

UNIVERSITY OF PORTHARCOURT

RIGHTBIRTH AS OUR BIRTHRIGHT: A REFLECTION TO ACT RIGHT

An Inaugural Lecture

by

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Dedication

To my late parents Chief Eziwhuo and Wuchegbule Akani for teaching me humility, integrity, compassion and courage to believe in myself.

To my life mate, my wife and mother of my wonderful children, Prof. Nwadiuto A. Akani for her support, resilience and understanding while I took on many issues of life.

To my wonderful children Wobia, Chizy, Chituru and Ugochukwu; for whom I sojourned thus far to create a future.

To the numerous mothers and babies who have been a great source of inspiration.

To the source of wisdom, knowledge, strength and designer of destiny, my Lord and Master.

Acknowledgements

On an auspicious occasion such as the one afforded me by the University of Port Harcourt to tell the world what I profess, my debt profile is really overflowing in numerous directions. Let me start from my home: My dear wife Diuto Akani, you have been the bedrock of support and encouragement even in moments of turbulence and tribulation. Diuto thanks for bearing those deprivations. I am happy that we are in this exciting intellectual adventure together as soul mates and colleagues in the hallowed corridors of the academia.

I acknowledge my wonderful children Wobia, Chizy, Chituru and Ugochukwu whose cries, smiles and laughter served as tonics for the struggle to this height and made my lesson sessions on fatherhood worthwhile. You added flavour to my career and gave me inestimable joy in life. I owe everything to you for affording me an opportunity to experience the inestimable joys of fatherhood.

I pay tribute to my parents, Chief Friday Eziwhuo Akani and Mrs Grace Wuchegbule Akani – both of blessed memory – for playing their roles magnificently well in bringing me into this world without birth complications; otherwise how can I stand strong before this audience today? My siblings: Mrs Abigail Pepple (Sister) and Auntie Dora deserve special mention, as well as my brothers: Nyenweze, Uche, Azunda, Nnamdi, Chukwuma, Worgu and Aham, for their fervent prayers while the struggle lasted.

Today, I call to memory, Late Chief Okogbule Wonodi, who had a strong conviction that I could weather through the academic storms in Nigeria and subsequently compelled my father to call off all arrangements for me to travel to the United States; not even the lure

of a Foreign Scholarship award to study in the defunct Soviet Union could persuade the intrepid administrator to change his mind. I am glad I heeded his advice to stay in Nigeria and battle it out, rather than “checking out like Andrew:

Late Professor Vincent Aimakhu deserves special mention for his implicit confidence in me a prospective university material. How I wish he was alive to witness the dance of this day.

I am ever grateful to Rev & Barr (Mrs) Felix Akara, the multitude of friends, critics and teachers, who have shaped my life and helped me learn the truth about life and a breath-taking career in medicine.

I appreciate all my friends, colleagues, mentors and benefactors, whose names I have not mentioned, but in one way or the other positively influenced my early life as a pupil, student and today a scholar.

Special thanks go to Emeritus Professor Nimi Briggs and Professor Celestine John who stood as pillars of the Department of Obstetrics and Gynaecology to see us grow to maturity. My contemporaries Prof. Anthony Okpani, Prof. John Ikimalo, Prof. Samuel Uzoigwe and Dr. Nestor Inimgba for your valuable partnership and valued friendship in our maternal health agenda that is so decisive to the survival and wellbeing of the next generation. My colleagues, especially Consultants in the department of obstetrics and gynaecology deserve my gratitude on this occasion. I sincerely appreciate you all for your support.

The Vice Chancellor of the University of Port-Harcourt Professor Joseph A. Ajienka and the entire University Administration deserve my sincere thanks for giving me this opportunity to present the 116th Inaugural Lecture – the first in 2015. To this great audience, I say *Gracias*.

Finally, I reverence God Almighty for His goodness and mercy towards me and privilege of life to actualize today.

My hope is built on Christ Jesus. I point to the cross to show the cancelled note of any mistakes placarded for all to see. Lord I am eternally grateful.

ACRONYMS

APIN	–	Aids Prevention Initiative in Nigeria
AIDS	–	Acquired Immune Deficiency Syndrome
ANC	–	Ante Natal Care
CPD	–	Cephalopelvic Disproportion
CSW	–	Community Social Worker
D&C	–	Dilatation and Curettage
FGM	–	Female Genital Mutilation
FIDA	–	International Federation of Women Lawyers
GAIN	–	Global Aids Initiative in Nigeria
HIV	–	Human Immunodeficiency Virus
HPV	–	Human Pappiloma Virus
IMPAC	–	Integrated Management of Pregnancy and Childbirth
LEB	–	Life Expectancy at Birth
MDG	–	Millennium Development Goal
MMR	–	Maternal Mortality Rate
MVA	-	Manual Vacuum Aspiration
NPHCDA	–	National Primary Health Care Development Agency
PMTCT	–	Prevention of Mother to Child Transmission
PNMR	–	Perinatal Mortality Rate
RI	-	Reproductive Index

TBA	-	Traditional Birth Attendant
UNICEF	-	United Nations International Child Education Fund
WHO	-	World Health Organization
%	-	Percentage

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Preamble

I feel highly honoured to stand before you today to deliver the University's 116th Inaugural Lecture and the third from the Department of Obstetrics and Gynaecology, Faculty of Clinical Sciences, College of Health Sciences of our unique University. The first from The College of Health Sciences and the Department of Obstetrics and Gynaecology titled "Cancer: why are we so helpless?" was delivered by Prof. Nimi D. Briggs in 1992. The second titled "International collaborations in obstetric practice: My personal experience" was delivered in 2006 by Prof Celestine T. John.

In preparing for this lecture, my challenges were two-fold. The first was choosing a topic which would be stimulating and the second, deciding on a topic that is contemporary in appeal in the discipline of Obstetrics and Gynaecology; a subject in which I have made modest contributions and professed in almost a decade.

Historical perspectives of Obstetrics/Gynaecology

Obstetrics is the branch of medicine that deals with the care of women in pregnancy, childbirth and six weeks after the delivery of the mother (pregnancy and pregnancy-related complications). **Gynaecology** deals with the scientific study and treatment of abnormalities and diseases of the female reproductive system.

The history of Obstetrics is inextricably linked with midwifery. It took its origin from the Latin word '*obstare*' (Holts 1999), which is coined from two words '*ob*' synonymous with toward, against, over or to and '*stare*' meaning '*to stand*'. From *obstare* derives the word *obstetrix* which literally means the one who stands opposite the one giving birth (midwife).

In 1819 the word 'Obstetrics' and in 1829, the word 'Obstetrician' came into being.

Mr Vice Chancellor Sir, in our practice as obstetricians, we do not only stand before our women, we stand by them, behind them, watching over them and standing against the challenges that emerge in the course of the pregnancy and delivery.

Today's discussion is a recount of how far the Almighty God has brought me in this discipline involving protecting and saving the lives of our mothers, wives, sisters, daughters and even our granddaughters. The thrust of care and challenges facing the modern obstetrician in the developing world revolves around fertility control, safe motherhood, prevention of peri-natal deaths and close censorship of the health of our mothers. After many years of clinical obstetrics and burdened by the magnitude of complications among our obstetric population presenting to the hospital, I was moved to choose for this lecture, the topic '**Rightbirth is Our Birthright: A Reflection to Act Right**'.

I chose this topic because it seems to offer me many approaches to the subject of safe motherhood; a subject which has occupied almost all my adult life. It also affords me the opportunity to explore the features of birth and factors associated with it. In discussing this topic, the key words to be borne in mind are Right (as an adjective, an adverb and a noun), Birth, Birthright and Childbirth.

Definitions

- **Right** (as an adjective) - In conformity with fact, truth, standards or principles in accordance with what is good, proper or just (as an adverb) - timing,: immediately, promptly, straight or directly
- **Birth** - The process of bringing forth a new one (delivery of a baby)
- **Right birth** - the process of delivery in compliance with professionally accepted standards, methods and decorum. This constitutes the ability to give prompt attention to a patient within reasonable time limit; competence in the assessment of a patient; making correct diagnosis particularly when the clinical presentation is glaring; not making glaringly avoidable mistakes

in the course of giving treatment; not caused by act of commission or omission, other health care professionals under his/her supervision or working in association with him/her to act to the detriment of the patient.

- **Right** (noun) - An expectation in terms of matters affecting the interest of individuals within a particular society which the consensus of opinion in that society accepts as justiciable [Sir Harold Wimsworth, 1973]. This is truly applicable anywhere in the world including Nigeria.
- **Birthright** - The Collins English Dictionary defines birthright as privileges or possessions or entitlements the person has as soon as he/she is born. It is that which is due anyone by just claim, legal guarantees or moral principles because the person is born into a particular position, society, state or nation.
- **Legal rights**- are claims that are justified by legal principles and rules and moral rights are claims that are justified by moral principles and rules. A positive right is a right to be provided with a particular good or service by others while a negative right is a right to be free from some action taken by others. The right to forego a recommended surgical procedure such as caesarean section is regarded as negative right. A right holder need not assert his right to have them. For example, small children, the comatose, and the mentally handicapped may not be able to claim their rights. Nonetheless, claims can be made for them by authorized representatives. So the **unborn** child has rights that can be claimed by representatives.

My submission is that it is the birth right of everyone on this planet to be born right [right birth] and it is the collective responsibility of individuals, community and governments to ensure not only that it is possible, but that the minimum facilities and skilled personnel to promote, produce, protect and preserve good health are equitably and generously distributed within the communities they govern (WHO, 1952; Fatalla, 2004).

We value rights because when enforced they provide:

- protection against unscrupulous behaviour

- promote orderly change
- promote cohesiveness in communities.

Rights stand as shield against threat and intrusions; and assert prima facie claims. The whole point about rights is that they restrain the communities or governments from acting at the expense of individuals (in this case the child bearing women).

WHY DISCUSS RIGHT BIRTHS?

In many villages, towns, countries and religions of the world once a man and a woman have been joined in matrimony, it is expected that the next thing will be pregnancy and then children.

The Bible declares in Psalms 127vs 3-5 “Children are a heritage from the Lord, the fruit of the womb is his reward. Blessed is the man whose quivers are filled with them”. However, pregnancy and childbirth clearly mean different things to different women, depending on whether they are willing mothers or reluctant ones; healthy or ill; supported or alone and whether they are in or out of wedlock.

