

UNIVERSITY OF PORT HARCOURT

**THE ADVOCATE: FOR RICHER FOR
POORER, IN SICKNESS AND IN HEALTH,
PRESERVING THE HERITAGE**

An Inaugural Lecture

By

Professor N. A. Akani

MBBS(Ibadan), FMCPaed

Dept of Paediatrics and Child Health,

Faculty of Clinical Sciences,

College of Health Sciences

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DEDICATION

- To my parents - Smart O. Kanu and Victoria C. Kanu for sharing love unreservedly.
- To my siblings who paid the ultimate price for love shared unreservedly.
- To my siblings with whom I shared the pain of loved ones lost
- To my family for speaking out against inequities for peace and healthy living.
- To Erunchi Annabel, my bundle of joy, my granddaughter-hoping and praying that your generation will experience a better society where justice, equity and peace reign.

ACKNOWLEDGEMENTS

In humility, I bow before the Almighty God who spared my life and made it possible for me to fulfill this once in a life time obligation despite the vicissitudes of life. I owe all gratitude to Him, the Creator.

I am very grateful to my parents Mr. Smart O. Kanu and Mrs. Victoria C. Kanu (both of blessed memory) for the opportunities they gave me in life, for provisions, intimacy, interest, their exemplary hardwork and christian virtues which I imbibed in early life. These have kept me going despite the oddities of life.

I appreciate my brother, Mr. Uzodinma U. Kanu and my sisters Nnennaya U. Ukeje, Ngozi E. Mba and Nkechi I. Okoronkwo for their support and encouragement. I pay a special tribute to my late brother Chinweuba E. Kanu . I recall with pain in my heart your sudden demise and really miss you at this occasion. I also appreciate the late Chief Okogbule Wonodi who purchased my first Nelson's Textbook of Paediatrics when I started my Paediatric residency programme.

My regards go to my colleagues with whom I have worked ceaselessly over the years and who have inspired me to provide the needed leadership. Let me specially mention Dr. Gracia Eke for holding the forte in my absence and ensuring that the Oncology unit does not collapse. I also specially appreciate Prof. C. Nwankwo, Drs. Agi and Oboabo West (Radiology), Dr. Gbobbo Dr. Okoro (Paediatric Surgery), Prof. Chijioke Nwauche (Haematology), Prof. Seleye- Fubara and Dr. Obiora both of Morbid Anatomy. Others deserving special mention include Mrs. Yetunde Akani, Noble Nwogu, Mr.

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I specially express my appreciation to their Excellencies, Dr. Peter and Hon. Justice Mary Odili for providing the initial platform and support for self expression in the area of school/adolescent health and safe motherhood. To my sisters in the TAP Nigeria family, I appreciate the bond God has helped us to establish and we owe it to the society to show exemplary leadership.

For those who stood with me while the battles raged on - Evang. Ikechi Aliche, Pst and Evang. Amos, Evang. Stella Rufai, Evang. Faith Nwachukwu, Pastors Victory Ikpeama, Walters Ifedi, Bayo Ajala and Chima Chukwunyere- may God also stand with you and reward you. Let me respectfully appreciate the one who does the battle while I sleep peacefully, my General Overseer, Rev Felix Akara and his dear wife Pastor (Mrs) Gloria Akara. In and out of season you shall remain blessed.

I also say thank you to my numerous relations, friends and admirers for your smiles ,encouragement and prayers.

My children have been very much a part of my journey through my career. I recall their sleeping in the call rooms while I took my calls as a resident. They have been my sisters and brothers, my confidants and companions when life's path seemed lonely. You will indeed be a wonder to your generation.

Finally, to you Acho, my husband, we have been in this business together for as long as we have known each other. Thank you for being there as a pillar of support and encouragement when I am down. My prayer is that God will continually shield you and the children He has blessed us with and grant you all good health and long life to accomplish His purpose for your creation here on earth. Amen.

ACRONYMS

NCWS	National Council of Women Societies
TAP	The Adolescent Project
USA	United States of America
AAP	American Academy of Paediatrics
ESSOP	European Society for Social Paediatrics
PPFN	Planned Parenthood Federation of Nigeria
NAGRP	National Animal Genome Research Project
UNESCO	United Nations Educational and Scientific Committee
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organization
UNICEF	United Nations Children's Fund
NDHS	National Demographic Health Survey
NPC	National population Commission
UNFPA	United Nations Fund for Population Activities
PRB	Population Reference Bureau
BPC	Beyond Parental Control
IDPs	Internally Displaced Persons
MDGs	Millennium Development Goals
ARI/DTU	Acute Respiratory Infections/ Diarrhoea Training Unit
IMCI	Integrated Management of Childhood Illnesses
WAHO	West African Health Organization
AAU	Association of African Universities
IPAF	International Paediatric Association Foundation

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THE ADVOCATE- FOR RICHER FOR POORER, IN SICKNESS AND IN HEALTH, PRESERVING THE HERITAGE

P R O T O C O L

INTRODUCTION

Today, I have the pleasure of giving the 130th Inaugural Lecture of this University, indeed the sixth from the Department of Paediatrics and Child Health, Faculty of Clinical Sciences. Like many scholars who have gone this path before me, arriving at a title for an Inaugural Lecture may sometimes be daunting. So it was for me until I woke up one morning with no other option but this – “The Advocate: For Richer for Poorer, in Sickness and in Health, Preserving the Heritage”.

Preparatory to this lecture , the reactions to the title from some of my friends were "it sounds like a marriage seminar", "what are you doing with culture" and some who are yet to speak out on this may probably be asking in their minds what the business of a Paediatrician is with heritage preservation. Quite a lot if we understand who a Paediatrician is.

Paediatrics, the Paediatrician and Paediatric Practice

Paediatrics stems from two Greek words - "Pais"- Child and "Iatros" - Doctor/Healer. Thus Paediatrics means " Healer of children". Until 1859, child health care was subsumed in the care of adults, and children were treated like any other adult without reference to their special needs, development and body mass. It took the efforts of Dr. Jacobi popularly referred to as the Father of Paediatrics to separate the health care of children from that of adults under the specialty called Paediatrics. This field of Paediatrics has since developed to become a highly

flexible medical specialty offering extraordinary career options.

A Paediatrician is primarily a medical doctor who has undergone many more years of training, passed the prerequisite examinations in the field of Paediatrics and has been certified by an approved board/authority. He/She is developmentally oriented and trained in skilled assessment and management of physical, behavioural and mental health in addition to social problems that affect children from birth to 18 years (or up to 21 years in the case of USA). This what differentiates Paediatricians from other child healthcare providers. A Paediatrician is trained to protect children.

Over the years, the need for specialization has also grown with many Paediatricians now specializing in their areas of interests. Thus we have the Paediatric generalists and specialists like cardiologists - looking after the heart, nephrologists - the kidneys etc. It has also become difficult to generalize on what Paediatricians do as this depends on their areas of practice and modes of practice. Service delivery like the adult care has been focused on treating the sick and preventive education in the hospital or clinic settings.

With the recognition that factors in the community impact on children's health, the concept of Community Paediatrics has emerged. Community Paediatrics is different from community based Paediatrics practice where the latter is delivered under the usual clinic based arrangements within a community.

Community Paediatrics is an integrated system of care based on health, education and family support. It is essential in each community to foster optimal growth and development of the

child. The American Academy of Paediatrics (AAP) defines it as

- A perspective that enlarges the paediatrician's focus from one child to all in the community and includes advocacy especially for those who face barriers to health care because of social or economic conditions.
- A recognition that family, educational, social, cultural, spiritual, economic, environmental, and political forces act favourably or unfavourably, but always significantly, on the health of children.
- A synthesis of clinical practice and public health principles directed towards providing health care to a given child and promoting the health of all children within the context of the family, school, and community.
- A commitment to use a community's resources in collaboration with other professionals, agencies, and parents to achieve optimal accessibility, appropriateness, and quality of services for all children and to advocate especially for those who lack access to care because of social or economic conditions or their special health care needs.
- An integral part of paediatrics practice.

