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Profile of a Pediatrician

GLADYS EJOMI MARTIN, M.B., B.S., M.P.H.

Editor's note: From time to time, *IPA News* will present in-depth articles about pediatricians. IPA is comprised of member pediatric societies and associations, but each of its member groups is comprised in turn of individuals, the pediatricians who care for children around the world. IPA salutes these individuals, and is pleased to share their stories. Profiles of pediatricians are also offered on the Association's World Wide Web site.



Figure 1

Dr. Gladys Ejomi Martin has been a physician for 35 years. She received her M.B. and B.S. degrees (London) in 1962, from the University College and University College Hospital, Ibadan, Nigeria, and was awarded the University's Prize in Public Health. She received her Diploma in Child Health from the Conjoint Board of England and Wales in 1966, and her M.P.H. degree from Harvard University, U.S.A., in 1971. She completed internship and residency training in pathology and rheumatology in the United Kingdom and in pediatrics in the United States and Canada. Dr. Martin was certified as a pediatrician by the American Board of Pediatrics in 1972.

Positions and roles Dr. Martin has fulfilled in her career include:

- Consultant Pediatrician, New York City Health Department
- Senior Lecturer in Community Health and Pediatrics, University Center for Health Sciences, University of Yaounde, Cameroon
- Consultant Pediatrician, University Teaching Hospital, Yaounde; Chief of the Center for Nutrition Research, Institute for Medical Research and Study of Medicinal Plants, Cameroon Ministry of Scientific and Technical Research
- UNICEF Regional Adviser in Health and Nutrition for East and Southern Africa (1986 - 1993), and for West and Central Africa (1994 - 1995)
- Local consultant for an inter-country study on WHO support, coordinated by the London School of Tropical Medicine and Hygiene.

Dr. Martin says that she never thought of becoming a doctor while she was growing up, but at her graduation her mother told her that she "had said so at a very early age." A life-long love of books, flowers, and stars led her to first consider horticulture or astronomy, but in college she turned to medicine. She did not decide on an area of specialization until near the end of medical school, when she decided on pediatrics; in the meantime, her broad interests (obstetrics and gynecology, internal medicine, clinical pathology, and

rheumatology) broadened her outlook and prepared her for the different positions she held later.

Before leaving England in 1967, Dr. Martin obtained her Diploma in Child Health and a Certificate in Family Planning, and was accepted for the pediatric residency program at the Children's Hospital of the University of Dalhousie in Halifax, Nova Scotia, Canada. Prior to travelling to Canada in 1968, she worked in Cameroon, caring for workers and their families in an agro-industrial hospital, health centers and health posts network, where the emphasis was on curative care and compensation for disabilities. Like most health-care services in Africa, demand for curative care was high; wards and outpatient clinics were overcrowded. Nurses in outreach clinics handled all cases and referred the serious cases to the hospital for further care. Dr. Martin made fortnightly visits to the outreach clinics, and started a family planning clinic for women who could not get such service elsewhere. The family planning clinic was not successful: the effort was ahead of its time.

During her postgraduate training, Dr. Martin sought experiences, electives, and subspecialties geared towards priority needs in Africa: family planning, maternal and child health, ambulatory care, and outreach programs in poor communities. She believed then, as she does now, that parents will reduce their family size when the survival of the children born is assured. Throughout her postgraduate studies, Dr. Martin says,

I was able to reflect on how I had performed at home. I saw myself in hurried ward rounds, silently watched by mothers and other child care-takers, and surrounded by nurses. I also saw myself in those periodic outreach clinics, consulting very routine cases that were handled effectively by nurses. I realized that I had missed several "teachable moments" and thought of ways that I could effectively use my time for patient care, health promotion through communicating with and education of mothers, as well as on-the-job training of staff.