Childbirth is a dramatic episode in a woman’s life. It is a time when the past merges with the present and holds potential for the future. For choice pregnancies, wonder, excitement, awe and reverence are stirred by evidence of creation of another human, a creation that began with conception, moved through orderly process of biologic development, and culminated in birth. For such, childbirth therefore, is universally, a celebrated event; an occasion for dancing, giving flowers or gifts. Yet each day, worldwide, for thousands of women, childbirth is not a joyful event as it should be, but an agony that may lead to death (Aimakhu, 1990).

Many of us are probably familiar with the following global statistics:

- Every year 536,000 women die from pregnancy-related causes. This adds up to more than 10 million women over a generation.
- Every year, more than 1 million children are left motherless and vulnerable because of maternal death.

- The risk of a woman dying as a result of pregnancy or childbirth during her lifetime is about 1 in 15 in Nigeria as opposed to 1 in 5,000 in developed nations (NPHCDA, 2009).
- Maternal Mortality Rate (MMR) is 800 per 100,000 live births while neonatal mortality rate is 48 per 1,000 live birth with wide variation between regions (NPHCDA, 2009).
- In Nigeria, an estimated 52,900 women and estimated 250,000 newborn die from pregnancy related complication annually (NPHCDA, 2009).
- Only about 40% of deliveries are conducted by skilled personnel (NPHCDA, 2009).
- Maternal death, still birth and newborn death are strongly linked to place of births and the three “delays” associated with maternity care (NPHCDA, 2009).
- Approximately, 10-15 million women a year suffer severe or long-lasting illnesses or disabilities caused by complications during pregnancy or childbirth. These range from obstetric fistula to infertility and depression.
- Every year, an estimated 68,000 women die as a result of unsafe abortions and millions more suffer complications (CHOICES 2010).

Did the Bible not say in Prov. 10 vs 22 “the blessings of the Lord it maketh rich and He addeth no sorrow with it”?

Did the Bible not say in 1Timothy 2¹⁵ concerning women giving birth “notwithstanding she shall be saved in child bearing”? So, why do some of our women and babies die during child birth from preventable causes related to child birth?

In the bible the book of Genesis 35 vs 15 – 19 mentioned midwife attending to a woman (Rachael) in labour (travail). It further documented that Rachael had hard labour. She had the baby but she died. Exodus 1 vs 15 – 19 also documented the attendance of midwives at the deliveries of the Hebrew and Egyptian women and the different experiences they had with the groups (comparative ease of labour in the Hebrews as against the Egyptians – whether real or apparent).

The Bible's documentation of midwives attending women during the birth process suggests an age long recognition of the fact that the carrier of the blessing (the mother) and the blessing being carried (the baby) needed to be carefully handled; suggests that the birth process experience may not always be the same for every mother; and the possible need for intervention in some cases which is why the midwives were in attendance. Like in every area of life's endeavour, knowledge of what to do and what not to do to produce the desired outcome is very necessary. Thus, to understand why our women die carrying out their God-given role, we need to first understand the normal birth process and the factors associated with it for a right outcome.

THE BIRTH PROCESS

The process of birth itself is dependent on the various dimensions of the bony structure of the female pelvis, the foetal skull and propelling force of uterine contraction. A vivid understanding of the anatomy and physiology of reproduction remains a vital guide to a successful birth and indeed a right birth. Figs 1a and 1b show the anatomy of the female pelvis and the foetal skull respectively.

Anatomy of the pelvis and foetal skull

The pelvic outlet is formed by the lower border of the pubic bones at the front, and the lower border of the sacrum at the back. The ischial spines point into this space on both sides. Figures 1a and 1b below show the dimensions of the space that the foetus must pass through as it emerges from the mother's pelvis and what the superior surface of the head of the foetus looks like. As you look at the Figure, imagine that you are the birth attendant who is looking up the birth canal, waiting to see the foetal head emerging.

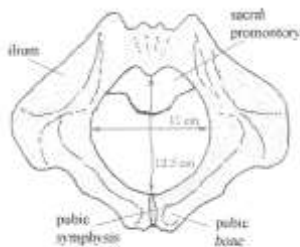


Figure 1a: Diameters of the pelvic outlet, viewed from below.

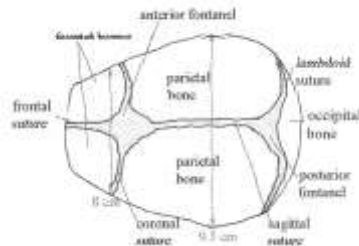


Figure 1b: The foetal skull

Figure 1a: The pelvic outlet

Anatomy of the foetal skull

The foetal skull is the most difficult part of the baby to pass through the mother's pelvic canal, due to the hard bony nature of the skull. Understanding the anatomy of the foetal skull and its diameter will help you recognise how a labour is progressing, and whether the baby's head is 'presenting' correctly as it comes down the birth canal. This gives a better understanding of whether a normal vaginal delivery is likely, or if the mother needs referral because the descent of the baby's head is not making sufficient progress.

Correct presentation of the smallest diameter of the foetal skull to the largest diameter of the mother's bony pelvis is essential if delivery is to proceed normally. But if the presenting diameter of the foetal skull is larger than the maternal pelvic diameter, it needs very close attention for the baby to go through a normal vaginal delivery.

Moulding of the Head

This occurs with the descent of the foetal head to the pelvis to reduce the head circumference, for this to occur the frontal bones slip under parietal bones, parietal bones override each other and the parietal bones slip under the occipital bones. The presence of fontanelles enables the bones to overlap, to decrease its size and enable the head of the foetus to pass.

Likely anatomical structural combinations at childbirth

Ideal pelvis + ideal foetal head

Ideal pelvis + big foetal head and body/weight

Small pelvis + ideal foetal head

These situations have a bearing on the likely outcome of the birth process depending on the medical facilities present at the place of delivery, the delivery presentation as shown below, as well as three major factors which include, the passenger(baby size), the passage (birth canal) and power (strength of contraction).

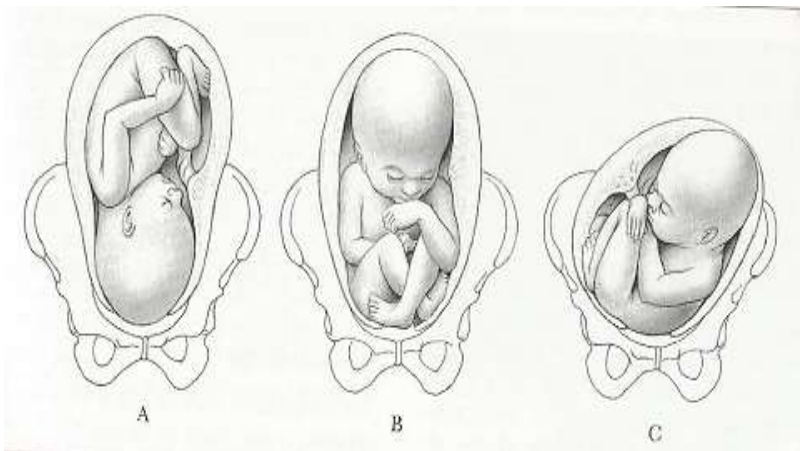


Figure 2: A – Cephalic presentation, B – Breech presentation, and C - Shoulder Presentation

Delivery Presentations

Normal Delivery



Head First Facing Backwards

Abnormal Deliveries



Breech



Face



Shoulder

Figure 3: Delivery presentations

http://weill.cornell.edu/cms/health_library/images/ei_0362.gif

THE NORMAL BIRTH PROCESS

The process of birth itself is dependent on the various dimensions of the bony structure of the female pelvis, the foetal skull and propelling force of uterine contraction.

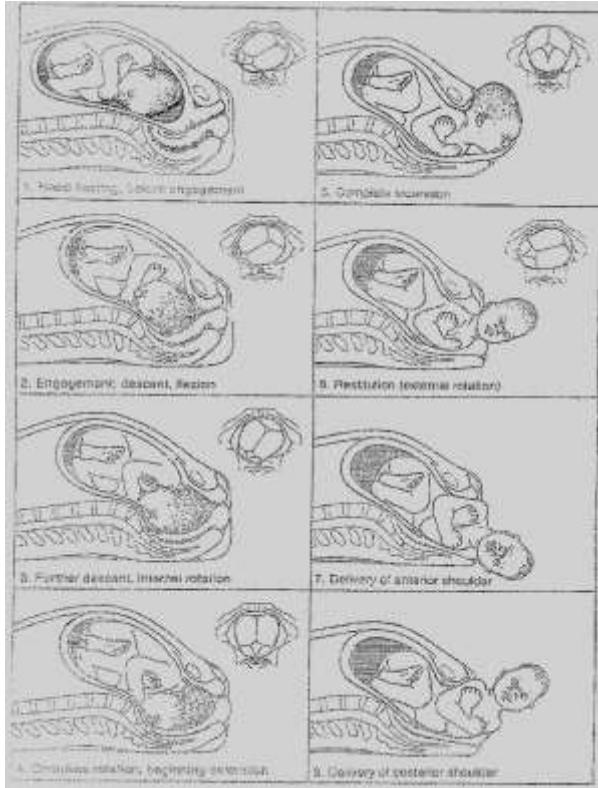


Figure 4 showing mechanism of labour.

The Figures 3, 4 and 5 demonstrate the fitting concept of the foetal head as it navigates through the maternal pelvis.

Labour

Labour is made up of three (3) stages. The first stage is from the beginning of contractions to full cervical dilatation. The second stage is from full dilatation to delivery of the baby while the third stage is the delivery of the placenta and membranes. The first stage of labour is the longest of the three stages and can be sub divided into three (3) phases namely:

- (a) Latent phase or early labour. It is the period from onset of contraction to cervical dilatation of 3+ cm which lasts for about four hours.
- (b) The Active phase from 4cm to 7cm cervical dilatation stage of labour lasts about six (6) hours in a normal situation.
- (c) Transition phase is from 7cm to full cervical dilatation.