Within this arrangement we can actually see **SEVEN FACES OF PAEDIATRICS**

- Paediatrics of sickness
- Paediatrics of prevention
- Paediatrics of community health
- Paediatrics of lifestyle and habit at home
- Paediatrics of education through school health services

- Paediatrics of development through identification and care of the handicapped
- Paediatrics of mental health through promotion of mental health of the family.

Closely linked to Community Paediatrics is **Social Paediatrics** which the European Society for Social Paediatrics (ESSOP) defined as " A global, holistic, and multidisciplinary approach to child health which considers the health of the child within the context of their society, environment, school, and family; integrating the physical, mental, and social dimensions of child health and development as well as care, prevention and promotion of health and quality of life." **Social Paediatrics** acts in three areas – child health problems with social causes, child health problems with social consequences, and child healthcare in society. It encompasses four areas of child health care – curative Paediatrics, health promotion, disease prevention, and rehabilitation.

It is from these two perspectives -Community and Social Paediatrics that I shall be addressing the topic of today's lecture.

To set the stage therefore, permit me to start with this story - a life experience.

Sir, as a Youth Corps Medical Officer serving in a comprehensive health centre, I came across a woman carrying her twentieth pregnancy (Gravida 20) with only four children alive. She came for Antenatal care and one could see a tired abdominal wall, very lax and ugly looking. I kept wondering what will become of her in labour. At the Orogbum health centre then, pregnant women were usually referred to a secondary facility at 36 weeks gestation for delivery and

scarcely did we get a feedback unless the woman came with her baby for immunization or was repeating for antenatal care (ANC) with another pregnancy. What I can remember is that I never saw her again until I left that health centre.

I am not an obstetrician (even though one by induction) but every good Paediatrician must be concerned about the pre-conceptional health status as well as the status throughout pregnancy and delivery of a mother because circumstances and events surrounding pregnancy and delivery can affect the quality of a child at birth. This may impact on subsequent productive life of the individual and the future economic potential of the nation.

Twenty pregnancies, Four Alive! What a waste!! but no government – local, national or international took notice. This encounter took me to the only family planning centre in the state then - Planned Parenthood Federation of Nigeria (PPFN) where I volunteered my services. It was also the stimulus to my paper on "Family Planning in Rivers State: Implications for Child Survival" in 1983.

As I made recommendations based on my findings from data of acceptors at the PPFN, and maternal and child health statistics from the health centre, it became clearer that for a woman to access family planning services in our setting, several other issues need to be addressed. These include her perceived need for it, availability and accessibility of the services, permission from her husband, religious belief, views from her cultural background, the number of male siblings the husband has, the number of male children that she has, the number of previous child deaths and the desire to replace the lost ones. These are not medical issues but some of them may have informed her health behaviour and choices.

EVERY HUMAN BEHAVIOUR IS CAUSED. (Ademuwagun 1977/78)

Some of these factors (sometimes a combination of them) may be the propelling factors in the child bearing history of some families like the woman cited. They may also be reasons for some of the names (eg. Onwubiko - death please; Torbia - house of women; Chinenyenwa - God that gives children; Nwajinmaogo - the good relationship between in-laws is based on children; Enwusonye - who does death respect and the likes) that we sometimes give to our children for posterity to understand circumstances surrounding their births. The question is – how does this help in the survival of the child?

DEFINITIONS

Back to the topic of this lecture - let us look at the definitions of the key words.

1. **Advocate:** The Oxford Dictionary defines an advocate as a person who publicly supports or recommends a particular cause or policy; a person who puts a case on someone else's behalf.
2. **Sickness:** Reported illness i.e. illness for which an individual goes to seek treatment.
3. **Health:** “A state of complete physical, emotional (mental) and social well being and not merely the absence of disease or infirmity”. (WHO 1948).
4. **Preserving/To preserve** (verb) (Thesaurus Dictionary)
 - (a) To keep alive or in existence.
 - (b) To keep safe from harm / injury, protect, spare.
 - (c) To keep possession of or retain
 - (d) To maintain something in its original state.
 - (e) To treat to prevent decomposition.

(Synonyms: conserve, safeguard, shield, defend, protect.)

5. **Heritage:** (oxford dictionary)

- (a) Property that is or may be inherited.
- (b) Valued objects /qualities that have been passed down.
- (c) Anything considered important enough to be passed on from generation to the future generation.
- (d) Irreplaceable sources of life and inspiration.

HISTORICAL BACKGROUND

Historically, according to Jodilyn Trujillo (a biological analyst, a historical anthropologist and a behavioural economist) , the concept of preservation of heritage started with the National Animal Genomic Research Program (NAGRP) in America when it was observed that people looted or took away objects from other people's lands – in some cases body parts and in some others sacred and ceremonial pieces – indeed objects that were not meant to be seen . When the items were examined by some of the governments, they decided to keep them for museum purposes. Due to globalization, this action gained global attention and has since evolved to the point that cultural heritage is now important. She made this assertion while commenting on "Safe guarding" from the UNESCO and UN Declaration of the Rights of Indigenous People. People and governments now make so much effort to preserve what they perceive is being lost or going into extinction ranging from language, buildings, animal species to cultural practices, and ancient ways of life like Pottery, and basket making. In 1972 UNESCO adopted the International treaty called Convention Concerning Protection of World Culture and Natural Heritage

and also set up a world Heritage centre to which state parties make contributions.

Museums have since been established in big cities by governments, organizations and individuals and people travel and spend money to visit such centres. Although heritage has been broadly classified into two – natural and cultural, the one that is usually much talked about is the cultural heritage.

Vice Chancellor Sir, for as many of these heritage preservation centres as I looked up, I found that whether it be cultural, religious practices, language or sports preservation, the motive behind it all (including the UNESCO centers) was for ‘FUTURE GENERATION’ to see and be reminded that these things once existed.

Distinguished audience, Psalms 127 vs 3 of the Holy Bible says “Children are a heritage from the Lord” but in my quest to understand the items being preserved with so much economic efforts and connections, I found something missing – no centre or museum had a hold for child preservation. One may also ask who/what constitutes this “Future Generation” for which governments – local, national and international – are spending so much resources to build museums? Is it not still children of today? If these children are not preserved to grow to become the future generation, then the museums would have become a waste of resources. Should the first priority not be to preserve our God,-proclaimed Heritage?

The title in the context of this lecture.

In this lecture therefore, we shall be discussing children as our collective heritage whether they are advantaged or disadvantaged, deprived or not, and dispossessed or not. Children are children in whatever state we find them and they

have the rights to survival, development, participation and protection for optimal growth to live out their potential.

WHY DISCUSS PRESERVATION OF “THE HERITAGE”

Psalms 127 vs 3 which I alluded to earlier on went on to say “Blessed (Happy) is the man whose quivers are filled with them (i.e children). Certainly, a man whose barns are filled with yams must be a happy man but what will be his joy when he finds that the yams are distasteful or show no promise of good yield? My belief is that when God’s word promised - blessed is the man whose quivers are filled with children, God was not thinking of the type of yams with blemish because the Bible says “He gives good gifts (including children) and in Proverbs 10 vs 22 "The blessing of the Lord, it maketh rich and He addeth no sorrow with it". Why therefore are many families in sorrow from what should otherwise be “good gifts” – Children.

