups in developing countries. Many of you will never have the choice of sending us money to cover your subscriptions. Either the foreign exchange is not available or your money is needed elsewhere. We understand this. The bulk of the cost of producing *Contact* is therefore covered by the *Contact* budget, and not subscriptions.

Last year, we informed you that the WCC has met with severe financial constraints. This situation continues despite efforts to cut back. You may have noticed, for example, that the *Contact* logo on the cover is now gray, rather than red. This change alone has meant a savings. Some of you may not be aware that there are only one and a half staff persons assigned to producing and mailing the four regular language versions of *Contact*. It is difficult to see where we might cut back there.

We share this information so that you might understand why we now appeal to those of you who can to help us cover the cost of subscriptions—not only of your own but also those of others. A year's subscription is US\$12. For that amount, would you consider helping to put *Contact* into the hands of front-line health workers such as the sisters of the Navrongo/Bolgatanga Diocese, Ghana.

Please be in touch if you can help in this way.

## WORLD BREASTFEEDING WEEK

The World Alliance of Breastfeeding Action (WABA) is coordinating a series of events around the world to take place for the first time from 1 to 7 August 1992, entitled World Breastfeeding Week. The purpose of the week is to focus public attention on breastfeeding as a basic human right—the right of the child to adequate nutrition and the right of the mother to breastfeed without interference from commercial interests. While this *Contact* issue will not be in your hands in time for this year's event, you can begin now if you would like to plan an activity for World Breastfeeding Week 1993 or simply become informed on the benefits of breastfeeding to mothers and babies. For more information, write to

World Breastfeeding Week  
34-11 146th Street, 1st Floor  
Flushing, New York 10354, U.S.A.

or

World Alliance for Breastfeeding Action  
P.O. Box 1200  
10850 Penang, Malaysia.

The **European Association for Palliative Care** announces its second congress, to be held in Brussels, 19-22 October 1992. The working languages of the congress will be Dutch, English, and French. To register, write to

Professor Deckers  
Centre des Tumeurs, UCL  
Avenue Hippocrate 10  
1200 Bruxelles, Belgium.

## CALL FOR PAPERS

*Health Education Quarterly* is soliciting original manuscripts for a 1994 theme issue on the subject of community empowerment, participatory education, and health. Articles are solicited that demonstrate how empowerment strategies—dialogic, learner-centred, popular education, community mobilization and capacity-building—relate to health education, community health, community health workers, and health professional education.

The *Quarterly* welcomes articles based on theoretical explorations, case studies, participatory research, and evaluation of intervention processes and outcomes. Of particular interest is how empowerment approaches attempt to overcome the many conflicts and barriers faced by health professionals, such as the role of experts versus community members; issues concerning equity and discrimination; and the ability to work in communities with differences in race, culture, ethnicity, gender, language, and class status. Authors are encouraged to explore their successes, mistakes, and lessons learned.

Articles should be submitted by 1 February 1993. Please refer to *Health Education Quarterly* for instructions to authors. Send four copies of the manuscript or inquiries to

Nina Wallerstein, Assistant Professor  
Dept. of Family and Community Medicine  
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Albuquerque, New Mexico 87131, U.S.A.

**CONTACT** is the periodical bulletin of the Christian Medical Commission (CMC) of the World Council of Churches (WCC). It is published six times a year in English, French, and Spanish. Selected issues are also published in Portuguese in Geneva, Kiswahili in Kenya, and Arabic in Egypt. Present circulation exceeds 35,000.

**CONTACT** deals with varied aspects of the community's involvement in health and seeks to report topical, innovative, and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to **CONTACT**, the bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.

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The average cost of producing and mailing each copy of **CONTACT** is SF 3 (US\$2), which totals SF 18 (US\$12) per year for six issues. Readers who can afford it are strongly encouraged to subscribe to **CONTACT** to cover these costs. Please note that orders of back issues of **CONTACT** are charged at the above rate. The CCP account number, for payments made in Switzerland in Swiss francs, is CMC/WCC, 1211 Geneva, CCP 12-572-3.