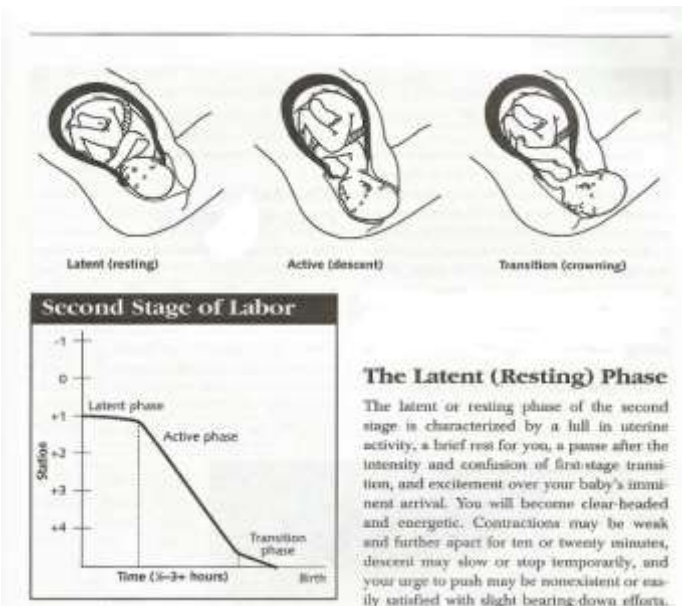


Figure 5: Second Stage of Labour

Birth can be classified into (a) Natural Vaginal Birth, (b) Assisted Vaginal Birth and (c) Caesarean Birth

a) Natural Vaginal Birth

In a normal vaginal birth the head engages transversely into the pelvis facing one side of the hip. There is a further descent with an internal rotation in the dimension that would accommodate the head anterior-posteriorly. Further progress down ensures complete rotation of the head then followed by complete extension and finally restitution (external rotation) of the head leading to complete delivery of the baby. Delivery of the placenta is accomplished within an interval of thirty minutes with effective contraction of the uterus to ensure minimal blood loss.

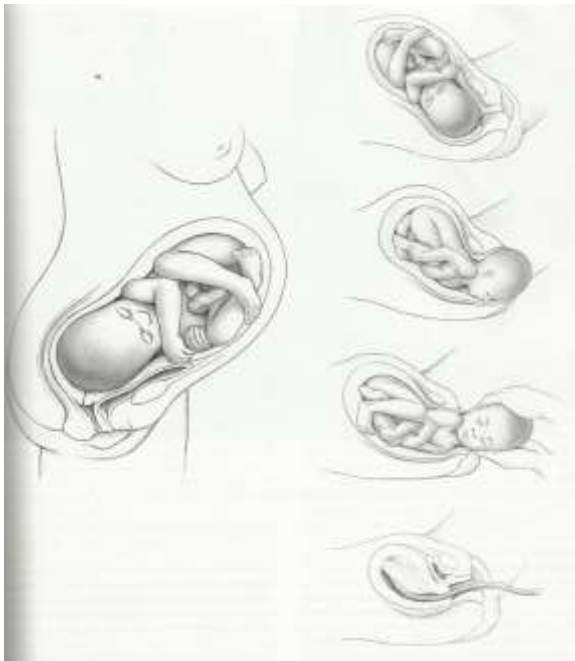


Figure 6: Movement of the Baby: Labour Contractions help to move the Uterus to the outside World (Albert and Elizabeth, 1995)

Vaginal Childbirth Animation



Vaginal Childbirth (Birth) Animation.mp4

Where the baby does not present cephalic, it is usually not possible to negotiate similar manoeuvres as in cephalic presentations. Therefore, an intervention will be required. Such interventions include:

b) Assisted Vaginal Birth which can be achieved with the aid of instruments like vacuum extractor or ventouse and forceps delivery

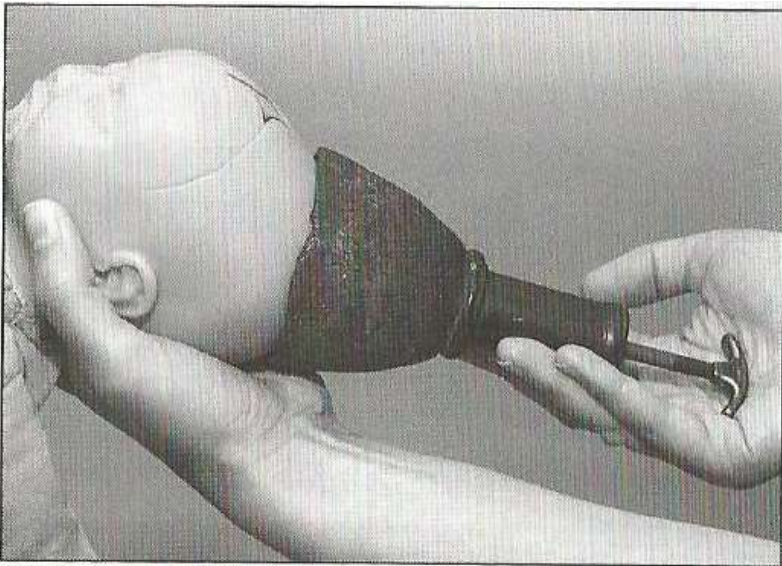


Figure 7a: Vacuum extraction to facilitate delivery (Baskett et al.,2007)

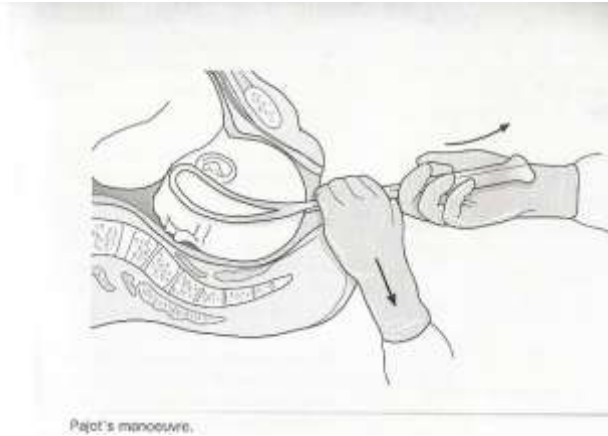


Figure 7b: Forcep delivery to enhance delivery in the second stage of labour (Baskett et al.,2007)

c) Caesarean Birth - this is applied when

1. the feasibility of a vaginal birth is near impossible
2. there is imminent danger to the life of the woman or the foetus.

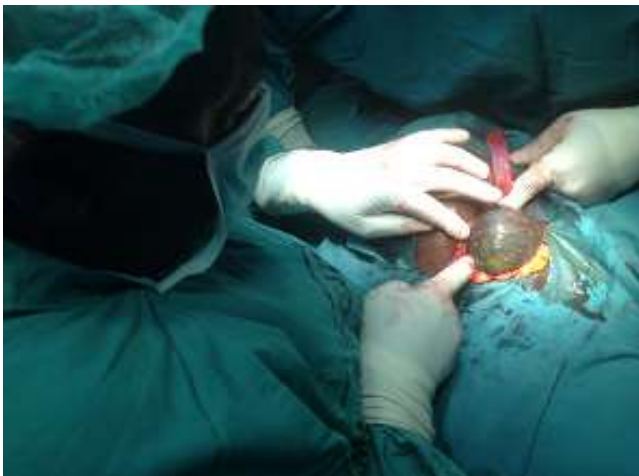


Figure 8a: showing delivery of the head of the baby at Caesarean section



Figure 8b: showing complete delivery of the baby at Caesarean section



Figure 8c: showing resuscitation of the new-born at the slightest need of assistance

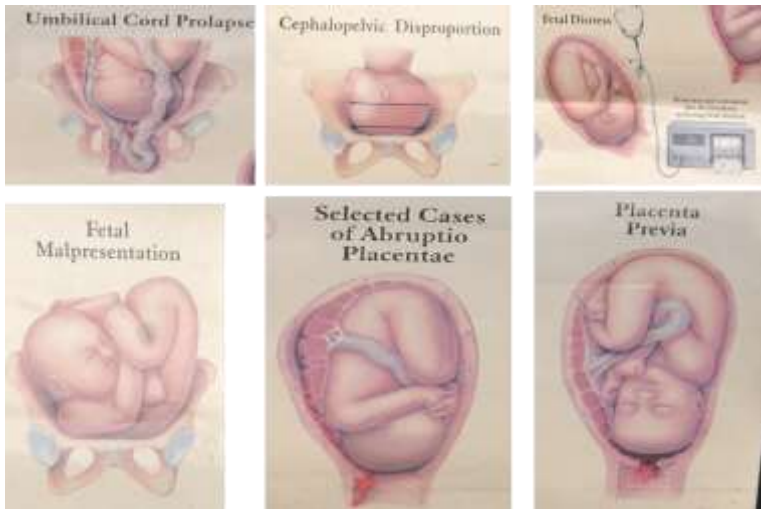


Figure 9: Indications for Caesarean Section

For effective management of labour, there is need for a labour management tool called **the Partogram** which is a graphical representation of events during labour and delivery. Entries on this chart regarding the clinical status of the mother and the baby as well as parameters recorded against time provide a quick glance to interpret activities during labour.

A graphic representation of the progress of labour will show;

- Cervicograph
- Descent of Head
- Uterine contractions
- state of the membranes
- Augmentation/drugs
- Maternal condition [heart rate, Blood Pressure, urinalysis]
- Foetal condition [heart rate, liquor]

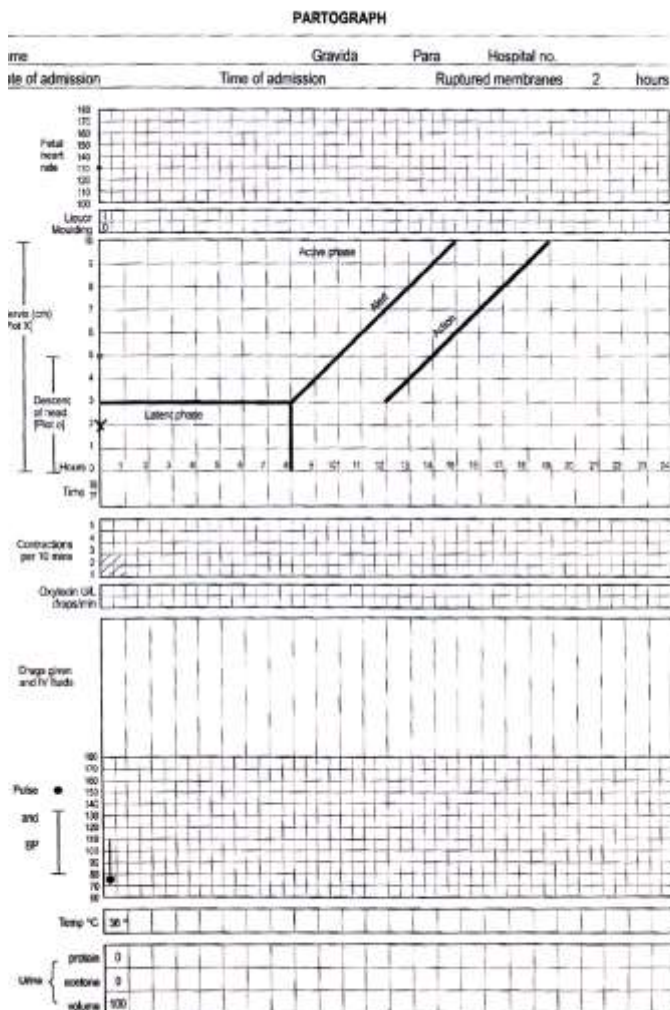


Figure 10: The Partogram

Pain in Labour

One of the most critical concerns in every birth is labour pain. The Holy Bible states emphatically "in pains shall thou bring forth..." Gen. 3:16. Pain relief therefore in all ramifications is an important subject in the management of labour. Pain in labour is adjudged differently in various cultures. Some view pain as normal in labour and bravery in womanhood while others request judicious pain relief. Medicine as a profession has documented significant advances in this area. Our hospital provides epidural anaesthesia on demand.