It is a natural reaction that when you receive a gift especially one that you consider valuable, you do everything possible to protect it from damage, theft and preserve it for long term use or as a legacy.. When we lose such gifts, we always mourn, feel sad and recount the loss as it becomes a burden although wears out with time. Why are families in sorrow? They are in sorrow because we are losing the children - God's gift to us. If you take a cursory look on our streets and highways you will see children who should be in school being paraded or roaming as child beggars, children in labour under the harsh weather, youth violence, and in corrective homes they are there as 'beyond parental control.' Our news headlines are filled with stories of sexual abuse of children, children stolen for rituals, some accused of witchcraft and burnt or tortured; young girls are recruited as commercial baby factories and babies in the womb are sold as items of commodity and adults are buying!.

In 1989, Nigeria joined other nations of the world in ratifying the United Nations Convention on the Rights of the Child(UNCRC). By that ratification, Nigeria committed itself to ensuring the survival, development, participation and protection of her children and further more to the fact that in decisions of government and its people, the interest of the child shall be the touch stone. As at 2014, **23 out of 36 states of Nigeria** have domesticated it into law. In this same country, a ten year old female was amputated for running away from a marriage contract she was not part of while Nigerians looked on. It was in this country that a lawmaker in the seventh national assembly took a child for a wife and while the public cried out, it was defended in the name of religion. Only a few months ago, a 14 year old female was kidnapped from Bayelsa state and taken to Kano and as at rescue time (March 2016) she was five months pregnant - a baby mother going to have a baby. That is a possible low birth weight baby, an obstructed labour, an asphyxiated baby, a vesico-vaginal fistula and a possible maternal death in the making!!

If a lawmaker who should have ensured the implementation of the law to protect the child committed an offence against the child and felt no remorse at all, and society could not fight for the child, then childhood is not just highly vulnerable but **our heritage at risk of extinction. We must fight for its preservation.**

Vice chancellor sir, distinguished audience, the factors or issues that threaten our heritage come from different sources but ultimately target their health and development. I shall attempt to look at these generally but in the last two and half decades I have spent time working in the following areas: school health, adolescent health, childhood cancers, child

abuse, harmful traditional practices, children in especially difficult circumstances and maternal and child health. These shall be the areas of focus as we progress in this presentation.

CHILDHOOD and HEALTH

CHILDHOOD is a period of life that begins from birth and ends at age 18yrs. Anybody below the age of 18yrs is regarded as a child (UNCRC). Within this period of life are recognized phases of childhood as shown below:-

Neonatal Phase	-	Birth- 28days
Infancy	-	1mth –12months
Toddler	-	1 – 3years
Pre-school	-	3 – 5 years
School age	-	5/ 6 – 10 years+
Adolescence	-	10 – 19years.

Childhood is a dynamic period and each phase of childhood is characterized by its own joys, anxiety, challenges and difficulties.

HEALTH is defined by WHO (1948) as "a state of complete physical, emotional and social well being and not merely the absence of disease or infirmity". This definition implies that freedom from disease is not necessarily health but rather that all round well being is what constitutes health. In 1986, the Ottawa Charter for Health Promotion declared that to reach a state of complete physical, mental and social well being, an individual or group must be able to

- Identify and realize aspirations
- Satisfy needs and
- Change or cope with the environment

thus modifying the definition of health to **the ability of an individual to identify and realize aspirations, satisfy needs and change or cope with the environment.**

Nations and health practitioners over the years have continued to measure health in terms of **MORBIDITY** (ill health) and **MORTALITY** (death). Causes of morbidity and mortality tend to vary with the changing phases of childhood.

Table I SOME CHILD HEALTH INDICES IN NIGERIA-LEVELS AND TRENDS 2003-2013

Basic indicators	2006	2003	2006	2008	2013	2013 urban	2013 rural	2013 No edu	2013 Sec edu	2013 >sec edu
NMR/1000live births	53	48		40	37					
IMR		100	99	75	69	60	86			
U-5MR		201	191	157	128	100	167	180	91	60
U-5MR & birth interval in yrs <2yrs						213				
2yrs						140				
3yrs						103				
4yrs						79				
Vaccine Coverage %										
BCG		48		50	51					
Polio3		29		39	54					
DPT3		21		35	38					
Measles		36		41	42					
ALL		13		23	25					
NONE		27		29	21					

Source: NATIONAL DEMOGRAPHIC HEALTH SURVEY (NDHS) 2013

Table II DATA ON MATERNAL AND OBSTETRIC CARE

SERVICE	AVERAGE 2013	URBAN	RURAL	2008	2003
Skilled provider at delivery%	38	67	23		
Delivered in health facility%	36	62	22		
Had ANTENATAL CARE%	61	86	47		
Fully vaccinated %	25	43	16		
Use of family planning services%	15				13

Source: NATIONAL DEMOGRAPHIC HEALTH SURVEY (NDHS) 2013

Age specific causes of morbidity and mortality

- **Neonatal mortality** -birth asphyxia, severe infections including tetanus, premature births and birth complications.
- **U-5 MORTALITY**- 70% of the over 1million annual deaths in this age group are caused by malaria, pneumonia, diarrhoea, measles, HIV/AIDS, with malnutrition in over 50% of cases.
- Each day 2,300 U-5 children die(approx 1million/yr and 10% of total global U-5 deaths)
- Each day145 women of child bearing age die
 - ❖ Thus Nigeria is the 2nd largest contributor to U-5 and maternal mortalities.
 - ❖ Additionally, the life of a baby is intricately woven with that of the mother such that whatever can kill the baby can also kill the mother.

NOTE: From Tables I and II

- A generally very slow trend in improvement in the above indicators (NNMR, IMR, U-5MR and vaccine coverage)
- the urban rural disparity in child deaths and obstetric care in favour of urban dwellers.
- the relative advantage of education in improving U-5 mortality
- the relative advantage of spacing birth intervals in reducing U-5 deaths
- the very low and poor coverage of our services especially immunization and family planning.

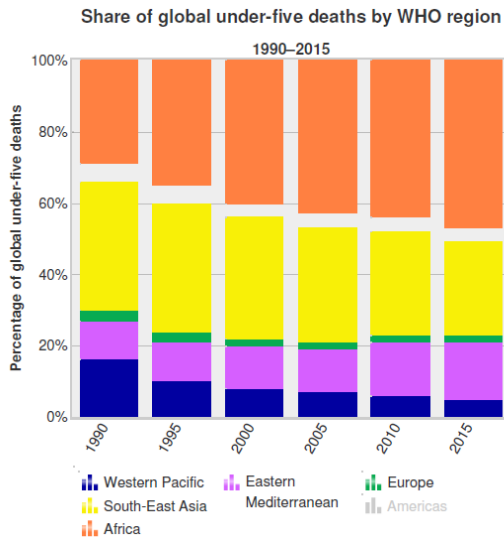


Fig. 1

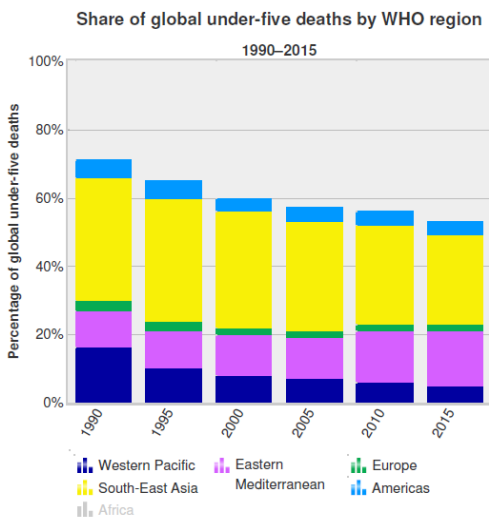


Fig. 2 Share of global under-five deaths by WHO region

School- age and Adolescents

Childhood is a spectrum but as we can see the school aged and adolescents are not part of our basic health indicators. As a matter of fact, it is only recently that the Almajirins in the north started counting. What about those in the creeks, the fishing ports and farm settlements (like ELI ISRAEL in Emohua local government area)yet to be captured.?