Upon her return to Cameroon at the end of 1971, Dr. Martin applied her insights. She spent more time on ward rounds and discussed with mothers and staff those patients admitted with common, preventable childhood diseases, placing emphasis on prevention and early home management (vaccination, breast feeding and rehydration, child spacing). In outreach clinics she and the nurses who had treated the routine patients joined to consult patients; more-severe cases were reserved for special care or for teaching/learning. As a result, mothers were more motivated to use the available health promotion/disease prevention services; fewer patients were referred from outreach clinics and health posts; the number of severe complications and deaths dropped in patients referred to hospital because essential treatment was started before referral. In all of this, Dr. Martin also gained practical experience in providing health care to a hospital with a community-based health center network.

In 1973 Dr. Martin joined the University Health Center for Health Sciences (CUSS) as a pediatrician and public health physician, in charge of the community health program. CUSS was established to test new concepts of appropriate medical education for Africa; two pillars of this new approach were *community-based* and *integrated* teaching. Mvolye,

on the outskirts of Yaounde, was selected to test the community-based activities of CUSS because it was easily accessible, consisted of a suburban and rural areas, and local authorities agreed to its use for teaching, developing primary health-care services, and research. Mvolye had to be properly prepared to achieve the set objectives and goals of the CUSS program. The community had a government health center with a maternity section, and a Catholic mission health center. A member of the ruling family provided a building that became the CUSS Annex. Some drugs were available, but vaccines and the usual primary health-care drugs for common ailments were not. Routine vaccination was not available except through the periodic mobile service. The task was challenging, but a committed Director of CUSS, joint projects with other institutions, such as Harvard University, and existing community-based activities in Mvolye provided a foundation. Dr. Martin and her colleagues developed protocols and started clinics for pregnant women, children and adults. With the assistance of a small team—two full-time physicians, a public health nurse-midwife and other part-time physicians, nurses, sociologist, nutritionist and environmentalist—Dr. Martin oversaw the program for 13 years.

Dr. Martin's experience encapsulates the tasks that must be done to establish an effective community health program. A few essential drugs were available, hence curative care was free but preventive care was not. The first vaccines were provided by the Harvard /CUSS project; thereafter, Dr. Martin's friends and relatives paid for the first set of DPT Polio, while patients paid approximately \$1.00 for the series. Disposable syringes were provided by a friend and colleague in the U.S.A; Dr. Martin personally cleaned and sterilized them, and stored the vaccines at home. UNICEF provided some weighing scales. Staff were able to talk about disease prevention and vaccinate children with DPT and OPV vaccines purchased from the Pasteur Institute in Cameroon, but measles vaccine was then too expensive to be purchased. When the national EPI was launched in 1975, CUSS Annex was one of the first centers to be established; its popularity grew so rapidly that approximately 300 children received well-baby care at the half-day sessions.

The antenatal clinic became popular. Daily attendance grew to exceed 180 women, but because the rotation serving the clinic was changed, the number of new pregnant women had to be limited to 25 per session, to maintain the quality of patient care and teaching of students. Dr. Martin recounts that "it was sad to see `the wall' of women leave, either to attend the maternity clinic next door or try to arrive early the next week, to be among the few selected." In the clinic, all essential tests were performed, using low-cost but accurate methods. Women were referred for blood grouping and syphilis testing when indicated.

Although services were offered in the CUSS Annex, Dr. Martin and her team also worked with students in the community, on activities such as home visits to study families or to follow up special cases. Community diagnosis, periodic health education sessions and health days for disease screening, patient care, and vaccinations were also provided.

The project had to address crises having little to do with medical care. For example, when the owner of the building died CUSS was asked to pay higher rent. In a bid to further increase the number of rooms to be rented, the owners blocked the main windows, obliging Dr. Martin's team to close down the three half-day clinic sessions and hold all

the activities in the villages where the needs were greatest. Room space was made available in the villages selected by the leaders, and students worked in small groups, full time, in each village.

Data collection and analysis, important both in the clinic and the community for preparing reports and for research, were accomplished with help from the villages. Volunteers were trained to record births and deaths, weigh children, manage diarrhea with ORS, educate and motivate for healthy practices such as infant feeding, vaccination, clean environment, and antenatal care, in their respective villages. Each village had a health committee and sent two members to the Mvolye health community.