To be a mother is not a disease. Pregnancy is a biosocial function entrusted on women to ensure survival of the human race without which we would go extinct. Sadly, some women die in a bid to fulfil the divine instruction 'to replenish the earth' as I have earlier shown with the global statistics.

Global statistics we call it but the details will shock you. Do you know that sub-Saharan Africa makes up only 11% of the world's population yet it contributes 50% of the world's burden of maternal deaths and 4.7 million of the 4.9 million new born and child deaths per year?. Do you know that Nigeria as the most populous country in the region accounts for 25% of all maternal, new born and child deaths in the region?

Let us come back home to Rivers State and Port Harcourt in particular.

Table 1: The number of babies at deliveries by booked and unbooked patients

DELIVERIES	2011		2012		2013	
	Booked	Unbooked	Booked	Unbooked	Booked	Unbooked
Singleton	2953	622	2738	588	1959	473
Twins	66	19	72	3	63	17
Triplets	-	-	9	2	3	-
Quadruplets	-	-	1	-	-	-
TOTAL	*3019	641	2820	593	*2025	490

Table 2: Mode of deliveries by booked and unbooked patients

Mode of Delivery	2011		2012		2013	
	Booked	Unbooked	Booked	Unbooked	Booked	Unbooked
SVD	1779	280	1458	134	1033	160
Caesarean section(CS)						
Elective	384	-	436	-	373	-
Emergency	754	296	814	410	543	304
Total CS	1138	296	1250	410	916	304
Assisted vaginal breech	8	9	13	8	8	7
Ventouse	20	7	17	5	2	-
Craniotomy	-	3	-	2	-	2
Laparotomy	8	27	-	29	-	-
Forceps	-	-	-	-	-	-
TOTAL	2953	622	2738	588	1959	473

still births, perinatal mortality and maternal mortality between 2011 and 2013 in booked and unbooked cases

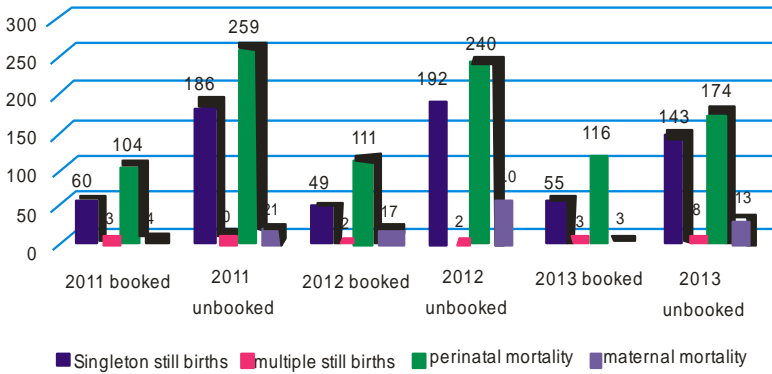


Figure 11: Still births, perinatal and maternal mortality among booked and unbooked patients.

Caesarean section rate

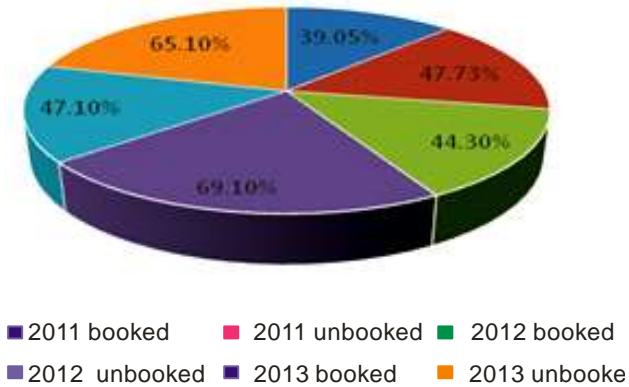


Figure 12: Pie chart showing Caesarean section rate among booked and unbooked patients

Table 3: Still births, perinatal and maternal mortality among booked and unbooked patients

	2011		2012		2013	
	Booked	Unbooked	Booked	Unbooked	Booked	Unbooked
Caesarean section rate	39.05%	47.73%	44.3%	69.1%	47.1%	65.1%
Hospital C-section rate	40.7%		50.3%		50.6%	
Singleton						
i) live births	2893	436	2689	396	1904	371
*ii) still births	60	186	49	192	55	143
iii) still births %	2.0	29.9	17.9	326.5	28.1	278.2
Multiple						
i) live births	63	9	173	12	132	26
ii) still births	3	10	2	2	3	8
iii) still birth %	4.5	52	11.4	142.8	22.2	235.3
Perinatal mortality	104	259	111	240	116	174
Perinatal mortality rate	34.1	40.4	38.1	40.0	55.4	317.5
Maternal mortality	4	21	17	60	3	33
Maternal mortality rates	109.2	3900.1	602.8	10118	143.3	7857.1

Women in the developed countries have long forgotten what maternal mortality is, while their sisters in the developing countries have come to accept the birth process as a matter of faith.

From the aforementioned, maternal mortality is not just words and definitely not numbers. It is about women who have names. It is about human faces seen in the throes of agony, distress and despair; faces that live forever in our memories and continue to haunt our dreams.

Whether we are white, black or brown; poor or rich; sane or insane, at childbirth the foetus will come forth either through a vaginal delivery or abdominal delivery for which we must plan.

In the journey of pregnancy and child birth, there is the principle of “9”: It takes less than 9 seconds to conceive a pregnancy (after sperm ovum contact), 9 months to carry the pregnancy to term, about 9 hours to labour. Even so are the cases of very short labour interval we call “Precipitate labour” in which from the beginning of ‘show’ and strong contraction babies are born within 2-3 hours. I have recorded it in daughter, mother and grandmother – may be genetic; a quiz for scientific mind. So why do we not plan?

Whatever the method of delivery, the birth process should entail a leak proof regimen or management protocol for providing safe outcome.

Common complications present at Birth

Most times births go all the way uneventful but in a some cases complications arise when they set in prompt intervention to arrest deterioration should be the response. Complications include:

Maternal

- Disproportion
- Eclampsia
- Antepatum haemorrhage
- Intrapatum haemorrhage
- Postpatum haemorrhage

Foetal

- * Cord accidents
- * Foetal distress
- * Foetal death

Placenta

- Placenta praevia
- Retained placenta
- Adherent placenta (Acreta, Increta and Percreta)
- Vasa Praevia

These complications will require urgent intervention to preserve the lives of the mother and baby. The vascularity of the uterus and birth canal is richer than in the non-pregnant, so, in case of injury at birth the rate of bleeding is heavier and at times could compromise circulation. The salvage time at the brink of any life threatening

complication could just be a matter of minutes. This is most applicable to patients who are within the hospital vicinity or very close by. Our road network and traffic challenges may not be helpful in these circumstances. When the complications arise in the places lacking skills to identify the problem or expertise to offer solution, families resort to prayers, consult oracles while some throw blames of infidelity in the realms of culture. With this conflict of opinions, ideas and where to get solution, there is a prolonged delay.

So the parallel midwives and ‘midhusbands’ resort to masterly inactivity waiting for the best. Three basic delays are often encountered.

Delay I: In decision making

Delay II: In seeking emergency/appropriate care

Delay III: In receiving appropriate medical attention

The first two delays arise at the level of the patient, the patient’s family and support groups while the last operates at the level of government and local health/maternity services.

It is common belief that when evidence-based knowledge is lacking, people resort to magic or trial and error. Therefore, when there is a disconnect between valuable counsel, assistance or beneficial referral, many things can go wrong. In most of the birth complications, when there is severe bleeding, blood is required to correct the loss and sustain life. Incidentally, reluctant attitude in which culture and religious doctrines limit blood donation cause further delays or disrupt management timelines.

Ruptured uterus result from prolonged unrelieved obstructed labour, and if it occurs within a health facility where skilled help cannot be timely reached, the mortality is assured to be very high.

Mr. Vice-Chancellor, at the various points listed above, further manipulation by unskilled attendants will be tantamount to damaging the life of mother and baby. This is where we locate our

patients in the parallel maternity practice so the death count continues to rise by the day.

My colleague and I examined the social construct, belief and practice that influence the birth outcome in our environment. Let me spare you the ordeal of going through the carnage of childbirth in pictures.

The native midwives or TBA do not observe all the 'Don'ts in maternity care. These are:

- (a) No vaginal examination when there is heavy vaginal bleeding`
- (b) Do not delay in referring a patient in prolonged labour.
- (c) Avoid beating, slapping, and ringing bells while praying over a convulsing woman in labour who should be nursed in a quite eclamptic room.
- (d) Do not conduct delivery with bare hands (this negates all principles of global midwifery practice).
- (e) Do not offer salt drink to women with postpartum haemorrhage and eclampsia who need anything but salt (Salt is contraindicated in raised blood pressure).
- (f) Do not perform version/forcing the baby's lie to any plane or dimension without respect to the location of the placenta.

Most times, those who are HIV positive are delivered with bare hands without any precautions leaving room for high risk of transmission, to subsequent clients and the practitioner herself. This is well demonstrated in the report (Akani and Akani, 2006).

Comparison of cost of maternity services.

A key factor in uptake of maternity care is the cost of treatment. Although the specific bill will be precisely dependent on the range of services in respect to bed space facilities, length of stay in hospital, special procedures and sometimes who pays the bills . Affordability defines access in most cases while ignorance of how and what next to do takes a heavy part of the regrets.