School age Population

School aged constitute about 25%-30% of our national population and that these are the gains of all our child survival strategies (having survived to age 5). However, it would appear that erroneously the society and government assume that after age 5 children become immune to disease and death and therefore do not require any health care. Hence, there is no organized care for them. From age 6 most children are enrolled in school(sometimes even earlier) as required by law and so spend about 8 to 12hours of their day or sometimes

months in school, outside the domain of their homes and some hours through busy roads with the attendant hazards. Some children never get to be enrolled due to circumstances beyond the control of the children.

- ❖ Enrolment 65%-68% of eligible population (into primary school); (32-35% not in school)
- ❖ Total completion rate 69.2% of the enrolled
- ❖ Dropout rate 30.8% (m 25%, f 35%)
{13% annually in the West (Oduntan 1975)}
- ❖ Gender disparity & High level of non enrolment

Reasons for high dropout rate

- ❖ High levels of school absenteeism for health reasons - 95.6% (Oduntan 1975)
73.5% of Primary 4 pupils (NPC 1997)
- ❖ Teenage unwanted pregnancy - 58% of drop out (NPC 2000)
- ❖ Malnutrition & hunger (1995) 41% go to school without breakfast
- ❖ Economic hardship – cannot pay fees
- ❖ Frequent community clashes
- ❖ Cultism and violence
- ❖ Natural disasters (flood) –relocation of children (IDPs)

It is important to consider schooling for the following reasons:

- the link between education and health has long been established in the 1950s; that an uneducated child cannot make healthful choices and an unhealthy child cannot learn effectively
- the level of attainment before leaving school has a profound influence on future life choices of employment and living style.
- academic success has been identified as an excellent indicator of youth health

- academic success is also an early predictor and determinant of adult health.

What is the health status of the school -aged like? This will be considered in two separate categories- the in-school and the out-of-school child.

The in-school child:

Infections, Anaemia and Road traffic accidents (RTAs) are common health problems of the school aged with RTAs contributing to high mortality (20.5% of which 45% are pedestrian injuries, Ebong). Emerging and re-emerging diseases-like HIV infection, Tuberculosis (58.2%, Okeahialam) childhood malignancies, Ebola and Lassa Fever are new health challenges. Improved survival of pre-terms and asphyxiated babies imply that more children with neurological disabilities (18.8%, Asindi), albeit subtle, will be attending schools posing a challenge to the growing child and the non-suspecting school managers.

Health related factors like hunger, abuse and chronic illnesses can lead to poor school performance and its correlates resulting in school drop outs, street children and children in conflict with the law. Early sexual initiation and violence are linked with poor grades and lower academic attainment.

The out -of- school child:

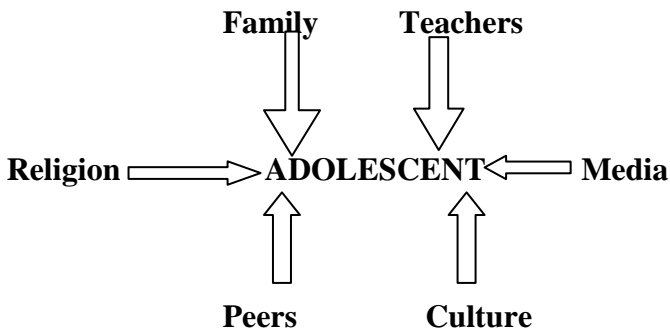
While they are also at risk of the age- health related conditions like their in-school peers they pass through greater risks merely to survive. Many of these are seen on the streets as children on the street or of the street. This exponentially increases their risk to road traffic accidents, sexual abuse and climatic hazards. They are easily introduced to maladaptive behaviours like smoking and drugs.

The adolescent

Adolescents are children between ages 10 and 19. A non-homogeneous group, they are embedded in a complex societal matrix (as shown below) which also tends to influence their behaviours.

Adolescence is a transition period that is highly challenging and accompanied by bio- physical, emotional and psychosocial changes some of which require personal and social adjustments. It Involves periods of stress, innovation, experimentation and disorganization.

It is a period when the adolescent though largely dependent on parents would prefer to be addressed as an adult . However from this phase of life to adulthood, there are five major transitions which the adolescent has to go through. These include the transitions of learning, work, marriage, family and citizenship.



Although the infections and other health challenges of younger children are not common in adolescence, it will be erroneous to assume that they do have their own challenges. These challenges arise from circumstances created by our culture,

religion, socioeconomic status, political atmosphere and governance. These circumstances include -

- Circumstances of Growing Up
- Circumstances of Warfare and Violence
- Circumstances of Unemployment
- Circumstances of Rough Socio-Political Climate
- Circumstances of Temporary Loss of Family/Care Givers
- Circumstances of Harmful Socio-Cultural Practices
- Circumstances of Extreme Poverty
- Circumstances of No Laws / Non Implementation of Laws
- Circumstances of Religion

The consequences of these may impact on their education, health, dignity, social integration and their adaptation within the society.

Is it any wonder therefore that Nigeria parades the type of statistics shown below?

School enrolment

(PRB 2013)

-Transition primary to secondary	41% f,	47% m;
- secondary to tertiary	9% f	12% m

NEDS 2016

2015 Rural Females	Without Schooling	49%
2015 Urban Females		22%
2013 Rural Females		53.5%

(Increase in transition from primary to sec.)

(secondary to Tertiary dropped by 10%)

Marriage

-Nigeria	20% of females by 15years and 39% by 18years	(PRB 2013)
- In the north	45% of girls before 15years, 72% by age 18	(UNFPA2013)

-Girls <15yrs 2million of the 7.3million new adolescent mothers of the world (UNFPA2013)

The deduction here is that our children's education is sacrificed on the alters of child marriages and teenage pregnancies enhancing the ripples of peri-natal, neonatal, Under -5 and maternal mortalities from early sexual initiation and birthing process and motherhood in especially difficult circumstances. The lack or stunted educational status sets in motion the other adverse social factors of low socioeconomic status further worsening the health out-look.

Obviously, most of these issues are not primarily medical but their outcome impact not only on the health of the persons involved, but trickles down to involve the family, the community and the nation at large. The Paediatricians are not exempt as they have to grapple with the burden of health issues created by these challenges and sometimes their inter-generational cycle.

It has been documented that there are three main factors that determine healthy growth and development. These are **nature, nurture and the environment**. Nature refers to the child's condition at birth while nurture is how the child is brought up. It is believed that nature and nurture can impact on the genome of a child. Three other factors are also known to contribute to the maintenance and promotion of health and these are

- availability and accessibility of facilities for early diagnosis and treatment
- acquisition and application of appropriate health knowledge and
- a healthy environment.

Are these available for our children?

With the high levels of school dropout from primary to secondary and secondary to tertiary certainly appropriate health knowledge acquisition is marred and the application not feasible. On health services in Nigeria as far back as the year 2000, Prof. Adetokunbo Lucas wrote "The Nigerian health system is sick, very sick and in urgent need of intensive care. It is blind, lacking vision of its goals and strategies. It is deaf, failing to respond to the cries of the sick and dying; and it is impotent, seemingly incapable of doing things that neighbouring states have mastered".

As if corroborating this assertion, on page 11 of the UNION Newspaper of Wednesday, November 5, 2014 paragraph 3, Polycarp Onwubiko wrote "Depreciating Health Care Delivery and Increasing poverty in Nigeria".