Although CUSS paid salaries and provided transportation to and from the community, and some essential materials were provided by other sources (Harvard/CUSS, Canada, WHO) and a Canadian NGO, the project needed funds to purchase more drugs and other supplies. Funds had to be generated locally; the project decided on several means of cost sharing with patients, a process by which the community learned about the costs of their health care and contributed in whatever ways possible to help the program survive and remain effective. The experience Dr. Martin acquired in cost sharing for health-care services in Mvolye made it possible for her to actively contribute to the development of the Bamako Initiative proposed by UNICEF and WHO, including formulation of guidelines and later implementation.

The CUSS/Mvolye program became a reality. Staff provided drugs and performed routine laboratory tests regularly. Community health workers and members of the health committee were selected by the villagers and worked as volunteers; they were compensated in their villages by increased recognition and respect. The project, in Dr. Martin's words, was "a field laboratory" for teaching primary health care to medical students, nursing students, and health technicians. It also attracted postgraduate medical students who wanted to do primary-care electives, and undergraduate and postgraduate students from Europe and North America. The project became a site for field visits during international seminars, and spawned successors. Students' theses and staff research have been undertaken with primary and secondary data from Mvolye. It also became a field laboratory for research in food science and nutrition. In Dr. Martin's opinion, the project succeeded because everyone worked as a team; "everyone" included cleaners, drivers, and secretaries, who learned to do simple but essential tasks that left the health professionals with more time to teach and perform more-technical tasks.

In 1980 Dr. Martin was named head of the Center for Nutrition Research in the Institute for Medical Research and the Study of Medicinal Plants, Ministry of Scientific and Technical Research, Cameroon. In that post she combined research, teaching, and patient care in the Center for Nutrition, the Center for Health Sciences and the Teaching Hospital. In 1986, UNICEF offered her the post of Regional Adviser in Primary Health Care. She worked in the East and Southern region of UNICEF for 8 years, based first in Madagascar and then in Nairobi, Kenya. In 1994 Dr. Martin moved to the West and Central Africa region, based in Abidjan, Cote d'Ivoire. She has travelled to almost all African countries south of the Sahara, and has met with decision makers, national and international technicians, and with UNICEF colleagues. With the latter, at regional, national, and global meetings, seminars, workshops and conferences, she helped to

encourage decision makers and health technicians to adopt new strategies, accelerate or expand programs to promote children's health, and reduce morbidity, mortality, and disability.

Dr. Martin's experiences in practice and in international organizations have led her to some definite opinions about the role of the latter. For example, she thinks that "there have been far too many initiatives and resolutions coming from outside" Africa. While acknowledging that the initiatives do positively affect the health of children, women, and countries as a whole, she believes that each agency or donor has its own viewpoint about priorities. She thinks that development agencies should, rather, work together in their respective countries to assist the countries to formulate their own national development plans, including goals, objectives, strategies, and activities. New initiatives to be funded by the development agencies should come from within the respective countries, which develop at different rates and so should not be expected to address the same problems at the same time, nor with the same strategies. In Dr. Martin's opinion, development agencies and other donors should assist developing countries to review problems and previous achievements, and empower them with technical, financial, and logistical support to select their priorities and proven strategies to achieve the set goals.

Dr. Martin's experience and beliefs are best summarized in her own words:

There is a great need for health promotion and disease prevention through health information, education, and communication. Opportunities for sharing information are many, including mass media (radio and newspapers), health and environment clubs in schools and colleges, and weekly and monthly social and tribal meetings. There is a need for translating learning and teaching materials into the languages and styles that different groups understand. More people should be trained as leaders and trainers. Undergraduates and graduates from developed and developing nations play an important role as they exchange ideas while learning and contributing to health development in communities. Facilities should be created for this to happen.

I would like to focus once again on putting into practice at the grass roots those low-cost, simple technologies that empower families to live healthy lives. Opportunities exist to do so.

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