Table 7: Cost of maternity services

	Public				Private	TBA
	Tertiary N	Secondary N	Primary N	Clinic N	Maternity N	
Antenatal	15,000	FREE	FREE	30,000- 60,000	15,000	5,000
Normal delivery	25,000	21,000	-	80,000- 120,000	30,000	2,000
Caesarean section	50,000	40,000	-	250,000- 400,000	120,000- 200,000	NA
Episiotomy repair	3,500	-	-	15,000		
Uterine evacuation	4,000	3,000	2,000	15,000		

Like it is said, ‘a stitch in time saves nine’. Prevention is better than cure. It is better to pay 5,000- 15,000 for a delivery bill than spend 50,000, donate a pint of blood for poorly managed third stage of labour sometimes, at the risk of losing the baby or mother.

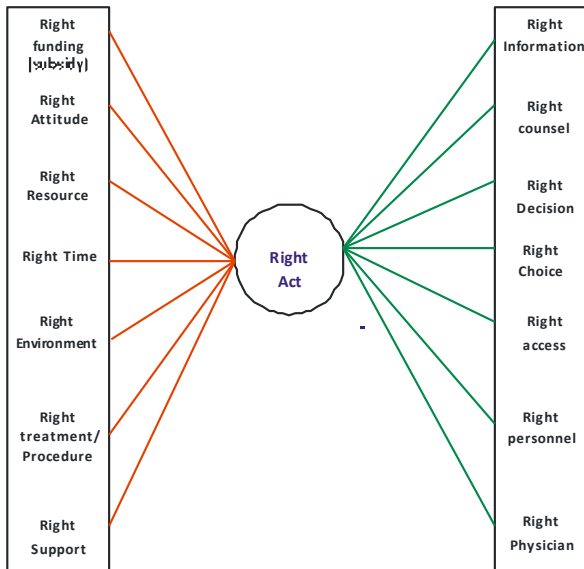
Unemployment is still common in our communities, with many people living below two dollars per day. The families must eat before thinking of saving for unexpected obstetric emergencies. Should funding maternity services be a social responsibility of the government alone? On the other, once a child is born he now belongs to the community and a child of the state. We cannot pretend to ignore that the greater the importance of the decisions and funding to be taken, as in the case of the healthcare. To address the above; Our decisions should consider the following:

1. Basic idea is that healthcare resources should be employed so as to produce the greatest good.
2. Measurement of greater good in terms of treatment and prolonging or improving quality of life.
3. If the cost of a particular pathology is higher in the case of another, then should the pathology that costs more be given higher priority?

4. Resources should be allocated as a matter of priority to the big problem – maternity care and services.
5. Health care delivery challenges should guide the decisions of mothers.
6. A right to rightbirth remains universal and is unconditional.

Composite elements in a birth plan

A meticulous and well organised plan reduces stress and cost even in the face of unpredicted emergency. Since unpreparedness is undoubtedly linked to overall access and engagement of care, in a situation where a man borrows five thousand naira to hire a cab to convey the wife to a hospital, manages to register for card but neither can proceed to pay for treatment nor provide basic items, it only means that she cannot afford the cost of treatment so there is need to educate families on birth plan. Fig 8 illustrates the problem oriented elements in birth plan.



Factors that determine birth plan and preparedness

CASE SCENARIOS

Mr Vice Chancellor Sir, may I use some of these case presentations to elucidate some points

Case 1

A Nigerian woman, a postgraduate student in tertiary institution presented with hypertension in labour. Blood pressure was elevated. She refused parenteral antihypertensive with the reason that the church was praying over it. She fitted an hour later and died.

Case 2

The wife of a driver to a political office holder was brought into the labour ward with severe post-partum haemorrhage. She had spent almost 20 hours in a local maternity as a result of ruptured uterus in her ninth delivery. She stopped breathing 9 minutes after arrival baby weight was 4kg

Case 3

A 37 year academic with a terminal degree was admitted in hypovolaemic shock after an abdominal massage in a TBA's place. The baby had died but she was saved just by a hairs breath. She could recount her ordeal.

Case 4

31 year old mother of 4 in her 5th pregnancy had a confirmed diagnosis of transverse lie and was offered an elective C/S but she absconded to a local midwife. Midway into labour her membranes ruptured, cord prolapsed, hand prolapsed and baby died. The mother finally died at the Casualty Unit at a Health Centre from ruptured uterus.

Case 5

A 23 year old pools agent tested positive to HIV antibodies in labour and was managed accordingly. She, while in hospital had resolved to pass the virus to as many as will come her way as a vendetta. After discharge, it was noticed that her baby was abandoned by a sulo bin 2 poles away from the hospital.

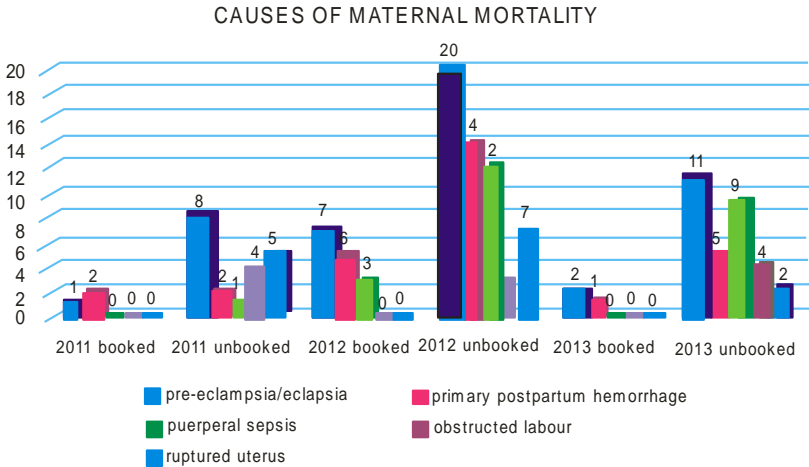


Figure 13: Chart showing Causes of Maternal Mortality

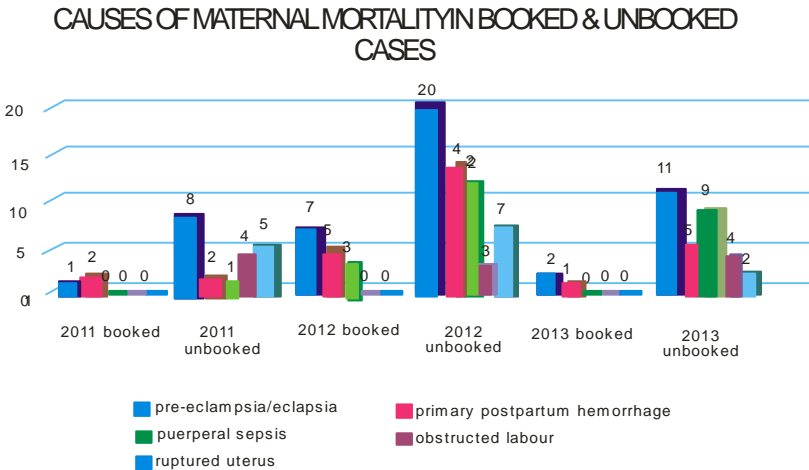


Figure 14: Causes of Maternal Mortality in Booked and Unbooked Cases

Determinants of Adverse Obstetric Outcomes in our Local Setting

Provision of appropriate and ideal birth scheme:

There was a need to find an answer to why the women were dying during child birth. We were able to determine for the first time, in the history of our practice, the various harmful determinants for Obstetrics outcome in our local setting. Our studies therefore afforded us the opportunity to determine the magnitude and contribution of our parallel competitors to birth complications. We reviewed the activities of TBA and their abuse of women rights in mutilating the genital tracts of women during child birth. We conducted an Audit in 2 Local Governments in Rivers State and the information extracted was quite revealing. It was observed that over 80% of our female patients had genital mutilation and 17% of our women had abdominal massage in pregnancy by Traditional Birth Attendants and herbalists.

Thus while we laboured in the hospital to keep the women alive, things were going wrong outside the setting as if labour and child birth had become a curse and a self-sacrificial exercise.

My study on TBAs showed that the knowledge of hand-washing was 10%, glove use 3% and lastly knowledge of HIV was 5%. These are detrimental to babies, mothers and of course the care giver (Akani and Akani, 2006).

A key contribution in this area was capacity building – cascade of training of TBA on reduction of harmful practices that complicate child birth and identification of danger signs in pregnancy and child birth for prompt referral

1. TRADITIONAL PRACTICES

a. Abdominal Massage

Abdominal massage is undertaken for various aches and pains in pregnancy and child birth. It varies from very gentle strokes to firm pressures from the fist and knuckles (kneading of the muscles of anterior abdominal wall and gentle lifting of the soft tissue); Sometimes, the two hands are utilized with some force to achieve

results. The indications for the massage include correction of abnormal lie, ensuring foetal wellbeing; postdate of prolonged pregnancy, strengthening the nerves and arteries and to arrest haemorrhages/deliver the placenta. Their intention may be good but they often lack scientific reasoning and evidence. The resultant complications reach the hospital, in many cases, very late for meaningful intervention. If the patient comes in on time, the outcome is usually better. They also come with no record or account of what has been administered orally and parentally. This again is dangerous.

We conducted a survey on the incidence and complication and reported an incidence of 14.79% among a population with 11% complication rate (Akani et al., 2003). The complications recorded from massage patients were abruptio placenta 23.80%, placenta previa, 4.76%, perinatal deaths, 14.28%, uterine rupture 9.52%, maternal mortality 4.76% and cephalopelvic disproportion/obstructed labour 28.57% (Ugboma & Akani, 2004, Bassey & Akani 2014). Abdominal massage complicated 20-30% of all pregnancies. Advocacy was instituted accordingly. We also documented immediate neonatal death following rupture of the baby's liver discovered at post-mortem.

On Abdominal massage/version, we recorded many cases of abruptio placenta and uterine rupture between 1995-2000 (Annual Report). Today, we rarely see that pattern.

The Traditional birth practitioners had no respect for the 3rd stage. We recorded cases of uterine inversion following excessive pressure on the fundus after birth causing uterine rupture. This gives rise to so much bleeding because the uterus is unable to contract; endometrium is exposed to the outside and infection sets in (Akani, 1996; Fubara & Akani, 2005).