Looking at the global statistics, Nigeria presents one of the poorest child health indices. In terms of trends, while we admit that we have made some progress in some areas we acknowledge that this progress has been very slow and where we are now is quite far from where we intend to be. This is in spite of several efforts and tools that have been developed to improve on child health indices through vertical programmes like child survival strategies, ARI/DTU infant feeding practices, kangaroo nursing to integrated programmes like Integrated Management of Childhood Illnesses (IMCI), Partnership for Maternal, Newborn & Child Health, (PMNCH) community based newborn care and the promotion of Rights of Children by the United Nations. The biggest of them all which appeared to have held a good promise for the world was the MDGs – an outcome of the World Summit for Children. **Some targets of the MDGs were**

- To reduce U-5 mortality rates to 30/1000 live births by 2000
- Improve care to school children and
- Improve the status of females through education

The year 2015 was supposed to have seen our child health indices emerge among the recommended acceptable limits yet we could not attain it.

In a report “Why Children Die” by Dr, Ingrid Wolfe and his colleagues in the United Kingdom documented that in 2012,

- over 3000 babies died before age one
- more than 2000 children and young people died between 1 and 19 years
- more than 50% of childhood deaths occurred during 1st year of life
- injury is the most frequent cause of death after age one
- RTAs are responsible for more than 75% of deaths from injury among 10 – 18 year olds
- Suicide is the leading cause of death among young people and that number of deaths from deliberate self harm has not decreased in 30 years.

The report highlighted the importance of high quality health care for children and young people, called for a reduction in preventable deaths through better training of health care professionals to enable confident, competent early identification and treatment of illness and better use of tools and coordinated care between hospitals and schools.

Vice Chancellor sir, the causes of mortality in early life are similar and largely preventable but certainly the absolute numbers are not comparable at all. Additionally, the reach of

their health services is wider with concern for coordinated care between hospitals and schools but in our circumstance, our health services coverage has failed us as shown in tables I and II above.

Distinguished audience, whilst agreeing to a certain extent with Dr. Ingrid Wolfe and his colleagues on the recommendation of better training for health care professionals, certainly where we are today in terms of training is far much better than what it used to be (before Dr. Abraham Jacobi in 1859 founded the specialty called Paediatrics) with so many Paediatricians some of whom are subspecialists in some fields and other care givers and the numbers keep increasing.

In joining others to attempt to find a solution to our poor child health indices, my submission today is that if we have been doing things in a particular manner and not getting the desired results, the situation demands a change in understanding, process and methods.

Health Care Services and New Concept for “Children’s Health”

Our health care services as designed have continued to be delivered using the Medical Model.

Table III The Medical Model of Health

- Views health predominantly as the absence of disease and as functional fitness
- Directs its services mainly towards treating sick and disabled people
- Places high premium on the provision of specialist medical services mainly in institutional settings
- Doctors and other experts diagnose illness and diseases
- Regards its functions as mainly curative or remedial to get people back to productive labour
- Explains disease / sickness within a biological framework emphasizing physical nature of diseases
- Works with pathogenic focus, emphasizing risk factors & establishing abnormality (and normality)
- Places a high value on use of scientific methods of research and knowledge
- Accords a lower status as knowledge for qualitative evidence than quantitative evidence.

Curled from Linda Jones' WHAT IS HEALTH? in: Promoting Health Knowledge and Practice

However, understanding the terms illness, sickness and disease which are often times used as synonyms will enable one see the pitfalls in this model of health care.

Illness is a feeling of unwellness. It is possible for a person to feel ill without symptoms or any evidence of something being wrong. Meanwhile someone else may actually have a grave condition without knowing because that is what he has always known as normal until identified.

Sickness is described as reported illness – that is illness for which the person actually goes for treatment. This is the one

that is usually recorded in our health statistics. However, it is known that not all illnesses get to the hospitals/clinics, and that many sicknesses get treated based on recommendations of friends and relations. Thus health statistics based on such records in an environment where so much self medication and alternate approach thrive must be deficient.

Disease refers to a state of ill health that is identifiable with a specific part of the body or pathologic condition.

It follows therefore that many of the children I represent here today, are not enjoying health but have not been captured/reached by our medical model of health care services either because they have not gone to receive treatment or because the facilities to reach them are not available.

For this reason, the medical model of health care has been viewed as “mainly concerned with alleviating suffering – pulling people out of the river downstream without moving upstream to see why they keep falling into the river!” (Zolain Mckinlay, 1979)

Antonovsky between 1987 and 1993, studied groups of people to know why some people remain in good health and others do not in spite of being in the same environment. He found that among survivors of second world war, people could cope because by early adulthood they had developed a feeling of confidence that the world had a meaning and was predictable; they had the resources to cope with the challenges they were facing and believed that the challenges were worth responding to. Do our children have the resources to cope with the numerous challenges they are facing? Can they really in their present state attempt to change the environment for the better?

Do their interactions with adults give them any hope that the world has any meaning?

Quoting Elizabeth Lee Ford-Jones et al in their review of the World Bank Report of 2007,

"There has never been a better time to push for concerted action to ensure that as many young people as possible grow up well educated, remain healthy, and have opportunity to participate in society as active and valued citizens. Failure to invest now (sic) may lead to disillusionment, social unrest, and fragmented societies". The social unrest referred to, of course, includes terrorism in which some, albeit illusory, sacrificial dignity is preferred by suicidal and/or homicidal bombers to the degradation of a poverty that appears inescapable. This desperation is an unfortunate close cousin to the high-risk gun and drug trader now operating in some parts of our society - those trying to 'get rich or die trying'".

The Ottawa Charter definition of health implies that "health" is a personal struggle and that communities and nations need to work towards it to attain such a goal. It views "health" as a resource for living and recognizes that social, personal resources and physical capabilities are necessary for its attainment. Therein lies the difficulties of our children ever attaining HEALTH as defined because in the present day society, many children will continue to depend on their parents or care givers for basic necessities of life for quite some time either because they are still in school and have no resources of their own or that they are not capable of making decisions for themselves like the much younger children. For any progress to be made in this direction, responsible adults must necessarily live up to their responsibilities towards their wards.

Issues have arisen to question the suitability of this definition in relation to children. This is because it does not seem to have

take into consideration the differences between adults and children in terms of development, multiple influences and resources.

In 1997, the Institute of Medicine Committee (US) sought for a comprehensive and integrative definition of HEALTH that is conceptually sound and based on scientific evidence that will reflect the dynamic nature of childhood and provide a basis for both measuring and improving children's health.

The committee came up with a new definition of Children's Health which states **“Children's Health is the extent to which individual children or group of children are able to or enabled to (a) develop and realize their potential (b) satisfy their needs; and (c) develop the capacities that allow them to interact successfully with their biological, physical and social environment.** The committee went further to identify 3 main domains of health by which children's health should be measured. These are

- Health conditions
- Functionality
- Health potential

Since health results from complex interactions of the child's environment with genetics and behavioral responses, each influencing the other, the timing of influences occurring at sensitive and critical periods of transitions in a child's developmental journey through childhood may make or mar the health of such a child.

Whereas the child has the right to survival, development, participation and protection, the child in the womb has no decision on what a mother should eat to avoid the baby having

neural tube defects, know where she must be delivered to avoid birth complications e.g. asphyxia. Baby cannot insist on being exclusively breastfed to be healthy and intelligent. Neither can the child decide on the birth interval before a subsequent birth to help him or her survive beyond age 5.

The child does not have an opinion on where you choose as parents to live and what type of housing nor when couples decide to live together or separate nor can he/she insist on being in school when parents say they cannot pay fees. Somebody is in a position to make that decision on behalf of the child.