Table 4: Massage Status of Patients Studied

	Number	Percentage(%)
Massage	42	14.79
No Massage	242	85.21
Total	284	100

Table 5: Mortality in the Massage Group

	Number	Percentage(%)
Maternal Mortality	2	4.76
Perinatal Mortality	6	14.29

Table 6: Booking Status and parity

Booking Status	Number	Percentage (%)
Booked	10	32.81
Unbooked	32	76.19
Parity		
Primigravida	16	38.09
Multigravida	26	69.90

Table7: Complications of Abdominal Massage

	Prolonged obstructed labour	Abruptio placenta	Placenta praevia	Retained placenta	Abortion/ pre-term labour	Genital injuries/ tears	Perinatal death	Uterine rupture	Maternal mortality
Number	12	10	4	2	8	3	6	4	2
Percentage	28.57	23.80	9.52	4.76	19.04	7.14	14.28	9.52	4.76

b. Female Genital Mutilation (FGM)

Female genital mutilation involves the surgical excision of parts of or the entire external female genital organ for cultural or any other non-therapeutic reasons. It is often performed in childhood, puberty, during the first pregnancy or during the first stage of labour without any anaesthetic agents, the operators are not held liable for whatever complications that may result. Complications in our survey included urethral injuries, severe antepartum haemorrhage, perineal tears (Akani and Pepple, 2003). We observed horrendous presentation of genital cuttings in adolescents in labour from some riverine communities. These were complicated by severe haemorrhage that threatened the babies and mothers alike. Our survey in two local government areas highlighted the magnitude of this problem (Ugboma and Akani, 2004). We undertook community/media sensitization and alerted the Ministry of Health, the Female Lawyers (FIDA) and The Adolescent Project, a non governmental organisation working on health issues in women and the girl child.

This resulted in joint efforts and finally a decree was scripted and adopted by the Rivers State Government on genital mutilation. The rate reduced though custom compliant individuals we observed changed the concept to beat the law with the assistance of health personnel. We conducted yet another study on medicalization of FGM, a community survey in Ogba-Egbema LGA with a high prevalence rate of FGM which was reported to the Ministry of Health. Subsequently a cascade of training of TBAs was done to change their roles to referral agents and Community Health.

My research focus followed a wild question begging for answer -the social construct, belief and attitude underlining pregnancy and its outcome.

First we made bold to bring to the public glare the events in the confines of the delivery suite. In the country, normal birth is often witnessed or supervised by a skilled attendant, but in the event that things go otherwise, the expertise of the obstetrician is required. Harmful maternity practices such as drinking concoction or

concentrated salt solution in a bid to cure eclampsia. Battering, and aggressive abdominal massage have led to traumatic ruptures, abruption of the placenta and strangulation of the foetus.

After our study, we raised the awareness and sensitised the health community/public on the evils of some of the harmful practices. An example is Female genital mutilation for new-borns. Unknown, but rampant amongst pregnant women in labour is supra-fundal pressure and excessive traction of the cord which may result to uterine inversion. This was also brought to limelight.

c. TBA Concept

TBA is a fancy description for rejection of orthodox maternity care. The echolistic attention provides a sense of confidence with a core in a traditional setting. Lack of funds has always been the reason for not acting but that is not enough to cause women to die in neglect. TBAs undertake Childbirth, Pre pregnancy care, Antenatal services.

The sparsely distributed maternity facilities with unfriendly services still compel women to patronise the traditional birth places. This includes women of unknown HIV status who abscond from health facilities on confirmation of their sero-positive status. The poor knowledge of the TBAs put 40% of Nigeria obstetrics population at risk of HIV infection. TBA practices where little or no infection control precaution is applied at births and female genital mutilation without any regard for viral status.

2. UNSAFE ABORTIONS

This is termination of pregnancy before viability (before 28 weeks) or foetal weight of 500 gm or less. In the face of harsh economy, some women who do not wish to continue with a pregnancy resort to quacks and unskilled personnel to achieve it. This accounts for about 3% of the total number of maternal deaths globally. Prompt evacuation of the uterus, appropriate antibiotics and post abortion counselling have significantly contributed to a change in the trend of morbidity and mortality. The department of obstetrics and

gynaecology runs 24 hours post abortion care services to reduce abortion complications.

Unsafe abortion results from desperate attempt at terminating unwanted pregnancies. About 25-40% of maternal deaths could be eliminated if unplanned and unwanted pregnancies were prevented through effective contraception. From our study unsafe abortion accounted for 75% of hysterectomies perform in adolescents (Akani & Akani Pepple2008), this has grave implications for their future obstetric career. This very disturbing finding meant no more babies for them (Akani et al., 2003). This may be contributing to the new wave of sale of babies. Post abortion care services and contraception have tremendously reduced the trend (Bassey & Akani 2014).

A comparative study of Manual Vacuum Aspiration (MVA) and the uterine curettage showed tremendous benefits in the MVA. This simple technology has reduced the long waiting period while the patient's bleeding reduced from 42 hours to an average of 2 hours (Akani, 1998). It offers an added advantage of reduced cost. It is performed in the MVA room in the department. It was common to see clients 6-9 months later for repeated mistakes but with post abortion counselling and contraception, the Egyptians we saw before we see them no more!

We had cases where unsterile weapons (spokes) were used to procure abortions. Abortion mortality was high. In our study we reported hysterectomy (removal of the uterus) in adolescents. We conducted training for health workers, patent medicine dealers etc who carry out abortion. Today, the picture has changed positively. We have also established post-abortion care service (using the manual vacuum aspiration) This very disturbing finding meant no more babies for them (Akani et al., 2003). This has improved care, reduced cost, waiting hours from 42 hours to about 2 hours today (Annual Report). Our patients with incomplete miscarriages can go home under 2 hours after good uterine evacuation.

At the hospital level, we looked at the micro-organisms commonly involved in post-abortal sepsis. This improved infection treatment and prevented further damage or mortality. We conducted a survey on the comparative management of incomplete abortion using the manual vacuum aspiration and the conventional dilation and curettage. The total time spent for the manual vacuum aspiration was under 10 mins as a side room procedure with cost implication of less than N5,000 compared to routine curettage which was dependent on theatre space, availability of blood and anaesthesia giving a time interval of 20-30 hours and cost of more than N30,000. This survey revolutionised our care of abortion management, reduced complications significantly and offered a golden opportunity to prevent future abortion by offering post-abortion counselling and contraception (Akani 1998, Akani and Green 2012). This simple technology of vacuum aspiration also helped us in the management of cases of post abortal tetanus. Usually, movement of the patient to theatre beyond the hospital bed environment often provoked seizures and made procedures difficult . The vacuum aspiration was now performed directly at the bedside to avert complications with minimal activity satisfactorily (Akani and John, 2003).

Mr Vice Chancellor Sir, for every minute we share here, in this lecture hall, about 2 lives are lost. This, in simple arithmetic leads to about 2880 women in a day, and, at times, with their babies dying. Hypothetically a plane crash carrying about 200 passengers every 2 hours. I want to state that these crashes were neither due to explosion nor bad runways but to abysmal complications of pregnancy and childbirth in our sub-region. These includes haemorrhage, infections, hypertension/ eclampsia, abortion and ruptured uterus. The aviation sector has zero tolerance to accidents, this they pursue aggressively; we can also have zero tolerance to mortality in child birth.

Post-abortion care services.

Perplexed by the level of maternal morbidity associated with post-abortion in our setting as documented in the first Nation-wide abortion study in Nigeria (Alan Gullmucher Study, 2006), I initiated programme centres in over 20 cottage hospitals in the South-South

region of Nigeria on post-abortion care. This has drastically reduced the waiting interval from 48 hours to less than 30 minutes in the management of unsafe abortion. This adds to many lives saved from abortion complications such as infection traumatic injuries to the genital tract and haemorrhage.

3. **HIV/AIDS IN YOUNG PEOPLE – REPRODUCTIVE AGE**

Reports show variation in sero-prevalence rate of HIV from state to state where travel distances are less than 2-4 hours. These figures seem merely imaginary as the Commercial Sex Workers and other high risk elements can do 2 round trips in a day within those states. The HIV sero-positivity rate in our centre was 7.3%. and 69.7% of them were pregnant for the first time. 84% were in advance stage of pregnancy. The implication of this finding is that the risk of vertical transmission and occupational exposure to laboratory and hospital staff no HIV infection was high. Babies infected with HIV cannot be said to be quality babies therefore their birth are far from been right birth without interventions.

4.

Table 9: Seroprevalence of HIV in Young People Based on Age.

Age group (years)	Total Screened	Number Seropositive	
		N	%
10-14	89	13	14.6
15-19	348	63	18.1
20-24	1596	629	39.4

Abandoned babies are frequently reported in our practice area and research shows that the babies are equally frequently exposed to HIV (Akani et al., 2006). During our survey, we reported a higher incidence of abandoned babies possibly from HIV infected mothers who were scared of stigma, discrimination as well as unquantifiable burden of caring for an infected baby who rare survived beyond the fifth birthday (Akani et al., 2005).

Challenges and controversies over couple discordance were first reported from Port Harcourt. The sero-concordance was 48% and sero-discordance rate was 52% and the peak occurred among age group 21-30 years. HIV1 was predominant in the sero-discordant group. This drew the attention of local and International Agencies on better care and management of HIV in the family settings. This introduced controversies in the management of HIV couples (Akani et al., 2005).

Our findings on the study of HIV in young people (the vulnerable group ripe for marriage) was worrisome so we studied the HIV sero-prevalence among premarital partners, our findings showed a high prevalence rate (Akani and Erhabor, 2004). This resulted in the institutionalizing premarital counselling and testing in most Faith-Based Organizations and churches. This publication has received request from many parts of the world (Canada, Australia and South America).