The older child, whilst he/she may not be comfortable with he/her circumstances, she/he cannot go on strike to gain attention like adults do. Rather he/she must necessarily adopt some coping skills to deal with the situation. The type of coping skills he or she will adopt is likely to be influenced by the internal assets of the individual and the life lines available. An individual who adopts a negative behaviour (e.g. smoking, drugs) or deviant behaviour (e.g. pick pocketing, violence and bullying) as a way of letting out his aggression may bring himself in conflict with the law or jeopardize his health.

Earlier in this presentation, we noticed that the NDHS reports displayed a relationship between parental levels of education and U-5 mortality, place of residence and U-5 mortality, birth spacing and U-5 mortality, place of residence and vaccine coverage; and U-5 mortality and obstetric care/skilled birth attendance at delivery. We also noted the contribution of hunger and malnutrition to poor school performance and how childhood health, education attainment are determinants of adult health.

It follows therefore that disease is only a fraction of determinants of health and that certain existing non -medical conditions/factors/circumstances may act as precursors that pattern the attitudes and behaviours of individuals eventually resulting in injury disease and death.

SOCIAL DETERMINANTS OF HEALTH

These are factors that contribute to a person's current state of health. They have been classified into five categories viz -

- (1) biology and genetics
- (2) individual behaviours
- (3) social environmental conditions
- (4) physical environment;
- and (5) health services

It has been noted however that beyond these there are factors that influence individual and group differences in health status. These have been termed **Social Determinants of Health (SDOH)**.SDOH are the economic and social conditions and their distribution among population - that influence individual and group differences in health status.

WHO defines **SDOH** as "**the economic and social conditions in which people are born, grow, live, work and age**". **They are shaped by the distribution of wealth, power and resources at the global, national and local levels.** Indeed they can be regarded as circumstances of people's lives (outside medical care) that can be shaped by social policies. Examples include education, birth spacing, place of domicile as has been earlier demonstrated. Others include employment, income, lifestyle, culture, religion, exposure to adverse environmental conditions, discriminatory practices and poverty. This list is by no means exhaustive.

The American Association of Family Physicians (AAFP) recognizes the following as factors that strongly influence health outcomes in individuals –

1. Access to medical care
2. Access to nutritious food
3. Access to clean water and functional utilities
4. Early child care
5. Education and health literacy
6. Family and social support
7. Gender
8. Housing and transportation resources
9. Linguistics and other communication
10. Neighbourhood safety and recreational facilities
11. Occupation and job security
12. Other social stressors e.g. exposure to violence and adverse factors in the home
13. Sexual identification
14. Socioeconomic station
15. Social Status (Degree of integration vs. Isolation)
16. Spiritual/religious values
17. Ethnicity/Cultural concerns

However, poverty or its absence has been recognized as a major determinant of child health and well being. Poverty refers to a situation where a person or group lacks human needs because they cannot afford them. The human needs include clean water, good nutrition, health care, education, clothing and shelter.

Often times poverty is implicated in children's ill health. Social determinants tend to affect the poor adversely and disproportionately, perpetuating further the disparity in health if not addressed. The poor are likely the ones living in

underserved, rural and remote areas with less access to clean water, unsafe housing, and no transport system. Health services where available, are inaccessible, unaffordable. Harmful traditional practices also thrive there worsening the health crisis. They are also not likely to aspire to policy making positions but will easily be recruited for crimes at cheap costs. Thus, poverty is a significant determinant of child health. For children living in poverty, child abuse and neglect, developmental delays are common occurrences compared to other children and health outcomes tend to be worse because of resources to address situations especially in emergencies.

Do you know that the rich and their children also cry? While the rich pursued their busy schedules, they have failed to pay attention to their heritage. Some of such children, in their modesty have cried out to say we too need our parents; we need to be protected from ourselves; while others have gotten involved with drugs, gangsters and sexual misconducts even right under their roofs only for such parents to discover them late. The children say it is not all about money and I agree with them. As a medical student, family and social history was the bedrock of clerking. That was actually the initial step in our training as medical practitioners to view our patients in the context of their family and environment. However, most times trainee paediatricians or even paediatricians and our colleagues in other specialties trivialize this. We sometimes ask screening questions about unmet basic needs but lack the resources/skills to take this a step further. The information remains only in the case notes. Time has come when we must look beyond medically related inquiries to the issues that actually perpetuate child illness.

Since in our present medical model of Paediatrics physicians are divorced from community groups and anti poverty programs, child care givers will have to consider a model that will effectively deal with child health problems with social causes, child health problems with social consequences, and child health care in society. That model is **the SOCIAL PAEDIATRICS model.**

Although Social Paediatrics operates on the principles of Community Paediatrics, it seeks to work with those living at the margins of society- **the disadvantaged, the deprived, the dispossessed and the disabled.** This is the field have found interest working in to improve lives through delivery of medical services , changing circumstances , capacity building and empowerment, conflict resolution, research , networking, community dialogues, advocacy and influencing policies formulation, modification or implementation.

RESEARCH EFFORTS

1. School health programme in primary schools in obio Akpor LGA: Effect of short term training of head teachers on implementation.

RATIONALE- Concern for the health of the school aged.

Findings: Low levels of knowledge among the head teachers

- Level of education equivalent to NCE and above- better health knowledge
- school environment very poor and hazardous
- health education periods not adhered to -reduced exposure
- teachers are generalists- can give only what they have.
- health services and emergency provisions severely lacking.

Training improved knowledge and knowledge level remained higher than baseline months after the training.

Akani N. A, Nkanginieme KEO, Oruamabo RS. Benin Journal of Educational Studies 2000; 14(1) :32-45

Akani NA, Nkanginieme KEO, Oruamabo RS 2001; 28(1):1-6.

- Stimulated more research works in this area in different parts of the country
- stimulated Government action to develop policies renovation of schools, free school feeding programme

Ezeonu CT, Ibe BC, **Akani NA**- An assessment of school health services in primary schools in Abakaliki Metropolis

Oladele Simeon Olatunya, Saheed Babajide Oseni, Oyeku Akibu Oyelami, Caleb Adegbenro, **Nwadiuto Akani** Health instruction in Nigerian schools: what are the missing links? Pan African Medical Journal

Olatunya O, Oseni S, Olaleye A, Olatunya A, **Akani N**, Oyelami O School Health Services in Nigeria: A sleeping giant? Afr J Health Sci. 2015; 28(1):127-

Akani NA, Okagua J, Douglas K, Green K, Nyeche S, Yarhere I, Abbey M - IMCHUNIPORT/IPAF School Health Project Report

ADOLESCENT HEALTH

- Paediatric and adolescent gynaecological problems seen in UPTH

Findings - high rates of septic abortion

Akani NA, Akani CI. Conference proceedings 34th Annual General Meeting and Scientific Conference of Paediatric Association of Nigeria, . January 2003

- Hysterectomies in adolescence a 20 year review

Akani NA, Akani CA, Pepple DKO TNHJ 2008; 8 (1-2): 20-23

Findings; Septic abortions were responsible in 75% of cases performed in UPTH.

- Sexual abuse in children seen in UPTH over a six month period

Findings: Sexual abuse common among the school aged and adolescents

Akani NA Socio-cultural context of Adolescent Reproductive health in Rivers state. The Adolescent Project and Society for Gynaecologists and Obstetricians workshop proceedings. Port Harcourt 2000.

Outcome: An organized interdisciplinary team and clinical protocol for management and follow up to ascertain true prevalence in our environment and community.