Table 10: Haematological indices in male partners of HIV discordant & affected pairs among long cohabiting partners in Rivers state (Akani et al., 2005)

Factors	Discordant pair N = 52	Affected pair N = 48	T	p-value
Hb (g/dl)	11.91 (1.62)	10.00 (1.56)	5.96	0.001
WBC (x 10 ³)	3.77 (0.84)	4.35 (2.05)	1.88	0.06
Platelet	181.06 (49.37)	151.17 (33.37)	3.52	0.001
ESR (mm/hr)	41.56 (38.48)	74.04 (39.76)	4.15	0.001**
Neutrophils (%)	53.19 (12.06)	57.35 (13.21)	1.65	0.10
Lymphocytes (%)	46.06 (11.86)	41.52 (13.76)	1.77	0.08
Eosinophils (%)	0.37 (1.12)	1.52 (3.58)	2.21	0.03
Monocytes (%)	0.25 (1.06)	0.21 (0.94)	0.21	0.84
CD4 count	451.35 (205.17)	257.29 (73.48)	6.19	0.001**

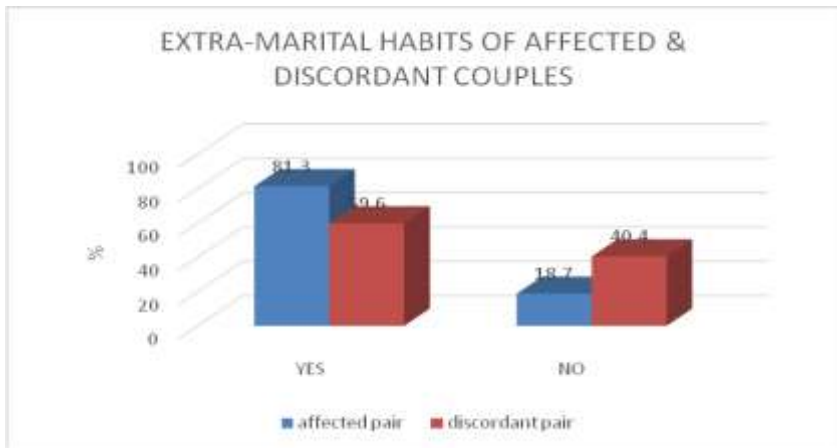
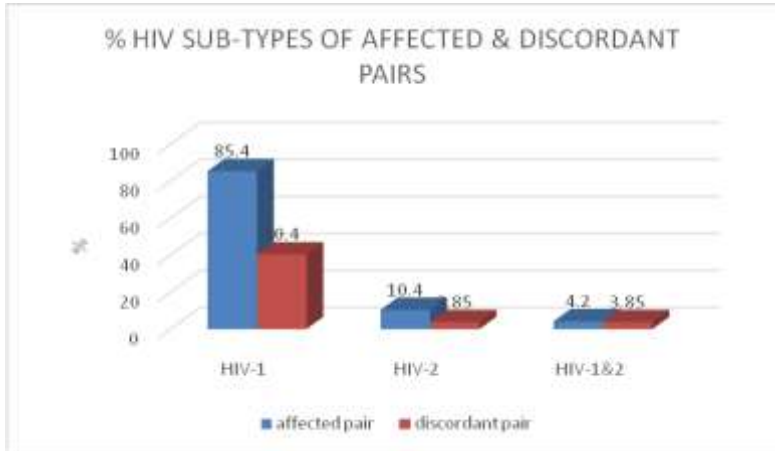


Figure 17: Chart showing Extra-Marital Habits of Affected and Discordant Couples (Akani et al., 2005).

Fuelling HIV sero-prevalence are bisexual activities among off shore workers.

PERINATAL INFECTIONS

a. ***Hiv Vertical Transmission:*** Vertical transmission of HIV- for over 3 decades the global attention has shifted to the increasing prevalence of paediatric HIV infection. Mother to child transmission accounts for more than 90% of infections. This has a very close co- relation with the seroprevalence with a national prevalence over 10 years (2002-2015). Our hospital seroprevalence rate was 7.3% among pregnant women (Akani, Ojule, Oporum, 2006). This posed



Figure 18: Picture showing infected HIV mother and Baby (Albert and Elizabeth, 1995).

serious risk and alert to the health workers. Port Harcourt strategically positioned for oil and gas exploration activities attracted expatriates and foreign nationals who if infected showed different HIV sub types and strains. This compounded treatment, created risk

of virologic failure or resistance more so if there was poor compliance at antiretroviral therapy (Akani and Erhabor, 2006).

Our study on counselling and testing profile of couples or partners of infected mothers revealed a high prevalence of sero discordance rate. This was obviously detrimental to future pregnancy without appropriate therapeutic intervention. With good tracking it was easy to assist the couple achieve quality babies.

Community and global leaders are acting in concert to support efforts at elimination of mother to child transmission of HIV.

Apparently, from our studies it was clear that the most vulnerable age range was 20-24 years. This is the prime age for marriage. We conducted a study for premarital pairs in some churches and our results showed a high sero prevalence rate. This was totally unacceptable to church leaders initially but this finding has informed church policies on premarital testing. (Akani et al., 2006)

They are subsequently offered appropriate counselling and allowed to make informed decision whether or not to continue with the wedding.

We studied the socio-demographic characteristics and trends of HIV sero-positivity among young people in the Niger Delta over a 5-year period (Akani & Erhabor, 2005). The findings were very informative showing a very high risk conduct and prevalence. This was very scary for young populations of future mothers and fathers of our sub region. We alerted the State governments after a national presentation and International Agencies came to the rescue by supporting various projects to mitigate the spread. This encouraged the formation and registration of many Civil Society Organizations that now work in concert with government in various aspects of HIV care.

Proverbs 3:27 enjoins us to ‘not withhold good from them to whom it is due when it is in the power of thine hand to do it’ Many people

in need still do not have access to medicines to protect their babies from HIV. 1000 more children will be infected with HIV today and 1000 more tomorrow until we declare it is a priority to stop HIV transmission.

Establishment of prevention strategy for HIV vertical transmission

Our efforts in this centre were to institute counselling, testing and intervention for HIV positive mothers to have HIV free babies. Assist HIV positive couple under anti-retroviral therapy to have HIV free babies. It has also attracted the collaboration of International Agencies (Institute of Human Virology) to build a Molecular Research Laboratory in our Teaching Hospital.

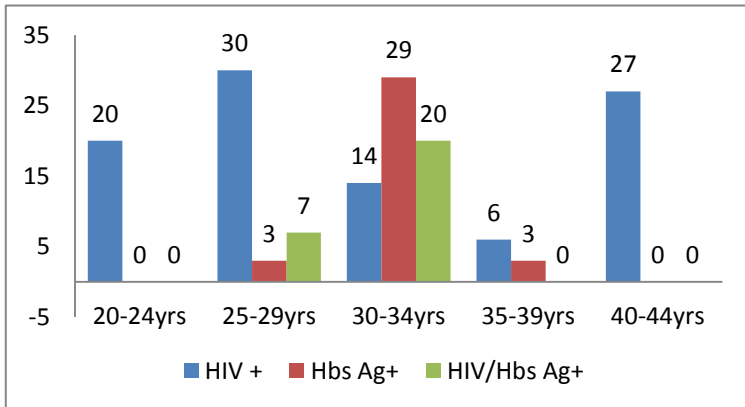


Figure 18: Chart Showing Vertical Transmission of HIV positive, Hbs Ag positive

b. Other Perinatal Infections

Infections in mothers during pregnancy obviously cause concern to the Obstetrician because of transplacental infections to the unborn child. These infections are transmitted from the mother to the newborn. These infections may occur in uterus during pregnancy, during childbirth or during breastfeeding. In addition to HIV, others include hepatitis B and C. These infections, if not identified may threaten the

health of the new-born and subsequently cause harm in later life. A survey of our pregnant population showed incidence of hepatitis B at 4.3% (higher than the 1.57 % among blood donors) and that of hepatitis C at 0.72%. This spelt an alert for greater surveillance and screening to avert complications. We therefore included this in a departmental handbook for treatment and training (Labour Ward Handbook, 2009). We also advocated for passive to active immunization of all HBV-exposed new-borns. We established the PMTCT unit to prophylactically reduce vertical transmission. This was supported by the UNICEF and Global fund. During the 2006 International Breastfeeding Day, the best and most well-nourished baby who won the prize was an HIV exposed baby who was declared HIV negative. This is one among many.

OTHER CONTRIBUTIONS

1. Provision of quality Antenatal Care services.
2. Many interventions in near missed circumstances when women who were carried in moribund state, later walked out of the hospitals alive and well. This reverberates joy and gives me hope to carry on in this business.
3. Capacity building – establishment of PMTCT in Bayelsa, Rivers, Ebonyi and Cross River States. Most of the people trained under our tutelage, now work as Programme Desk Officers and Managers in various International Agencies. Our training programmes enhanced establishment of State AIDS Control Agencies and strengthened the Ministries to contend with the velocity of the viral spread. This created elaborate awareness, sensitization, and training of midwives for rural services scheme.
4. Contribution to literature – As chairman of Nigeria Medical Association (NMA), I initiated the establishment of The Nigeria Health Journal and as a Deputy Provost of College of Health Sciences, with my Boss, Prof. Odia, we established the Port Harcourt Medical Journal. These two journals have improved research and teaching in this sub-region.

5. As a member of the National Task Team on PMTCT (contributed to the drafting and publication of Training Manuals, National Guidelines and Standard of Practice).
6. Participated in the Multicentre Magpie Trial Collaborative Group between 1998 and 2001.
7. Advocacy on Woman Centred Abortion for the reduction of unsafe abortion in Nigeria.
The dearth of Obstetricians in the state health service made me, as the chairman of NMA, to start advocacy for medical manpower development to address the maternity needs in rural communities. That yielded the routine in-service training for many doctors who are now consultants in obstetrics and gynaecology and many others in various specialities. This has definitely boosted the manpower disposition of the state in our healthcare system.
8. As a lead trainer and consultant to various International Agencies (UNICEF, GAIN, Family Health International, University of Columbia) we built capacity in health workers of various cadre and established PMTCT sites in all the secondary and tertiary hospitals in about 32 hospitals in Rivers, Bayelsa, Cross River, Akwa Ibom States and a few hospitals in neighbouring states.
9. In my career I have supervised over 20 fellowship dissertations and mentored numerous post graduate fellows who are now practicing as Consultant Obstetricians and Gynaecologists within and outside the country.

In our study of mother to child transmission of HIV, which was conducted at the peak of HIV epidemic in the country, we observed a high sero-prevalence of HIV in pregnant women (Akani et al., 2006). This was common in 20-30 years female indicating the need to sensitize health workers and vulnerable population. Our strategy was to reduce the viral load in couples and thus produce celebrated HIV free babies. Right birth should exclude or eliminate harm or hurt during delivery and prevent any envisaged problems. Eliminating HIV in the newborns of a infected is indeed a right concept .

SAFE BIRTH INITIATIVES

1. Countering birth terrorism and dangerous practices

It is obvious that there is teeming high patronage or appeal for alternative birth care born out of economic constraints, lack of planning and feared hostility at the point of care. To neutralize and eliminate the towering havoc wrecked by Traditional Birth Attendants and collaborators, government should ensure enrolment and training of more certified midwives, medical doctors and other health personnel who will remedy the need for skilled birth supervision and medical experts in our communities.

2. Millennium Development Goal (MDG)

MDGs 4 and 5 are targeting reducing by three-quarters the maternal mortality ratio and reducing by two-thirds the under-five mortality rate. The first part of these targets is of prime importance to us as this is the focus of the ideal birth right. Skilled birth at every birth within the context of continuum of care remains the universal approach. Integrated management of pregnancy and childbirth (IMPAC) is to help shape the technical support to countries with strategic and systemic ways to improve maternal, perinatal and newborn health (WHO, 2006). Coincidentally, this is the long awaited 2015, the anticipated magic year for the achievement of the targets of the MDGs. The nation stands witness to the various activities in the area of MDGs 4 and 5 but we are still far from reaching the targets.

3. Safe Motherhood Scheme

4. Free Maternity Care

Incidents and Responses to Obstetrics Deaths at childbirth

Universally history records calamities at childbirth, even with the high and mighty. Here are some examples. The Mughal Emperor, Shah Jahan of India decided to establish Institutions and programmes to ensure reduction in maternal death during childbirth. For this reason he put up the 17th century white marble, Taj Mahal,

India's 'monument to love' built as a mausoleum for his beloved wife, Muntaz Mahal, who died in childbirth.



Emperor Haile Selassie of Ethiopia had a similar experience. Likewise, the King of England and Julius Caesar, Great men and World Leaders who had had encounters with unfavourable outcomes at childbirth had done so much to impact and improve on womanhood and childbirth. Our rich men and women should borrow a leaf from this gesture.

PUTTING IT ALL TOGETHER

The end of labour is to gain leisure said the ancient Greek philosopher Aristotle but most women begin the post-delivery rest in pains/agonies following horrible child birth.

Why do we discuss birth?

The harrowing statistics and reality of the obstetric outcomes in our setting!

- High maternal mortality of 536/100,000 live births
- Longstanding sequelae of morbidities
- Unacceptable perinatal mortality rates
- High neonatal death rates
- Rising HIV seroprevalence in the paediatric population.
- 98% of maternal mortality arose from pregnancy and child birth.
- Unparallel abuses and neglect of women during child birth.

We demand a fair and just share of good healthcare which is their fundamental human right! An accruing benefit from our sovereign wealth and endowed resources of this Nigerian nation.

It is said that of all the journeys any individual is likely to undertake during his or her life time the passage down the birth canal is probably the most hazardous. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination of race, religion, political party, economic and social status. Wrong birth thus captures failure to meet acceptable standards, methods and decorum.

Therefore governments at all levels have the responsibility for the health of their people which can be fulfilled only by the provision of veritable and adequate health and social care system. More money to the rural men translates into acquisition of more wives but additional \$1.00 per woman head may enhance reduction in maternal mortality, I have presented childbirth a natural but consequential process for humanity globally and in an urban setting,

Child birth is often neglected, abused, traumatic to the woman's psyche, spirit and soul. Apart from being the gate through which we live, it is the primary battle for any expectant new-born and a crucial challenge to the expectant mother.

The obstetrician exploits the natural mechanism of labour, explores defects in the process, connects, offers necessary assistance, restores the cry of the new born and re-enacts the joy of the wailing mother. Imagine a woman in labour in desperate need, what would you do?-think right-act right for a right birth

Right birth ensures a healthy future for a nation, maybe our nation. Scripture mentions difficult labour in Genesis 35:16 when Rachael had a baby in a very painful and difficult labour in which she lost her life. Before she gasped to death, the bible recorded her naming the child 'Benoni' (the child of her pains) appropriating the events and

trauma of labour but God stepped in and Jacob said no that is not what God said. When you prevail in the present labour, you protect the future of the baby and the mother.

This account brings to memory numerous accounts of childbirth stories in different parts of the country. Benjamin grew up to be a giant with colossal reputation and from the princes of the tribe of Benjamin came David and then Jesus Christ. How many Benjamins do we waste in a month at childbirth and how many survived childbirth with assault?

Throughout human history, childbirth has been a dangerous enterprise. So much can go wrong that we have little or no control over in an unsupervised birth. A classical anthropological theory formulated by Bromislow Malinowski states that under conditions of chance or uncertainty when things cannot be controlled by knowledge, people will turn to magic .

RIGHTS – stand as a shield against threat and intrusion

Assert *prima facie* claims as a whole point of right is to constrain the community or government from acting at the expense of the individual i.e to compel government to provide facilities and services that will reduce hurt, harm, hardship and hazards at birth.

PROGRAMMATIC ISSUES

At some point in our research scheme we recorded some challenges as listed below:

1. Zero partnership declaration by the UN Agencies due to unsafe research environment as a result of militancy and kidnapping (No collaboration; No funding).
2. Community strife and conflicts atimes stalled project plan or disrupted activities.
3. There is need to link research to the community needs and priorities.

4. Apathy in funding and collaboration in clinical research ventures.
5. Neglect and lethargy on ownership of programmes on maternal health (Government and Communities).
6. Strife and schemes over research grants as common cake for all and sundry.

Future prospects and directions in research

1. We have commenced conducting a dose related effect of *udah* (Negroid Pepper) as an oxytocic beverage on our patients who are at high risk of post-partum haemorrhage. This we intend to collaborate with our colleagues in Human Physiology.
2. Design a community maternity concept where every female obtains a blue card while she receives care at any designated health facility- bills are cleared by the agency.
3. Our high sero discordance rate though worrisome, provides a pool of possible samples for a longitudinal research on cellular elements that provide viral infection in the uninfected partners of a long discordant relationship. The findings will help care and treatment to protect marriage and cultivate fertility regulation.
4. Attempt to unravel problems at play in precipitate labour (1% of women). The outcome will elucidate factors to prevent undue crisis in the management of these cases of women whose labour lasted below one hour.
5. With the sustained advancement in obstetrics, motherhood may be relative: By retrieving eggs and embryos from some women and implanting them in others, medical practitioners will gain unprecedented control over motherhood itself. Motherhood as a unified biological process will be effectively deconstructed in place of “mother”. There will then be the ovarian mothers who supply the eggs; Uterine mothers/Surrogate mothers who nurture

the pregnancies and give birth to the new-borns and the Social mothers who raise the babies.

RECOMMENDATIONS

The Government

- Government should put in place a certification procedure for skilled birth care backed by appropriate legislation
- Skilled, responsive and friendly birth centres to capture the masses in our society
- Enforce due process on the birth and death registration in all political wards of the country
- Wide spread media visibility should focus on women's right to make free decisions about their reproductive lives through sensitizations.
- While asking for Nigerian women representation, let us advocate for right birth, action plan (such moves will transform the societies (Obstructed labour may translate to deviant behaviour, mental retardation, strife and violence).
- Use the cell phones, radio waves, Television screens to drive home the messages. Imagine/imposing electronic childbirth images/Information Education and Communication concepts by LGA in place of political billboards running into multimillions.
- The Government at various levels should strengthen effective emergency obstetric services for the communities.

Academic/Educational Programmes of Training and Action

- Train a critical pool of medical manpower to meet the maternal needs of the rural settings.

- The University should design and organise short module courses for health care providers for improvement in skills and knowledge (through our Institute Maternal and Child Health).
- Family life education should commence in early primary school and University should incorporate the concept of safe birth in the general study programme
- The University should include family life education and reproductive health as mandatory GES courses to educate our teeming student population who will be mothers and fathers of tomorrow.
- Institute a birth alert project in collaboration with public and private health facilities on universal obstetric emergency coverage to treat emergencies and complications when there is need.
- The protection of our birth concept and culture at present are mostly speculative as an investment for the future; not as temporary concerns for the happenings of today. As a nation, there must be a national and political will to protect our women at pregnancy and childbirth.
- Validate and activate the University HIV workplace policy for the teeming staff and student population. This will reduce HIV infection in young people as well as reduce paediatric HIV through MTCT.

Re-orientation of the communities/media

- ❖ Enlist the partnership of the Entertainment Industry such as Nollywood to drive home points and messages on maternal health
- ❖ Enlist collaboration with the Mobile Telephone Networks to publicise right birth messages

- ❖ Sensitize the communities and if need be, create a role change for the innocuous TBAs in the community service
- ❖ Enact community programmes for behaviour change
- ❖ Retraining of health staff at the LGA for meaningful transformation
- ❖ Educate women folk and families on birth plan and birth preparedness
- ❖ Train more health personnel for urban and rural maternity services.



Figure 19: *Right birth in all races produces Quality Babies*

CONCLUSION

Mr Vice Chancellor Sir, I will conclude not on a sad note of the long account of perils and pains of birth. Now that we appreciate the sovereign right of mothers, lets us forbid the wrong acts, act right that our births will go right. It is not only about millions of people making childbirth but about childbirth making quality Nigerian new-borns for a better nation devoid of economic asphyxia and obstructed development.

We have learnt that when we do things contrary to the right frame, we set the stage for complications. When we fail to protect, respect and defend rights of women, things go wrong. What does it take to get it right? We need to commit the right resources, right funding

and right personnel will help to prevent wrong birth (crises and catastrophes).

These reflections will create a new culture of birth and the right births for a great nation such as ours.

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CITATION ON
PROFESSOR CHRIS IHEANACHO AKANI
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1. Chris Iheanacho Akani, a Professor of Obstetrics and Gynaecology is a 1981 Bachelor of Medicine, Bachelor of Surgery graduate of the University of Ibadan. He holds the post graduate fellowship degree of the West-African College of Surgeons in Obstetrics and Gynaecology. His core research interests are fetomaternal medicine, paediatric and adolescent gynaecology, and reproductive health linked to women's rights.

Born in 1955 in Aba, he hails from Rumuola town in Port-Harcourt, Rivers State. He commenced his primary school education at St. Michael's Boys School Aba. With a division one at the West African school certificate examinations, Chris gained admission to study medicine at the University of Ibadan in 1975.

2. Chris Akani had won many awards and scholarships. He is a life member of the Society of Obstetrics and Gynaecology of Nigeria, a convinced defender and advocate of women's rights.

3. He was Professor and Head of Department of Obstetrics and Gynaecology 2008-2010, a former Dean of Clinical Sciences 2010 to 2011 and is currently the Provost College of Health Sciences. He serves in many University Boards including Business School, University/Industry Partnership and the University of Port Harcourt Teaching Hospital. He has been editor and now a reviewer for several local and international journals. An examiner at the West African Post Graduate Examinations, he has over 50 published articles in local and international journals to his credit. He is a member of International Federation of Obstetrics and Gynaecology. He was Former Chairman of the Rivers State HIV Strategic Plan and visiting Professor to the Rivers State Government; he is a recipient of the Award of Justice of Peace.

Prof Chris Akani is an external examiner in obstetrics and gynaecology to various universities.

Our inaugural lecturer today is a royal breed of excellent birth, an articulate mentor, an academic per excellence, ardent believer in the faith, a refined administrator who has given all to the society, families, mothers and new-borns.

4. Vice chancellor sir, ladies and gentlemen! I present to you, the man to deliver the 116th Inaugural Lecture of the University of Port Harcourt.

Professor J.I. Ikimalo