- Frank-Briggs AI, **Akani NA** Establishing Youth Friendly Services in University Of Port-Harcourt Teaching Hospital: Needs and Services. TNHJ 2006; 6(1&2):363-368

CHILDHOOD MALIGNANCIES

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MATERNAL AND CHILD HEALTH

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Akani Chris, **Akani Nwadiuto** Tropical Doctor 2006; 36:208-210

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Akani NA, Orazulike N, Dougla K, Paul N, Green K, Nyeche S - IMCH/WAHO Maternal Mortality Audit Project Report, K-Dere Gokana

Akani NA, Okagua J, Douglas K, Green K, Nyeche S, Yarhere I, Abbey M - IMCHUNIPORT/IPAF School Health Project Report

Areas of Contributions

- Academic - Teaching, Publications, Research, capacity building/trainings
- Health care services delivery
- Tools development - School health evaluation scale
School entry medical exam forms,
- Policy formulation
 - University HIV Policy
 - Reproductive Health Services law of Rivers State
- Advocacy and Community Dialogue on Harmful Traditional practices
- Projects -
 - Establishment of school health clinics
 - AAU HIV Project
 - Adolescent friendly services

-Maternal Mortality Audit Project

There is the need to identify the factors that try to destroy our heritage, identify the levels at which they exert their influence, identify the team players at those levels and work with them in order to break the persistent cycle of injury, disease and death among our children. This is talking about **ADVOCACY**

THE WAY FORWARD

We need to adopt **ADVOCACY** as a way of life.

WHAT IS ADVOCACY?

Advocacy is a strategy to influence policy makers when they make laws and regulations, distribute resources and make other decisions that affect people. It is a strategy to reduce poverty and is appropriate when you want to influence policies that are the source of poverty and discrimination.

For the child health care givers and paediatricians in particular, advocacy means making a commitment to support the child and family beyond the issues related to the treatment of their individual medical conditions. The basis for this should be our wish to meet all of a child's health related needs within the context of family and community.

Advocacy aims at

- (i) Creating policies where they are needed and there is none in existence
 - (ii) Reforming harmful or ineffective policies
 - (iii) Ensuring good policies are implemented and enforced
- Poverty and discrimination stem from decisions we make at household levels and decisions made within community leadership structures, national legislatures, international organisations and powerful institutions. Various actors in the private and public arenas

contribute to livelihood, insecurity or violation of human rights and significant impact can only be achieved through changes in the policies and actions of powerful institutions as well as individual and households.

Why do children need advocacy?

- no political power
- limited say in decisions affecting their lives
- generally unable to obtain redress when decisions are taken against their best interests

Does Advocacy Work? The Evidences from my work

- Institutional HIV policy
- Routine screening of new entrants into University of Port Harcourt
- Adolescent health clinics in UPTH
- Oncology support group and Foundation
- School building reconstruction
- School health clinics in Rumuoparaeli
- Child sexual abuse
- Female Genital Mutilation
- Regular School Health checks

Steps in Advocacy

- Identify the problem(s) that need(s) to be changed
- Identify the levels of the problem
- Gather information on the issue
- Look for partners/Share your burden
- Significant or relevant stakeholders
- Anticipate challenges that may be encountered
- Work plan
- Proceed to work with team players
- Engage emergent or new interested partners

Essential tactics of conducting successful advocacy campaigns

- Communicating effectively using media
- Negotiating, and
- Managing Risk

Need for Advocacy

- (1) Child Abuse - Protection issues
 - Juvenile justice system overhaul
 - No homes for relocation



Fig. 3 *Child Battery*

- (2) Childhood oncology -
 - Treatment issues - pricing
 - Expertise lacking
 - Provision of facilities
 - Foundations

PIE CHART SHOWING THE AGE DISTRIBUTION OF CASES

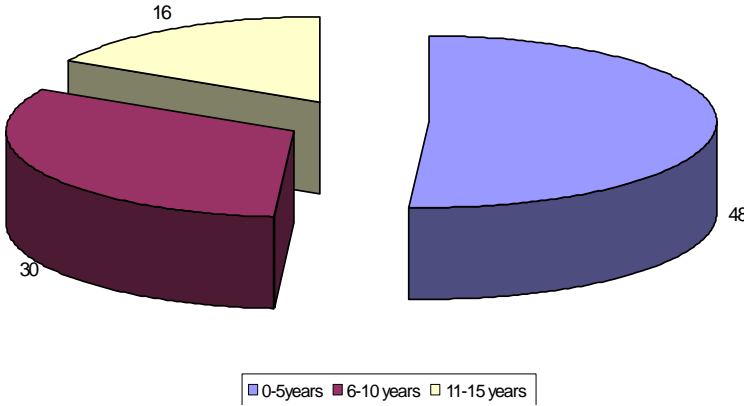


Fig. 4

TABLE 3 SHOWS THE AGE DISTRIBUTION OF THE TYPES OF MALIGNANCIES

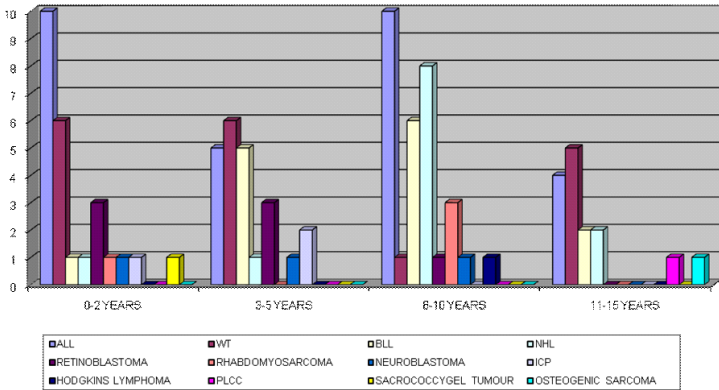


Fig. 5

FREQUENCY DISTRIBUTION OF DIFFERENT CANCER:

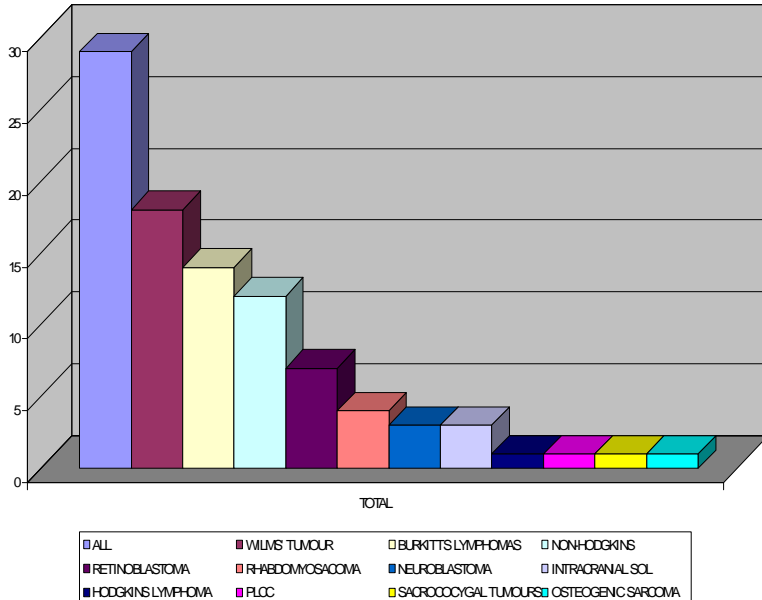


Fig. 6

- (3) Maternal and child health
 - Cultural issues - abolition of harmful cultural practices
 - Provision of services in rural areas
 - TBAs and alternatives - continue to sensitize until they are completely weaned off

* Implementation of the laws

- (4) Adolescent and Youth Health
 - Establish youth friendly centres
 - High prevalence of HIV
 - High sexual abuse
 - Homosexuality increasing in the school aged and drugs

- Institution of Sexuality education - in school and out of school

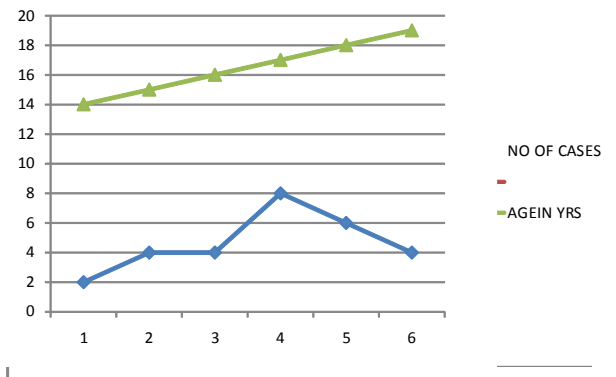


FIG 1 AGE DISTRIBUTION OF CASES OF HYSTERECTOMIES

Fig. 7

(5) School Health

- Glaucoma in school children
- Dental caries
- Every school needs it
- Re-enact health checks



Fig. 8 *School Children Leaning on bare floor*



Fig. 9 *New School Premises*



Fig. 10 & 11 Community Advocacy in Action

Steps taken - advocacy to churches, communities, opened register of pregnant women in the churches, monitor where they registered for ANC

THE ISSUES:

Our children need protection from:-

1. Harmful traditional practices that put them at risk of disease and death eg TBA practices, FGM and the roots of such practices uprooted
 - ostracism of parents with teenage unwanted pregnancies, abortion, septic, sale of babies
2. Culture of violence - domestic violence
 - intimate partner violence
 - bullying in schools - its relationship with the society under violence and sexual abuse
3. Poverty - vulnerability to sexual exploitation - through prostitution
 - child sale
 - abuse (physical and sexual) child battery
4. Environment
 - social practices - (multiple sexual partners - HIV)
 - Cultism/drugs - school truancy, failure, poor performance and drop outs
5. Exposure to toxic effects - pesticides
 - Protecting Children from pesticides
 - Pesticides exposure (especially pre-natal) effects on children
 - Attention and learning problems
 - Low birth weight
 - Paediatric cancer
 - Protecting Children from pesticides
6. abuse/neglect
7. Dental caries
8. Glaucoma
9. Bills - Reproductive Health
 - Free Medical Health Policy)
 - divorce of parents (alternative dispute resolution for co-parenting)

- - behavioural change, improve relationship among families, communities and social culture

Challenges to Advocacy

- Conflict of interests in schools
- Differing interests among advocacy team
- Funding
- Bureaucracy
- Laws - declaration of ward of court
- prosecution
- Children's issues not on the front burner



Fig. 12 *The target our Heritage*

CONCLUSION

**ON A FINAL NOTE, OUR PASSION
TO PRESERVE THIS PRECIOUS
HERITAGE POINTS TO OUR
INDIVIDUAL AND COOPERATE
ADVOCACY**



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CITATION OF



PROFESSOR NWADIUTO AFONNE AKANI

Professor Nwadiuto Afonne Akani is the fifth child of Smart Odinkenmere and Victoria Chijiuba Kanu of Umuda Isingwu, Umuahia. She had her primary education at the Wesley Methodist School, Port Harcourt and obtained the First School Leaving Certificate with Distinction. She proceeded to Archdeacon Crowther Memorial Girls College, Elelenwo for her secondary education but this was truncated by the NIgeria-Biafra civil war in 1967.

In 1970 she resumed schooling at Girls' Secondary School, Umuahia where in January 1973 she obtained the London GCE Ordinary Level Certificate and in June of the same year, the

West African School Certificate with Grade I. She studied Medicine at the University of Ibadan as a Federal Government Scholar and obtained the MBBS degree in June 1981. She had her one year housemanship training at the University College Hospital, Ibadan.

She served as Youth Corps Medical Officer at the Comprehensive Health Centre, Orogbum in Port Harcourt and thereafter worked as a Medical Officer under the ministry of health. She moved to the University of Port Harcourt Teaching Hospital for her residency training and in 1998 joined the services of the University of Port Harcourt as Lecturer I . She was promoted to the rank of Professor of Paediatrics and Child Health in October 2011.

She holds the Fellowship of National Postgraduate Medical College in Paediatrics (FMCPaed). She is an examiner at Parts I and II Fellowship exams of the NPMCN in Paediatrics and is for the second time, serving on the Faculty board of Paediatrics of the College for four years.

Apart from her job as lecturer to undergraduates, she also lectures the MPH students and is a supervisor of projects/dissertations at undergraduate and postgraduate levels. She has published widely in local and international journals, co-authored 2 books and contributed chapters in 3 books. An advocate for Children's Rights, she is a community paediatrician with a bias for Social Paediatrics. Her research focus is in the areas of school and adolescent health, child abuse, paediatric cancers, maternal and child health and harmful traditional practices. She has many conference presentations and public lectures to her credit.

She has held various positions of authority-Acting Head of Department 2005 - 2007, Head of department (UPTH) 2006-2008 and is the current Director, Institute of Maternal & Child Health of the University. She served as the Chairperson of the Committee that developed the University HIV Policy and also instituted the routine screening of our new entrants for HIV which has helped in early detection and institution of care to some of the affected persons. She served as the sub regional (West Africa) Coordinator for the AAU HIV/AIDS program for 3 years.

Professor Nwadiuto Akani has served as Faculty representative to Senate, Faculty representative to SCAPP, Member STADU, Member Prof T.I. Francis Memorial Lecture Committee, Member College Committee on University 40th Anniversary Celebration, and on various boards, committees and panels of enquiry in the university and its teaching hospital.

She is also the focal person for PAN's Adolescent Health. She is currently a member of the National Child Health Technical Working Group where she also chairs the school and adolescent health subcommittee and a member of the subcommittee on non- communicable diseases.

She is a member of many professional bodies including NMA, PAN, (IPA) MDCAN, MWAN (MWIA), ISPCAN, SIOP (NISPO). She has served on the editorial boards of NJP, TNHJ, NPMJ, The Gazette and reviewer to British Medical Journal, NJP, TNHJ, National Postgraduate Medical Journal. She has served the community through NCWS and MWAN in various capacities. She served as the Projects Adviser to The Adolescent Project (TAP) Nigeria and as State/National Coordinator, White Ribbon Alliance for Safe Motherhood.

Professor Akani is a recipient of so many awards and honours some of which include -

- Prize of Excellence, first ever awarded by Girls' Secondary school Umuahia.1973
- Justice of the Peace 2007
- Commendation Letter from Department of Paediatrics and Child Health for an excellent Keynote lecture at the 45th Annual Conference of the Paediatric Association of Nigeria in Calabar in January 2014.
- "Friend of FIDA"- FIDA Nigeria, Rivers State Branch
- Honorary Award by Rotary Club of Port Harcourt, GRA

An astute Christian, she is an ordained Deaconess and the International Coordinator of God's Heritage Women International. She loves worshipping God and singing and has over 30 songs of her own.

She is married to Chris Akani - a Professor of Obstetrics and Gynaecology and they are blessed with five children - Wobia - a lawyer, Chizy - an architect, Chituru - a medical doctor, Ugochukwu - a medical doctor and Oworchukwu - an engineer. She is the proud grandmother of pretty Erunchi Annabel.

Distinguished audience, to deliver the 130th Inaugural Lecture I present to you a 1991 Jerusalem Pilgrim, a child of God, a mother to many, a teacher of households, a researcher, a helper, a mobilizer for change, an initiator and skills builder ,humility personified, a distinguished personality, and an academician, Professor Nwadiuto Afonne Akani.

Professor Bridget Nwanze